STATE OF WASHINGTON

WASHINGTON STATE HEALTH CARE AUTHORITY
REQUEST FOR PROPOSAL (RFP)
NO. K1807

PROJECT TITLE: Administrative Services & Health Transformation Services—HCA Self-Insured Medical Plans

PURPOSE: The Washington State Health Care Authority (the HCA) is issuing this Request for Proposal (RFP) to execute a contract with an experienced entity to provide two categories of services for the HCA's current and possibly future self-funded medical plans, including its largest, the Uniform Medical Plans (UMP Plans).

EXPECTED PERIOD OF CONTRACT: The initial Contract term will be from January 1, 2018 through December 31, 2029. Implementation will begin in January 2018 and is expected to go through December 2019. Administration services will not begin until January 1, 2020. Upon expiration of the Contract, there will still be sixty (60) months of Claims runout. The Contract may be extended for up to an additional seven (7) years in increments of not less than one (1) year.

ELIGIBILITY TO BID: This procurement is open to entities that satisfy the minimum qualifications stated herein. The HCA will not accept a Proposal from any Bidder who does not meet and demonstrate the required minimum qualifications.

AMERICANS WITH DISABILITIES ACT (ADA): HCA complies with the ADA. Bidders may contact the RFP Coordinator to receive this RFP in Braille or tape.

PROPOSAL DUE DATE: Proposals are to be submitted on or before **April 21, 2017**, no later than **3:00 pm Pacific Time**.

It is the responsibility of each bidder to carefully read, understand, and follow all of the instructions contained in this RFP document and all amendments.

The HCA reserves the right to cancel or reissue this RFP at any time prior to execution of a Contract and for any reason.

Key dates in the Procurement Schedule are listed below. The HCA reserves the right, in its sole discretion, to change the Procurement Schedule at any time and for any reason.

Procurement Schedule

Activity	Due date/time
Pre-Bid Conference #1	July 22, 2016
Pre-Bid Conference #2	September 7, 2016
RFP Released	November 21, 2016
Letters of Intent and DSA for Data Files Due	December 16, 2016
Round 1 - Bidder Questions Due	January 4, 2017
Anticipated Release of Responses to Bidder Questions	January 20, 2017
Round 2 - Bidder Questions Due	February 24, 2017
Repricing Files Due to Milliman	March 1, 2017
Anticipated Release of Responses to Bidder Questions	March 15, 2017
Complaints Deadline	April 14, 2017
Repricing Files Finalized	April 21, 2017
Proposals Due	April 21, 2017 – 3:00 pm PT
Evaluation Period	April 24 – July 7, 2017
Finalist Announcement for Oral Presentations	July 7, 2017
Finalist Oral Presentations	July 17 – 21, 2017
Anticipated Announcement of ASB	August 25, 2017
Debrief Period	August 31 – September 5, 2017
Protest Period End Date	September 12, 2017
Contract Negotiations	September 13 – December 30, 2017
Contract Signed	December 31, 2017

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SECTION 1 – GENERAL INFORMATION

1.1 Introduction

The HCA is issuing this RFP to execute a contract with an experienced entity to provide two categories of services for the HCA's self-funded medical plans:

A. Administrative Services, including Clinical Management Services, such as implementation of HCA clinical policies, claims adjudication of worldwide claims, clinical and quality management and improvement, Member services, development and maintenance of a statewide and national provider network, account management, and online tools and services.

B. Health Transformation services, such as assistance with development and implementation of health transformation and Value-Based Payment strategies related to UMP Plans in alignment with Healthier Washington initiatives, including offering an Accountable Care Organization (ACO) commercial product that includes key components of HCA's Accountable Care Networks (ACNs). The ASB will be expected to change its own business practices and payment strategies to accelerate health transformation.

Currently, these self-funded health plans are organized under the branding convention Uniform Medical Plan or UMP. The current UMP Plans are: UMP Classic (a Preferred Provider Organization (PPO)) program, UMP Consumer-Directed Health Plan (UMP CDHP), and UMP Plus. UMP Plus has two ACNs but have the same benefit design. Administrative, Clinical Management and Health Transformation services for these plans are included within this RFP.

The HCA will select an Apparently Successful Bidder (ASB) that demonstrates:

A. Strong alignment with the HCA's purchasing and health transformation vision, including the HCA's Value-based Roadmap, as well as a demonstrated commitment and capability to implement other Value Based Payment models;

B. Commitment to active partnering and engagement with the HCA, the PEB Division, Members and their employing agencies, other UMP Plan contractors, and other key health partners to drive innovation in health care purchasing and delivery system reform in Washington State; and

C. Capacity and flexibility to implement HCA directed initiatives specific to the UMP Plans.

Prior to the launch of the implementation of administrative services on January 2020, the ASB will be expected to perform the following services:

A. Begin a structured Contract implementation plan beginning January 2018.

B. Support the HCA's annual Open Enrollment activities in fall 2019 for the 2020 plan year as specified by the HCA.

C. Provide all contracted administrative and Clinical Management Services and all other contracted responsibilities beginning January 1, 2020.

The HCA will retain full authority for benefit design, Clinical Management programs and quality measures, designation of a pharmacy benefits manager for the UMP Plans (UMP PBM), Member eligibility, customization of medical policies, development of customized provider agreements, and/or approval of the overall administration of the plans, including communications to Enrollees.

This is <u>not</u> a solicitation for an off-the-shelf commercial PPO health plan designed by the Bidder. The Bidder must demonstrate the ability to provide all staffing, systems, and procedures required to perform the services described in this RFP, have the ability to customize those systems to meet the needs of the UMP Plans, and demonstrate a culture of flexibility, innovation, and adaptability in order to develop

and administer innovative health care solutions and strategies that align with broader, evolving health care changes.

1.2 Background

A. HCA and its Purchasing Vision

The HCA is a cabinet-level agency within the Washington State executive branch and governed by chapter 41.05 Revised Code of Washington (RCW). The HCA's responsibilities include the administration of the PEBB "health care benefit programs for employees and retired or disabled school employees as specifically authorized" by statute, and of the Medicaid program (a total of 2.2 million Washington residents). As of November 2016, the HCA manages fully insured and self-insured Health Plans for approximately 361,000 persons.

"Paying for Value" is a core strategy of the Healthier Washington initiative, which charts a bold course for transforming the way health care is delivered and paid for in Washington State. Under RCW 41.05.021, HCA is required "to increase the use of value-based contracting, alternative quality contracting, and other payment incentives that promote quality, efficiency, cost savings, and health improvement, for Medicaid and public employee purchasing". 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."

As the largest purchaser of health care services in Washington State, the HCA is changing how it purchases health care so that payment is based on value, not volume. In the HCA Value-based Roadmap (Appendix 6, Attachment 9), the HCA has pledged that 90% of HCA provider payments under Medicaid and the UMP Plans will be linked to quality and value by 2021 (as defined by the CMS Health Care Payment Learning & Action Network (LAN) Alternative Payment Model categories 2c-4b). (See Exhibit 1, Chart 1). By changing payment, the HCA hopes to fundamentally change how care is delivered. New population-based models of care will promote patient-centered care delivered at the right time, and in the right setting.

To accelerate market transformation, the HCA is engaging payers, providers, and other purchasers to align accountable care strategies, population-based models of care, and basic delivery system requirements across Washington State in tandem with its own State-purchasing efforts.

B. Health Plan Information

The HCA currently manages fully insured and self-insured health benefits plans for approximately 361,000 persons in the Health Plans. The Health Plans currently include:

1. Three (3) UMP Plans: UMP Classic (non-Medicare and Medicare), UMP CDHP, and UMP Plus (with two separate ACNs) (all are Self-funded PPOs — 239,119 Members)
2. Group Health Cooperative (GHC) Classic, GHC Value, GH CDHP, Sound Choice, and two (2) options for Medicare retirees (Insured Group Plan – 106,084 Members)
3. Kaiser Permanente (KP) Classic, KP CDHP, and one (1) Medicare retiree plan option (Insured Group Plan –6,110 Members)
4. Premera Medicare Plan F supplement plan (Medicare eligible only – 10,686 Members)

(See Appendix 2 for detailed enrollment information of the UMP Plans.)

C. PEBB Populations

The PEBB currently offers benefits to all state agency and higher education employees and retirees in Washington, and employees and retirees of certain other entities that meet specific

criteria that qualifies them as a public entity as mandated in chapter 41.05, RCW. The state agency and higher education employees are offered a complete package of benefits that includes all of the Health Plans and additional coverages for other benefits. Other public entities, such as cities, counties, or other local political subdivisions, can choose to subscribe to the complete package of PEBB benefits or only enroll within the Health Plans. All retirees of the K-12 system are also eligible to enroll in the Health Plans.

While all school districts qualify for PEBB benefits under Title 41.05, RCW, currently only smaller districts offer these benefits. Most active K-12 teachers and school employees are covered by medical plans arranged by their individual employing school districts and collective bargaining units. The HCA's 2015 estimate of total employees and Dependents for the K-12 teachers and school employees is between 200,000 to 250,000 persons.

The legislature has considered expanding the role of the HCA to include consolidated purchasing and management for all Washington K-12 employees' health benefits. Legislation passed in 2012 (RCW 41.05.655) directed the HCA to study options for such a change. The goals of the potential change are:

1. Improve transparency of health plan Claims and financial data;
2. Create greater affordability for full family coverage, and greater equity between premium costs for full family and employee only coverage for the same benefit plan;
3. Promote health care innovations and cost savings, and significantly reduce administrative costs; and
4. Provide greater parity in state allocations for state employee and K-12 employee health benefits.

A legislative decision on the mandatory inclusion of all K-12 employees in the UMP Plans may occur in the foreseeable future, potentially impacting the Contract. The HCA does not make any guarantees on whether, when, or how any such change may occur. All proposed Administrative Fees are guaranteed maximums for all HCA medical plans administered under the Contract regardless of the number of Health Plans introduced or any increase in the number of Subscribers. In the HCA's sole discretion, the Contract could be expanded by legislation or other decisions by the HCA for newly covered Members. At such time, there will be no change in Administrative Fees for the newly covered Members beyond the PSPM rates agreed to by the HCA and the ASB for the current UMP Plans.

D. UMP Plans

Currently, there are three (3) different types of plans offered under the UMP name: UMP Classic, UMP CDHP, and UMP Plus with ACNs for Puget Sound High Value Network and for University of Washington Medicine Accountable Care Network.

All UMP Plans share the following characteristics:

1. A defined scope of covered and excluded services through a Certificate of Coverage.
2. Consistent non-Medicare, medical policies and medical necessity criteria across all UMP Plans, unless otherwise directed by the HCA.
3. Services must be medically necessary.
4. Some services require pre-authorization/plan notification.
5. Pharmacy benefits management and network administered by Moda Health, the pharmacy benefits manager for the UMP Plans (UMP PBM), as Washington State Prescription Services.

6. Worldwide coverage for services that would be covered by each UMP Plan within the U.S.
7. Specific preventive care services with no cost sharing when the Member obtains services from a network provider
8. No requirement for selecting a designated Primary Care provider; this policy may be changed in future years.

The ASB will also oversee provider network reimbursement rates for all of the UMP Plans. The network must include Washington State and national negotiated rates (including all other 49 states, the District of Columbia, and all US territories), and in-network reimbursement rates for covered services outside the United States. The ASB will have to integrate statewide custom networks for some of the UMP Plans (such as UMP Plus) and update the network and provider search tools on a monthly basis.

For some UMP Plans, there are covered services administered through other HCA contractors such as a prescription drug benefits and bundled payments for episodes of care. The HCA also has a wellness contractor to administer wellness services for all Health Plans. For those Subscribers who complete wellness activities, wellness incentives are administered through the UMP Plans that lower Member cost-sharing either through a lower deductible or increased HSA contribution.

Subscribers have the option to select from any of the Health Plans each plan year during an annual Open Enrollment occurring in November. The HCA will proactively inform all Subscribers of the changes to the UMP Plans in order to facilitate informed decisions during the Open Enrollment period.

Currently, Enrollees who do not actively select a Health Plan are automatically enrolled in the UMP Classic plan at Subscriber-only coverage with no coverage for any Dependents. Enrollees can waive PEBB medical coverage only if the Enrollee is enrolled in another employer-based group medical insurance, Tricare, or Medicare. UMP Plans follow Affordable Care Act (ACA) mandates as required.

UMP Plan premiums for calendar year 2017 can be found at: http://www.hca.wa.gov/public-employee-benefits/employees/medical-plan-premiums#Medical-plan-premiums

Features unique to each UMP Plan are briefly listed below. Additional descriptions can be found on the HCA website located here: http://www.hca.wa.gov/public-employee-benefits. Current Plan Summary Coverage (for plan year 2016) for UMP Plans can be found in Table 1.2.1, below.

1. *UMP Classic*

   UMP Classic allows Members to choose providers within an extensive PPO network, or out-of-network with a higher Member cost-share. Medicare-primary Members are eligible for the same covered services as active or non-Medicare retiree UMP Classic Members, including some services not covered by Medicare, or which UMP Classic covers to a greater extent than Medicare.

2. *UMP CDHP*

   UMP CDHP has the lowest monthly premium contributions and features a Health Savings Account (HSA) with employer contributions. The deductible and out-of-pocket limits are “combined” to include both medical and prescription drug costs. Some services covered by UMP CDHP are subject to the medical deductible when the same service covered by UMP Classic or UMP Plus is not subject to the medical deductible.

UMP CDHP uses the same provider network and UMP PBM as UMP Classic, and covers the same services. The ASB will be required to submit daily file feeds to the UMP PBM for accumulators for the UMP CDHP.

3. *UMP Plus*

UMP Plus features two (2) clinically integrated care networks, within a limited geography. UMP Plus is offered to non-Medicare eligible Enrollees in eligible counties. There are currently two (2) ACNs included as part of UMP Plus: 1) Puget Sound High Value Network; and (2) University of Washington Medicine Accountable Care Network. HCA directly contracts with both ACNs, and the current UMP TPA supports UMP Plus by providing administrative services, including sharing data on a timely basis. Both ACNs assume clinical accountability and financial risk for Members, and risk is shared by the HCA and the ACNs. Benefits are designed to promote Primary Care and limit out-of-network use. For example, Members receive no cost-share Primary Care office visits when seeing a UMP Plus Primary Care provider. The UMP Plus medical deductible and premium are lower than UMP Classic, and there is no deductible for prescription drugs. The monthly premium contribution is the same for both ACNs.

Starting in January 2017, UMP Plus enrollment is limited to Enrollees residing in the Washington state counties of King, Kitsap, Pierce, Snohomish, Thurston, Grays Harbor, Spokane, and Yakima. Each ACN has the authority to add or subtract counties annually. This is considered part of the service relating to benefit changes and will be expected to be part of the UMP Plus Administrative Fee, and no additional allowances will be paid for these types of changes in the UMP Plus plans. The HCA expects UMP Plus will be offered statewide.

E. UMP Plans Regulatory Environment

The UMP Plans operate in a unique regulatory environment. Bidders should be conversant with all statutory requirements pertaining to the PEBB, including but not limited to the provisions of RCW 41.05 that define some benefits and administrative features of the UMP Plans. The UMP Plans are not subject to all provisions of ERISA. Instead, the UMP Plans are subjected to the Public Health Services Act (42 U.S.C. 6A). These plans are also subject to certain requirements in chapter 48.43 RCW, including the Washington Patient Bill of Rights (as described in RCW 41.05.017), and Chapter 70.14 RCW, which sets requirements for health care services purchased by state agencies.

The UMP CDHP is regulated by the IRS and the U.S. Department of Health and Human Services to ensure it is a qualified High Deductible Health Plan (HDHP), which ensures Subscribers may make pre-tax contributions to a HSA.

F. Other PEBB Offerings - Out of Scope

For the purposes of submitting a Proposal, the current Group Health, Kaiser, and Premera plans are outside of the scope of this RFP. Also outside of the scope of this RFP are administrative services for the PEBB's Flexible Spending Account (FSA), and the UMP PBM. However, the HCA reserves the right to add administration of these and other functions and services, or other newly developed plans, during the life of the resulting Contract.

G. Changes in the UMP Plans

The HCA may add or drop health benefit plans to or from the UMP Plans at any time (with ninety (90) Days' notice) as the agency serves under the direction of the PEBB and can be mandated to action by the state legislature. These directives may also include additional Health

Plans without the UMP name if the HCA is required or chooses to add additional populations, such as Washington State active K-12 employees and Dependents.

Table 1.2.1 HCA Current Plan Summary (as of 2016 Coverage Year) For UMP Plans

UMP Classic								
Premiums	**Deductibles**	**Out-of-Pocket Limits**	**Provider Networks**	**Network Reimbursement**	**Out-of-Network Reimbursement**	**Prescription Drugs**	**Facility/Hospital Charges**	**Special**
Highest of UMP Plans	**Medical:** $250 per person, $750 family maximum for three (3) or more **Prescription drug:** $100 per person, $300 family maximum for three (3) or more	**Medical:** $2,000/$4,000 family maximum **Medicare retirees (Medicare-primary):** $2,500/$5,000 family maximum **Prescription drugs:** $2,000 per person, no family maximum	Currently Regence BlueShield network within Regence Service Area. BlueCard affiliates outside service area	Plan pays 85% of allowed amount, Member pays 15%. **Preventive care**: Specific services covered in full, not subject to medical deductible	Plan pays 60% of allowed amount. Member pays 40% remaining, plus any amount billed by the provider over the allowed amount. **Preventive care:** Not subject to medical deductible, but still pay out-of-network coinsurance.	Based on tier system; for most generic drugs, the Member doesn't pay the prescription drug deductible. Member pays more for certain high-cost generic and brand-name drugs.	For preferred facilities: Member pays $200 per Day, up to $600 annually for inpatient facility charges. For Medicare-primary Members: The inpatient copay is $200 per Day, with a maximum of $600 per inpatient stay (up to the medical out-of-pocket limit). Professional providers bill separately from the facility, and are paid according to the provider's network status.	Only UMP plan that regularly offers coverage to Medicare-primary Members. Emergency care: Members pay a $75 copay. May participate in medical flexible spending arrangement under the PEBB.

UMP CDHP								
Premiums	**Deductibles**	**Out-of-Pocket Limits**	**Provider Networks**	**Network Reimbursement**	**Out-of-Network Reimbursement**	**Prescription Drugs**	**Facility/Hospital Charges**	**Special**
Lowest of UMP Plans	**Combined:** Applies to both medical services and prescription drugs. $1,400 for one (1) person on account; $2,800 for account with more than one (1) person	**Combined:** Applies to both medical services and prescription drugs. $4,200 for one (1) person on account; $8,400 for account with more than one (1) person Note: A single person will pay no more than $6,850 for out-of-pocket covered services per year	Same as UMP Classic	Plan pays 85% of allowed amount, Member pays 15%. Preventive care: Specific services covered in full, not subject to deductible.	Plan pays 60% of allowed amount. Member pays 40% remaining, plus any amount billed by the provider over the allowed amount. Preventive care: Not subject to deductible, but still pay out-of-network coinsurance	Once deductible is met, the Member pays 15% for all covered drugs, up to the out-of-pocket limit. The same limits apply as for UMP Classic and UMP Plus (quantity limits, step therapy, refill too soon, TIP).	Member pays facility charges based on coinsurance; no inpatient copay	HSA: Subject to IRS rules regarding annual contributions. May use HSA funds for any qualified medical expenses, including those not covered by UMP CDHP. May not participate in medical flexible spending arrangement under the PEBB. IRS rules preclude most Dependents from being enrolled in UMP CDHP and Medicare-primary.

UMP Plus								
Premiums	**Deductibles**	**Out-of-Pocket Limits**	**Provider Networks**	**Network Reimbursement**	**Out-of-Network Reimbursement**	**Prescription Drugs**	**Facility/Hospital Charges**	**Special**
Mid-range of UMP Plans	$125 per person, $375 family maximum for three (3) or more (lowest of UMP Plans) No deductible for prescription drugs	**Medical**: $2,000/$4,000 family maximum (same as UMP Classic) **Prescription drugs**: $2,000 per person, no family maximum (same as UMP Classic)	More complex than the network for UMP Classic and UMP CDHP. Networks are specific to UW and PSHVN providers except for ancillary services (currently UMP TPA network). Primary Care and Specialty providers must be in the Member's UMP Plus network to be covered at the network rate. ACN Ancillary Providers in the UMP Plus Service Area are covered as network for both UMP Plus networks Emergency and urgent care: May use Regence network providers and	**Providers outside both the UMP Plus and Regence networks:** Member pays 50% of the allowed amount, plus any amount billed by the provider over the allowed amount.	Identical to UMP Classic Based on tier system; for most generic drugs, the Member doesn't pay the prescription drug deductible. Member pays more for certain high-cost and brand-name drugs.	**For preferred facilities:** Member pays $200 per Day, up to $600 annually for inpatient facility charges. Professional providers bill separately from the facility, and are paid according to the provider's network status.	Coordinated Care by high-quality provider networks to improve patient outcomes, reduce cost, and enhance patient satisfaction. No-cost primary care services when seeing a Primary Care provider within the Member's UMP Plus network (not just preventive services). Emergency care: Member pays a $75 copay. May participate in medical flexible spending arrangement under the PEBB.	UMP Plus: Plan rules don't allow Medicare-primary Members to be enrolled in UMP Plus.

			receive network-level reimbursement. Certain services are considered exceptions; providers outside the UMP Plus or Regence networks may be paid at the network rate.					

*Applies to covered services only.

H. SmartHealth Wellness Program

SmartHealth is a voluntary and confidential wellness program offered by the PEBB. The program offers a financial wellness incentive to Subscribers enrolled in a Health Plan, including the UMP Plans. To qualify, a Subscriber must be an employee; leave without pay Subscriber; or retiree, COBRA, or PEBB Extension of Coverage Subscriber not enrolled in Medicare Part A and Part B.

To earn the wellness incentive, Subscribers must earn a certain number of points by completing a health assessment and joining activities featured on the SmartHealth website (https://smarthealth.hca.wa.gov). In January, Subscribers receive the wellness incentive earned the previous year (currently $125). The deductible for Subscribers in UMP Classic and UMP Plus are reduced by $125. For Subscribers in UMP CDHP, an additional $125 is deposited into their Health Savings Account.

I. Eligibility Administration of Plan

Determination of eligibility criteria for coverage for all Health Plans is the statutory responsibility of the PEBB (WAC 182-12-114), and is not open for alternative Proposals under this RFP. Agency benefits officers also make eligibility decisions for active employees within each state agency. The ASB will receive daily eligibility files from the HCA. The ASB is responsible for generating unique Member identification numbers for eligible Members, maintaining accurate and complete Coordination of Benefits information, and passing that information on to other contractors working with the HCA. This includes a daily and weekly eligibility file transmission within HCA required timelines. The ASB is also responsible for integrating information from other contractors to achieve effective and efficient coordination of services. Social Security numbers may be required for all Members to be transferred to other HCA vendors from the ASB. Quarterly reconciliation file audits will also be required with other vendors and the HCA.

The HCA expects to change its eligibility information system in the coming years. The details of the new system are under development and are not available at this time; however, the ASB should expect that some aspects of the electronic data interface may change as a result. For example, the new system may add unique identifiers instead of requiring the ASB to generate them (but the ASB would be required to use the HCA-generated unique identifier), and the interface may be with an application service provider instead of the HCA.

J. PEBB Responsibilities and the HCA's Final Authority

While determination of eligibility criteria is the statutory responsibility of the PEBB, the HCA retains administrative responsibility for individual eligibility determinations for PEBB benefits, and handles individual benefits eligibility Appeals.

The HCA retains final authority for UMP Plan administration, Clinical Management Services, and all other services required under the Contract, so the HCA reserves the right to review all activities, decisions, policies, etc., related to these services, including audits by third parties.

To effect a smooth transition of coverage, the ASB must agree that all Members enrolled under any UMP Plan will be covered on January 1, 2020, the date the HCA expects the ASB to begin providing administrative services.

K. Marketing UMP Plan Participation

The HCA is solely responsible for all marketing, advertising, education and solicitation, in any form, of the PEBB programs to all state agencies, state institutions of higher education, and other entities listed under RCW 41.05.011(6) and WAC 182-08-220. The HCA is to "publish and distribute to non-participating school districts and educational service districts by October 1 of each year a description of health care benefit plans available through the authority and the

estimated cost if school districts and educational service district employees were enrolled." (RCW 41.05.021(1)(i).) Accordingly, the ASB may only market, advertise, educate, or solicit participation in the UMP Plans with the written permission, and at the direction, of the HCA.

If the ASB has other lines of business beyond third-party administrative functions that relate to benefits offered by the PEBB, the ASB is prohibited from using any information obtained as a result of the Contract to solicit to such persons to purchase the ASB's other products or services. For example, an ASB may not solicit enrollment in their non-PEBB medical plans, including Medicare Advantage, Medicare Supplement, Medicaid and Health Insurance Exchange plans.

L. Other Contractors and Partners

The ASB will be required to work with a number of other contractors providing services to the HCA. This work may involve sharing eligibility, or clinical and service data, or other activities as directed by the HCA. Current contractors and services include the following and which could change from time to time at HCA's sole discretion:

1. Puget Sound High Value Network, LLC - UMP Plus ACN
2. UW Medicine Accountable Care Network - UMP Plus ACN
3. Moda, Inc. - the UMP PBM
4. Alere - Tobacco cessation
5. Milliman, Inc. - Actuarial and consulting services for the HCA and the UMP Plans
6. Mercer - Health care consulting services
7. OneHealthPort - Online Member Claim and eligibility portal for providers
8. General Dynamics MCSource - HCA Data Warehouse for clinical data collection, analysis and reporting
9. Limeade - Wellness program (SmartHealth) and incentives
10. SPH Analytics - Member experience surveys
11. Navia - Flexible Spending Account administrator
12. Washington Health Alliance - e-Value8™ and Community Checkup
13. Virginia Mason - Total Joint Replacement Center of Excellence (COE)
14. Premera - COE Third Party Administrator
15. Point B - Project Management Consulting Services

No services currently performed by other contractors are to be included in the Bidder's Proposal unless specifically requested in this RFP. In the event the HCA makes a decision to discontinue any service performed by a contractor other than the ASB, the HCA and the ASB will negotiate in good faith to incorporate such services into the Contract to the full extent permitted under Washington law.

The HCA will require the ASB to subcontract for some services with specific vendors, such as services for Diabetes Prevention Program and for a specific Health Savings Account Trustee.

1.3 Abbreviations and Definitions

For purposes of this RFP, the following abbreviations and terms have the meanings indicated below:

"**ADA**" means Americans with Disabilities Act, 42 U.S.C. §12101, and its corresponding federal regulations.

"Accountable Care Network" or "ACN" is a clinically integrated health organization with a formal network of providers and health systems that collaborates to deliver integrated care and assumes financial risk and clinical accountability for a defined population. HCA's ACNs are a part of UMP Plus, where HCA contracts directly with two networks of providers.

"Accountable Care Organization" or "ACO" is a clinically integrated health organization with a formal network of providers and health systems that collaborates to deliver integrated care and assumes financial risk and clinical accountability for a defined population. The ASB will be required to offer an ACO product to its fully-insured book-of-business.

"Accountable Communities of Health" or **"ACH"** is a regionally governed, public-private collaborative tailored by the region to align actions and initiatives of diverse coalition of players in order to achieve healthy communities. Nine ACHs serve the entirety of Washington State, the boundaries of which align with Medicaid Regional Service Areas.

"ACN Affiliate Providers" means hospitals, facilities, clinics, and physicians, including radiology, that are individually contracted with one or more ACN(s) to ensure access to providers.

"ACN Ancillary Providers" means a non-hospital provider that does not have any provider agreement with an ACN and have been designated by the HCA as an Ancillary Provider.

"ACN Partner Providers" means the core hospitals, facilities, clinics, and physicians, including radiology, with partner provider agreements, with one or more ACN(s).

"**ACN Providers**" means ACN Affiliate Providers, ACN Ancillary Providers, and ACN Partner Providers.

"ACN Welcome Packet" means materials that inform Members of the provider network and value-added services provided by the applicable ACN.

"Administrative Fee" means the monthly administrative fee for each UMP Plan set forth in Appendix 6, Attachment 27, Administrative Fees.

"Appeal" means a written or oral request for reconsideration of a decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services, including the admission to, or continued stay in, a health care facility.

"All-Payer Claims Database" or "**APCD**" means Washington's statewide all-payer health care claims database to support transparent public reporting of health care information as described in RCW 43.371.020.

"ASB" means Apparently Successful Bidder; the Bidder selected to be contracted as a result of the evaluation of Proposals. ASB is synonymous with Prime Contractor**.**

"Award" means to grant a Contract to a successful Bidder, which occurs on the date as specified in the award notice.

"Auto Adjudicate" means Claims received that were adjudicated without human intervention.

"BAA" means a Business Associate Agreement between HCA and Contractor regarding the protection of Personal Health Information as required by HIPAA.

"Behavioral Health" is a term used to refer to both mental health and substance use disorder treatment.

"BAFO" means Best and Final Offer. A BAFO may be requested by the HCA in order to permit improvements to certain Bidders' Proposals.

"Bidder" means each entity submitting a Response to this Request for Proposal.

"Book-of-Business" means all commercial business of the Bidder including fully-insured and self-insured products within the Bidder's accounts.

"Bree Collaborative" is a statewide public-private consortium 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." Annually, the Bree Collaborative identifies up to three areas where there is substantial variation in practice patterns and/or high utilization trends that do not produce better care outcomes. Recommendations from the Bree are sent to the HCA to guide state purchasing for programs such as Medicaid and Public Employees Benefits Board.

"Business Day" means Monday through Friday, 8:00 a.m. to 5:00 p.m., Pacific Time, except for holidays observed by the state of Washington, unless otherwise specified within the RFP.

"Care Coordination" is the coordination of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

"Case Management" is a collaborative process of assessment, planning, facilitation, Care Coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

"Certificate of Coverage" or **"COC"** is a summary of the essential features of the group coverage contract produced and made available to each covered person. "COC" is the UMP Certificate of Coverage, and, as the context requires, the plan year version in effect on the date of service.

"Chronic Care Model" means a multifaceted, evidence-based framework for enhancing care delivery by identifying essential components of the health care system that can be modified to support high-quality, patient-centered chronic disease management.

"Claim" is the written notice on a form acceptable to the TPA for reimbursement for any health care service or supply pursuant to the terms of the applicable Certificate of Coverage.

"Clinical Management" means the programs that apply systems, science, incentives, and information to improve medical practice and assist both consumers and their support system to become engaged in a collaborative process designed to manage medical/social/Behavioral Health conditions more effectively. The goal of Clinical Management is to achieve an optimal level of wellness and improve Care Coordination while providing cost effective, non-duplicative services.

"Clinical Management Services" means the use of best practice recommendations (such as the Bree Collaborative recommendations) in the provision of Clinical Management to support optimal health outcomes, in collaboration with the HCA's clinical team; proactive identification and management of Members who are at risk for health service utilization; provision of patient decision aids to support appropriate patient self-management; collaboration and integration with providers and delivery systems; reduction of unnecessary variation in clinical practice; and lower healthcare costs.

"CMS" means the Centers for Medicare and Medicaid Services, an agency of the federal government.

"COBRA" means Consolidated Omnibus Budget Reconciliation Act. COBRA requires employers to offer continuation of group health and/or dental benefits for a specified time to individuals who would otherwise lose coverage due to certain qualifying events.

"COE" means a Center of Excellence, a health care provider or facility that is identified by the HCA as a high quality, cost efficient provider that produces the best outcomes for a specific service.

"Common Measure Set" a set of statewide measures for Washington State that provide the foundation for health care accountability and measuring performance. The Performance Measures Coordinating Committee, which was created by legislation (RCW 41.05.690), approved a "starter set" of measures in December 2014 that are intended to evolve over time as the science of measurement and state priorities evolve.

"Complaint" means an oral or written expression of dissatisfaction submitted by or on behalf of a Member regarding:

a. The denial of health care services or payment for health care services;

b. Issues other than denial of or payment for health care services, including dissatisfaction with health care services, delays in obtaining health care services, conflicts with carrier staff or providers; or

c. Dissatisfaction with UMP Plan practices or action unrelated to health care services.

For the purpose of this document, grievances are considered to be the same.

"Contract" means the written agreement between the ASB and the HCA, including all exhibits, schedules, attachments, and other terms or documents referred to incorporated by reference or attached hereto. The HCA's proposed contract can be found in Appendix 6, Attachment 2.

"Coordination of Benefits" or **"COB"** is defined in WAC 284.51.195(7).

"Covered Lives" means the number of people enrolled in a particular health insurance plan**.**

"Day" is calendar Day, including weekends and holidays. All statements referring to a number of Days mean calendar days, regardless of the number of Days, unless something different is explicitly specified. If the time when something must be performed falls on a weekend, a day observed as a holiday by the State of Washington as an employer, or a day when HCA is officially closed for other reasons, then that action is due on the next Business Day. Day one is the Day after receipt, unless something different is explicitly specified.

"Dependent" means an eligible spouse, Washington State registered domestic partner, and/or dependent child of a Subscriber, who meets the eligibility requirements of WAC 182-12-260.

"Employee" shall have the meaning set forth in WAC 182-12-109**.**

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-12 WAC, and (1) is enrolled in PEBB benefits for whom all applicable premium payments and any applicable premium surcharges have been paid, or (2) waived medical coverage available as a PEBB benefit.

"Evaluation and Scoring Insight" means the key factors, if any, that will be considered by the HCA in the evaluation of the Bidder's Response to such exhibit.

"e-Value8" is a program of the National Business Group on Health which measures and evaluates health plan performance. The Washington Health Alliance deploys e-Value8 in Washington State every other year.

"Explanation of Benefits" or **"EOB"** is a statement sent to covered individuals explaining what medical treatments and/or services were paid on their behalf.

"Fee-for-Service" or "FFS" means payment to health care providers on the basis of each service performed, such as an office visit, test, or procedure; currently, the predominant reimbursement methodology in the United States and in Washington.

"Foreign" means not within United States, and outside the United States.

"Foundation for Healthcare Quality" means a non-profit organization based in Seattle that coordinates hospital Quality Improvement programs in the state of Washington. Among the projects are the: Surgical Care and Outcomes Assessment Program (SCOAP) and Cardiac Care and Outcomes Assessment Program (COAP).

"HCA Senior Account Sponsor" means one or more employee of the HCA designated to represent HCA in matters relating to the Contract.

"**HCA Value-based Roadmap**" is the HCA's plan to guide achievement of the HCA's Value Based Payment goals. Created in June 2016 and updated periodically, this document braids together various initiatives, including four payment models, a Medicaid transformation demonstration project, and engagement activities within the broader health care marketplace.

"**HDHP**" means an IRS-qualified high-deductible health plan that allows for tax-deferred contributions to a health savings account.

"**Health Benefit Exchange**" is responsible for the operation of Washington Healthplanfinder, an easily accessible, online marketplace for individuals, families, and small businesses to find, compare, and enroll in qualified health plans and Washington Apple Health (Medicaid).

"Health Care Quality" means the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

"Health Literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

"Health Plan" means one of the fully-insured or self-insured medical plans offered by the HCA**.** Each "Health Plan" includes a Certificate of Coverage for services relating to medical, Behavioral Health, and pharmacy claims.

"**Healthier Washington**" is the state initiative aimed at health transformation so Washington State residents experience better health and receive better, more affordable care.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended from time to time, and its corresponding federal regulations.

"HMO" means Health Maintenance Organization.

"HSA" means Health Savings Account, a tax-advantaged medical savings account linked to the UMP CDHP in which Members, the employer, and others may deposit funds**.**

"HSA Trustee" means the subcontracted IRS-qualified trustee responsible for managing HSAs for all UMP CDHP Members.

"HTCC" means Health Technology Clinical Committee as established under statute RCW 70.14.080.

"Independent Review Organization" or **"IRO"** shall have the meaning set forth in WAC 246-305-010(14).

"Key Elements to Be Addressed" means essential items that must be addressed in the Bidders' Responses and that when absent may render a Response to the relevant exhibit non-responsive.

"Key Subcontractor" means an entity that the Bidder plans to utilize for the purposes of services described in this RFP that will be involved in any activities involving account management, network management, direct Member contact, access to Personal Health Information, access to other information controlled by HIPAA or data security provisions, or sensitive financial information.

"LAN" means the Health Care Payment Learning and Action Network, a collaborative effort between Department of Health and Human Services, acting through CMS, and its private, public, and non-profit partners to transform the nation's health system to emphasize value over volume.

"Medical Drugs" means oral or infused drugs covered under the medical benefit of the UMP Plans.

"Medical Management" means a program component of Health Plan coverage that may contain multiple systems to manage and ensure all care is appropriate, within the HCA established benefit design, and is medically necessary, effective, and cost-efficient across all medical services, procedures and facilities.

"Member" means Subscribers and their Dependents who are enrolled in a UMP Plan, and for whom applicable premium contributions and any applicable premium surcharges have been made.

"National Committee for Quality Assurance" or "NCQA" is a private 501(c)(3) not-for-profit organization dedicated to improving Health Care Quality. NCQA is the accrediting body for health plans in the United States. NCQA uses the Healthcare Effectiveness Data and Information Set (HEDIS) tool to measure health plan performance on important dimensions of care and service.

"Never Events" are adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.

"**Open Enrollment**" means the annual period during which a Subscriber can change Health Plans, add or remove Dependents, and take certain other actions regarding benefits offered through the Health Plans and other plans offered by HCA.

"Operations Manual" means the document that includes additional details and specifications regarding the performance of the rights and obligations of each party to the Contract, and attached as Appendix 6, Attachment 8.

"Part-Time Employee" means a person who meets the eligibility requirements to enroll in the PEBB benefits program as described in WAC 182-12-114.

"Patient Centered Medical Home" or **"PCMH"** means a team based primary care model that provides comprehensive and continuous care to consumers over time with the goal of improving health and health care, and lowering costs.

"Patient Decision Aids" means tools that can help people engage in shared health decisions with their health care provider

"Patient Reported Outcomes" means outcomes from medical care that are important to patients and their support groups.

"Paying for Value Survey" means the questionnaire administered by the HCA to measure payer and provider progress towards Value-Based Payment adoption. The qualitative section of the survey is included with this RFP as Appendix 6, Attachment 24.

"PEB Division" means the Public Employees Benefits Division of the HCA, which manages the operations that provide insurance coverage for Members of Washington State agencies, higher education institutions, and certain other employer groups.

"PEBB" means the Public Employees Benefits Board, which is authorized to design benefits and determine the terms and conditions for participation in health insurance benefits for eligible public employees and retirees under RCW 41.05.065.

"Performance Credit" is the financial consequence associated with failure to meet the applicable performance standards or guarantees.

"Performance Guarantee" a list of expectations that the HCA views as critical to the success of the UMP Plans. Failure to achieve a Performance Guarantee will result in the issuance of Performance Credits.

"PHI" means Protected Health Information, as defined in 45 C.F.R. §160.103.

"PMM" means Portfolio Management and Monitoring, the PEB Division section that manages all contracts for Members benefits, including the Contract for administration services for the UMP Plans.

"**PMPM**" means per Member per month.

"**Pooled Hours**" means the service hours accumulated by HCA for the performance of services in connection with the Contract, for services not within the Contract and documented through Work Orders. The term "Pooled Hours" includes both the annual number of hours for these services earned by HCA as well as the accumulated, unused hours from prior years.

"**Pooled Rate**" means the blended hourly rate for the performance of services under the Work Order process described in the Contract for service hours incurred after all Pooled Hours have been used.

"PPO" means Preferred Provider Organization. All UMP Plans are currently supported by a PPO network.

"Preferred Provider" means any provider that has contracted with the TPA to be a part of the TPA's preferred provider organization network.

"Primary Care" means any one and all of the following specialties: general practice, family practice, internal medicine, obstetrics/gynecology, pediatric medicine, geriatric medicine, nurse practitioner, preventative medicine, certified clinical nurse specialist, physician assistant, and/or nurse (non-practitioner).

"Prime Bidder" means in the case of two (2) or more entities submitting a joint Proposal, the entity designated as the HCA's sole point of contact during the procurement.

"Prime Contractor" means in the case of two (2) or more entities submitting a joint Proposal, the entity identified as the HCA's primary point of contact that bears sole responsibility for performance under a contract resulting from this procurement.

"Proposal" means the written offer submitted by a Bidder to perform a contract to supply the materials, supplies, services and/or equipment in reply to this RFP.

"PSPM" means per Subscriber per month.

"Quality Assurance" is a retrospective review process, typically focusing on individuals, that measures compliance against necessary standards.

"Quality Improvement" is a systematic and continuous set of actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

"Quality Management" is a planned systemic, organization-wide approach to the monitoring, analysis, and improvement of organizational performance, thereby continually improving the quality of patient care and services provided and the likelihood of desired patient outcomes.

"RCW" means Revised Code of Washington. Any references to specific titles, chapters, or sections of the RCW include any substitute, successor, or replacement title, chapter, or section.

"Rebates" means retrospective payments or discounts, including promotional or volume-related refunds, incentives or other credits, however characterized, pre-arranged with pharmaceutical companies on certain prescription drugs, which are paid to or on behalf of a TPA, and are directly attributable to the utilization of certain drugs by Members, including Administrative Fees and software or data fees paid by pharmaceutical companies. "Rebate" includes all rebates, discounts, payments or

benefits, however characterized, generated by Medical Drug Claims, or derived from any other payment or benefit for the dispensing or administration of prescription drugs or classes or brands of drugs within the HCA's programs or arising out of any relationships the TPA has with pharmaceutical companies, including but not limited to Rebate sharing, market share allowances, educational allowances, gifts, promotions, or any other form of revenue whatsoever.

"Required Accompanying Documents" means specified documents the HCA requires Bidders to include in Proposals in support of narrative descriptions requested for each exhibit.

"Response" means the part of a Proposal that is a flexible narrative, clearly and concisely communicating the Bidder's experience and ability to meet or exceed the key elements identified in each exhibit. The Proposal should reflect the expertise, innovation, competencies, and resources that the Bidder brings to the table through the presentation of the best scope of service the Bidder is prepared to deliver within the proposed base fee.

"RFP" means this Request for Proposals.

"Run-Out Period" means the sixty (60) months following termination of the Contract during which the ASB will provide certain administrative services as set forth in the Contract for no additional charge.

"RxBin" means an assigned data element used by a pharmacy to identify the UMP PBM.

"RxPCN" means the Processor Control Number issued by the UMP PBM to identify the HCA, Member, and the pharmacy benefit plan**.**

"Senior Account Sponsor(s)" means the HCA employee(s) that is/are appointed by the HCA to work to coordinate resources and services to meet all Contract requirements. The Senior Account Sponsor may also be referred to as the "HCA Contract Manager."

"Shared Decision Making" means a process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences.

"SmartHealth" is the PEB Division's wellness incentive program initiated by Governor's Executive Order 13-06.

"Social Determinants of Health" describes a set of factors surrounding health equity that contribute to a person's current state of health. These factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature.

"Specific Instructions" means specific processes or methodology Bidders are required to follow in submitting a Response to each exhibit.

"Subcontractor" means person, partnership, or entity not in the employ of or owned by the Bidder, who is performing all or part of those services under a separate contract with or on behalf of the Bidder. The terms "Subcontractor" mean Subcontractors in any tier.

"Subscriber" means the employee, former employee, or retiree who has signed up to participate in a UMP Plan and, as a result of his or her current or former employment, is the main account holder (i.e., not a Dependent).

"**Top Box Score**" means the percent of survey respondents who chose the most positive score for a given item response scale.

"Third Party Administrator" or **"TPA"** means an organization that processes Claims and performs other administrative services on behalf of the UMP Plans. The TPA will handle the administration of the plans including: processing and adjudication of Claims, provider network, Claims database, services described in any work orders, and all other functions and services described in this RFP.

"Triple Aim" means a framework for optimizing health system performance to improve the health of populations, improve customer experience of care (quality and patient experience), and reduce cost.

"UMP CDHP" means UMP Consumer Directed Health Plan, plan type HDHP. Subscribers enrolled in the UMP CDHP have access to a HSA and the same PPO network as UMP Classic. IRS rules control dollar limits to annual contributions, use of HSA funds, and may allow Subscribers to pay less federal taxes. The deductible and out-of-pocket limits are significantly higher, and are "combined" (include both medical expenses and prescription drug costs). HDHPs are subject to IRS rules regarding who is eligible to enroll and use HSA funds. UMP CDHP also covers the same services and is designed to be an IRS qualified high deductible health plan.

"UMP Classic" is the state of Washington's self-insured PPO medical plan. Medicare-primary Members enrolled in UMP Classic have the same covered services as all UMP Classic Members, including some services not covered by Medicare, or for which UMP Classic covers more than Medicare.

"UMP Contractor" means the primary entity with which the HCA contracts for services of the UMP Plans as a result of this procurement.

"UMP PBM" means the HCA-contracted pharmacy benefits manager for the UMP Plans, currently Moda Health and known as Washington State Prescription Services.

"UMP Plans" is the collective term referring to the self-insured medical plans UMP Classic, UMP CDHP, and UMP Plus. UMP Plans also includes any future self-insured medical plans offered to Members.

"UMP Plus" means the UMP plan that includes an affiliation with an Accountable Care Network. It is a clinically integrated health organization with a formal network of providers and health systems that collaborates to deliver integrated care and assumes financial risk and clinical accountability for a defined population. UMP Plus currently includes two distinct ACNs (the University of Washington, the ACN of Puget Sound High Value Network), and the term will also include any future ACNs added by the HCA.

"Use" means with respect to individually identifiable health information, as defined in 45 CFR § 160.103, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

"Utilization Management" or **"UM"** means the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan. Utilization Management is sometimes called utilization review.

"Value Based Payment" is a form of reimbursement that ties payments for care delivery to the quality of care provided and rewards providers for both efficiency and effectiveness. The HCA defines Value Based Payments as payment arrangements in the CMS Health Care Learning & Action Network Categories 2c – 4b (see, Chart 1 in Exhibit 1, "Overview").

"WAC" means the Washington Administrative Code. Any references to specific titles, chapters, or sections of the WAC includes any substitute, successor, or replacement title, chapter, or section.

"Writing" includes, in addition to the usual meaning, communication by electronic mail.

1.4 Minimum Qualifications

Within the Letter of Intent, provide legible copies of the appropriate documents that demonstrate how the Bidder complies with the following eligibility requirements to participate as a Bidder in response to this RFP within the Proposal. Bidder must meet these minimum requirements at the time their proposal is submitted to the HCA.

A. Must have a health plan licensed by the Washington State Office of the Insurance Commissioner (OIC) operating within Washington State.

B. Must have been issued a UBI number to operate as a licensed business in Washington State.

C. Must have experience administering or offering an Accountable Care Organization for a self-insured or fully-insured product.

D. Must have demonstrated capability to analyze data and make recommendations as to improvement strategies for cost, utilization, and quality.

E. Must currently provide Clinical Management Services, including Utilization Management, complex Case Management, chronic condition management, and consumer support services for Book-of-Business.

F. Possess NCQA or URAC full health plan accreditation.

G. Must have a Washington State provider network that is approved by the OIC network requirements in WAC 284-170 for fully-insured book-of-business in all Washington counties.

H. Must have a national provider network and ability to process worldwide Claims.

I. Must comply with all OIC regulations about Complaints and Appeals processes.

J. Must be able to apply standard Coordination of Benefits rules for all Medicare retiree and other Medicare-primary Members' Claims (ESRD, etc.), consistent with Washington insurance regulations in chapter 284-51 WAC, and coordinate benefits with Medicare using all Medicare crossover Claims, including those paid in full by Medicare; and Claims from Members or their providers for services not covered by Medicare that may be covered by the HCA.

K. Must have medical policies and procedures that are provided to the HCA in order to make them publicly available online on the HCA website by no later than January 1, 2020; including, but not limited to, RCW 41.05.074 related to release of coverage criteria.

L. Comply with all state and federal privacy and security laws, statues and regulations for protecting Enrollee data, including HIPAA.

M. Must meet an AM Best financial rating of A- at the time of Proposal submittal.

N. Must have a minimum insurance coverages set forth in the draft Contract found at Appendix 6, Attachment 2.

O. Must comply with Washington State Office of the Chief Information Officer (OCIO) security standards and agree to undergo a Security Design Review conducted by Washington Technology Solutions.

P. Must operate an integrity program addressing fraud, waste, and abuse, including detection and prevention.

Q. Must participate for Book-of-Business in e-Value8™ during the Contract term, with the Washington Health Alliance.

1.5 Proposal Format & Length

In order to be considered for Award, Bidders must provide the following:

A. **Letter of Intent:** The Letter of Intent (LOI) and the signed Non-Disclosure and Data Sharing Agreement (DSA) may be submitted (1) by mail or courier to the address provided for the Procurement Coordinator, or (2) as unrestricted attachments to the email address provided for

the Procurement Coordinator. If the DSA is submitted electronically, it must be submitted as an unrestricted PDF document.

B. **Master Letter of Transmittal:** A single original of this letter shall be included with the Bidder's Proposal.

C. **Proposal:** Bidders must submit their Proposal in the following seven (7) separate exhibits:

1. Exhibit 1 - HCA Health Transformation Vision
2. Exhibit 2 - Clinical Management in Care Transformation
3. Exhibit 3 - Administrative Services
4. Exhibit 4 - Provider Network
5. Exhibit 5 - Contract Costs and Trend Guarantee
6. Exhibit 6 - Technical Data Requirements
7. Exhibit 7 - Market Presence

Proposals must comply with the format requirements or restrictions listed below. Failure to do so may result in the disqualification of the Bidder's Proposal.

A. Use standard 8.5" x 11" white paper, with no smaller than 11 point font. All page margins can be no less than 1 inch.

B. State the Bidder's full legal name on the first or cover page of all copies of the Proposal.

C. Submit the Proposal in the order given in the applicable exhibits. Title and number each item in the same way it appears in this RFP. The Bidder must respond to every section in the exhibits except where otherwise stated.

D. Exhibits in this RFP include an overview of the requested services, Key Elements and instructions for Bidder's Response, required additional documentation (if any), and mandatory page limitations. The paragraphs in these RFP sections and exhibits are numbered for ease of reference. Mark any portion claimed as exempt from public disclosure under RCW 41.05.026 as required in Section 1.18.

E. Page limits stated in this RFP are determined counting single-sides of the Response. The HCA has no obligation to read, consider, or score any material exceeding the stated page limits. Also, there will be no grounds for protest if critical information is on the pages exceeding the specified page limit that is not reviewed. **Key Elements must be included together in all Responses to assist the HCA evaluation teams reviewing the Proposal.**

F. Bidders are required to submit twenty-five (25) copies of their Proposal, each bound in a 3-ring binder. Each binder containing the Bidder's Proposal must be organized in the following manner:

1. Cover Sheet – include the Bidder's name and reference HCA RFP No. K1807.
2. Table of Contents
3. Exhibits (format for Bidder's Response to each exhibit)
    i. Cover Page
    ii. Key Elements and responses
    iii. Accompanying documents for each exhibit following Key Elements and responses.

4. Each Response to a particular exhibit must be separate and clearly labeled. Each page must have a footer that includes the name of the Bidder and the exhibit number and title (e.g., “Exhibit 3.2.4 – Claims Subrogation Service”).

G. Bidders are also required to submit one (1) electronic copy of all of the exhibits in separate individual files on a flash-drive supplied by the Bidder. The documents on the flash-drive must be in unrestricted MS Word, Excel or PDF format and the file names should be in the following format “Ex1.[Document Title].[Vendor Name].” Proposals may not be submitted by email or facsimile.

H. Bidders mailing Proposals should allow sufficient time for mail delivery ensure receipt by the Procurement Coordinator before the Proposal due date listed in the Procurement Schedule. Proposals received by the Procurement Coordinator after the due dates/times stated in the Procurement Schedule may be disqualified.

I. Proposals are to be prepared simply and economically, providing a straightforward, concise description of the Bidder's Proposal to meet the requirements of this RFP.

J. The HCA will not be liable for any costs incurred by the Bidder in preparation of a Proposal submitted in response to this RFP, in the conduct of an oral presentation, in facilitating site visits, or any other activities related to responding to this RFP.

K. Bidders are liable for all errors or omissions contained in their Proposals. Bidders will not be allowed to alter Proposal documents after the deadline for Proposal submission. The HCA is not liable for any errors in Proposals. The HCA reserves the right to contact a Bidder for clarification of Proposal contents.

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

1.6 Bidder Question Periods

Bidders are provided at two (2) scheduled opportunities to ask questions as set forth in the Procurement Schedule:

A. Round 1 Bidder Question Period; and

B. Round 2 Bidder Question Period,

The due dates by which Bidders must submit their questions for each of these periods is listed in the Procurement Schedule.

Both rounds are written question periods only. Questions regarding the RFP will only be accepted in writing, sent by email to the Procurement Coordinator during the Round 2 Bidder Question Period. The Bidder must include the email subject line as ‘UMP RFP Question – [Bidder name]”.

Bidders are to send email written questions concerning the RFP to:

Health Care Authority
Contract Services
RE: RFP # K1807 QUESTIONS
Email: **contracts@hca.wa.gov**

The HCA is only obligated to answer questions received in writing by the dates/times stated in the Procurement Schedule. The HCA will notify the Bidders’ designated points of contact as identified in the Letters of Intent when the HCA's answers to all Bidders’ questions are issued.

If the HCA chooses to offer additional Question and Answer opportunities for Bidders' questions, the HCA will notify the Bidders' designated points of contact as identified in the Letters of Intent.

The HCA is under no obligation to respond to any questions received after the scheduled question opportunities.

1.7 Complaint Procedures

A. A potential Bidder may submit a complaint regarding this RFP. Grounds for the complaint must be based only on one (1) or more of the following:

   1. The procurement unnecessarily restricts competition.
   2. The procurement evaluation or scoring process is unfair or flawed.
   3. The procurement requirements are inadequate or insufficient to prepare a response.

B. The complaint must be submitted in writing to the Procurement Coordinator by the Complaints Deadline set forth in the Procurement Schedule. The complaint may not be raised again during the protest period.

C. The complaint must contain ALL of the following:

   1. The complainant's name, name of primary point of contact, mailing address, telephone number, and e-mail address (if any).
   2. A clear and specific statement articulating the basis for the complaint.
   3. A proposed remedy.

D. The HCA will issue a written response to the complainant before the deadline for Proposal submissions. This is the sole and exclusive process for submitting any complaint regarding the RFP and for the HCA to resolve any such complaint. The complainant does not have the right to an adjudicative proceeding or to any other type of formal "hearing." The submission of the complaint, and any HCA action on any such complaint, is not subject to or governed by the Administrative Procedure Act. The response will explain the HCA's decision and steps it will take in response to the complaint, if any. The complaint and the HCA's response, including any changes to the RFP that may result, will be posted on the Washington Electronic Business Solution (WEBS). The HCA's decision is final, and no further appeal will be available.

1.8 Contract Term

Any contract(s) resulting from this RFP will be for the provision of specified services. The Contract will be effective January 1, 2018 for the purposes of implementation activities and to ensure a smooth transition from the current administrative services contract. The initial term of this Contract will expire December 31, 2029. Thereafter, the Contract may be extended for increments of one (1) year or more for no more than seven (7) additional years. The HCA monthly payment for Administrative Fees will begin following January 1, 2020. No other payment will be made prior to January 1, 2020. Any charges for implementation must be included in the Administrative Fees. The Contract term will encompass all required administration claims for services with dates of service, and includes the run-out administration. Run-out administration will continue for sixty (60) months after termination of the Contract (the Run-Out Period), during which no per Claims fees will be paid. Extension of the Contract beyond the initial term is not guaranteed by the HCA.

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

1.9 Contract Delay Contingency

In the event the implementation date under the Contract is delayed until a later year for any reason, the parties shall make a good faith effort to maintain the contractual relationship and to amend the Contract as necessary to address the delay. In this event, the HCA also reserves the right to terminate the Contract at its sole discretion.

1.10 Implementation/Timeframe

It is anticipated that contracted services will be implemented in two (2) phases.

Phase One - Implementation and Planning: This phase includes coordination with the HCA staff, consultants, and other contractors to transition activities from the HCA's current administrator to the ASB, and make sure the ASB is prepared to provide administrative services. It will begin on January 1, 2018 and continue through December 31, 2019.

Phase Two - Provision of Administrative Services: This phase is the provision of specified administrative services described in the Contract and will begin on January 1, 2020, or thereafter, as specified in the Contract and continue for the term of the Contract.

The HCA will work with the ASB to further define the contents of each phase in the implementation plan and Contract. The HCA reserves the right, in its sole discretion, to alter the timing of the implementation timeframe at any time.

1.11 Authorized Communications

Throughout the RFP schedule, all Bidder communications concerning this solicitation must be directed to the Procurement Coordinator or Alternate Contact listed below:

Procurement Coordinator: James W. Gayton

Alternate Contact: Cendy Ortiz

Email Address: contracts@hca.wa.gov

All oral communications will be considered unofficial and non-binding on the HCA. Bidders should rely only on written statements issued by the Procurement Coordinator or Alternate Contact.

Email or hard copy communication may be used by the Bidder or the HCA for any communication required in this RFP **with the exception** of the Bidder's Proposal (Exhibits 1-7) and protest, if any. The Bidder's Proposal must be submitted in accordance with Section 1.4, and any protest must be submitted in compliance with Section 3.6.

The HCA is not responsible for any problems that may arise with respect to email or package delivery services, either within or outside the HCA. The Bidder is responsible for ensuring timely and complete delivery of any communications related to this RFP.

News releases, social media postings, media releases, or other similar public releases by the Bidder concerning this RFP may not be made without the approval of the Procurement Coordinator, and then only in coordination with the HCA. Any unapproved news releases, press releases, media releases, social media postings, or any other similar public release of information concerning this RFP, or any contract terms for these services, may result in disqualification.

Except for the submission of Claims repricing (Exhibit 5.1) and network adequacy file (Exhibit 4.4) communications, or as specifically authorized by the Procurement Coordinator, communication with any other state employee regarding this RFP may result in disqualification. This prohibition extends to any employee, agent, or representative of the HCA's actuarial contractor, Milliman Inc., advisory consultant,

Mercer Health Care Solutions, or project management consultant, Point B, Inc., having any role in providing such services to the HCA. If any Bidder retains, hires, contracts with, or otherwise confers with any of these organizations or any employee, agent, or representative of any of these organizations, such relationship must be disclosed immediately to the Procurement Coordinator. Any impermissible contact or failure to report as required may result in disqualification.

If a Bidder communicates with any such employees or representatives concerning this RFP, unless such communication is otherwise required or allowed by law or written Washington State policy, the HCA will notify the Bidder in writing of its disqualification from responding to this RFP. Any information gained from direct contact with current HCA personnel other than those authorized in this RFP is not binding on the HCA.

1.12 Posting on WEBS

The HCA will use one official means to communicate with Bidders regarding activities related to this RFP. As required by RCW 39.26.150, the HCA will post this RFP and all amendments hereto to the WEBS website located at https://fortress.wa.gov/ga/webs/. Bidders should visit the website and download the procurement documents. The HCA is not responsible for technical difficulties associated with accessing WEBS or downloading documentation therefrom.

The HCA will also maintain, for convenience purposes only, an unofficial repository for this RFP and all attachments and amendments on its internet site at the following address: http://www.hca.wa.gov/about-hca/bids-and-contracts.

1.13 Multiple or Alternate Proposals

Bidder(s) may not submit more than one (1) Proposal. Only entities with the legal authority to independently enter into a contract to perform the services described in this RFP may submit a Proposal. In the case of parent entities and their subsidiaries, only the parent entity may submit the Proposal unless the subsidiary has legal authority to enter into the Contract independent of the parent entity and can guarantee its performance under the Contract.

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

1.14 Prime Bidder and Prime Contractor

In all instances of relationships with other parties related to this procurement, if two (2) or more entities submit a joint Proposal, one (1) entity must be designated as the Prime Bidder. The Prime Bidder will be the HCA's sole point of contact during the procurement. If selected for Award, the Prime Bidder will become the Prime Contractor and will be the HCA's primary point of contact that bears sole responsibility for performance under the awarded Contract.

1.15 Approach to Subcontracted Services

It is the HCA's intent to contract with an entity that meets or exceeds the minimum qualifications and mandatory requirements on its own merits. The HCA recognizes that in order to provide comprehensive services, Bidders may propose subcontracting services with other parties.

If Subcontractors are used, the HCA must be granted the right to remove a Subcontractor or other third party staff from the performance of services described in this RFP, the Proposal, or the Contract. Further, the Prime Contractor will bear sole responsibility for performance under any resulting contract. In addition, the Prime Contractor will also be required to incorporate some provisions of the Contract into any permitted subcontractor. Behavioral Health services may not be subcontracted by the Bidders for services under this RFP or Contract.

1.16 Cancellations, Acceptance, Minor Irregularities and Discussions

This RFP does not obligate the State of Washington or the HCA to contract for services specified herein in full or in part. The HCA reserves the right to:

A. Cancel all or part of this RFP at any time for any reason.

B. Accept or reject any and all Proposals, in whole or in part.

C. Reject any part of any or all Proposals and continue to evaluate the modified version of the Proposals.

D. To waive, or permit cure of, minor irregularities (however, waiver or permitting cure of a minor irregularity does not imply the HCA will waive or permit cure of other or subsequent minor irregularity(-ies)).

E. To modify the RFP at any time.

F. To conduct discussions with all qualified or potentially qualified Bidders in any manner necessary to serve the best interests of the HCA and the people of the State of Washington. The HCA also reserves the right, in its sole discretion, to award a Contract based upon the written Proposals received without prior discussions or negotiations.

1.17 Oral Presentations (optional)

At the HCA's sole discretion, Bidders may be invited to make one (1) or more oral presentations to HCA representatives in an effort to provide additional details on specific services or capabilities of the Bidder. The HCA may provide questions to selected Bidders in advance of the oral presentation(s) and, when specified by the HCA, the Bidder must provide the Procurement Coordinator written responses to the questions no later than one (1) Business Day before the scheduled oral presentation. HCA may also determine the types and numbers of personnel from the Bidder that will be allowed to participate in the oral presentations.

Bidders invited to make an oral presentation must provide twenty-five (25) copies of all materials the Bidder wishes to distribute at its oral presentation. All such materials will be included as part of the Bidder's Proposal, and will be an exhibit, attachment, or schedule to the Contract. The Procurement Coordinator will notify Bidders of any additional arrangements regarding oral presentations.

The oral presentations will be held at HCA's headquarters in Olympia, Washington:

The Health Care Authority
Cherry Street Plaza
626 8th Avenue SE
Olympia, WA 98504

1.18 Proprietary and/or Confidential Information—Public Disclosure

Upon submission, all Proposals become the property of the HCA and, except for purposes of evaluation, shall not be released or otherwise distributed until after the HCA completes the evaluation

and announces the ASB. Evaluation team members will maintain confidentiality of information to ensure the integrity of the process. After the announcement of the ASB, RFP documents, including but not limited to, bids, quotes, Proposals, and evaluation summaries for all Bidders, shall be open to public inspection at the HCA Contracts Office during normal office hours, except as noted below.

After the announcement of the ASB, copies of documents subject to public disclosure will be made available upon request in accordance with the Public Records Act (Chapter 42.56 RCW) and RCW 41.05.026. A charge will be made for copying and shipping, as outlined in the Public Records Act. No fee shall be charged for inspection of contract files. All requests for records should be directed to the Public Records Officer and copied to the Procurement Coordinator.

Any information in the Proposal that the Bidder desires to claim as proprietary and therefore exempt from disclosure under the provisions of the Public Records Act or RCW 41.05.026, or other law, must be clearly designated and listed in the Master Letter of Transmittal. **Each page or data file claimed to be exempt from disclosure must be clearly identified by the word "Confidential" printed on the page.**

The Bidder may not mark the entire Proposal as proprietary or confidential. Marking the entire Proposal exempt from disclosure will not be honored. The Bidder must be reasonable in designating information as confidential. If any information is marked as proprietary in the Proposal, such information will not be made available to the public until the affected Bidder has been given an opportunity to seek a court injunction against the requested disclosure.

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

The HCA's sole responsibility is limited to maintaining properly identified proprietary or confidential information in a secure area and to notify the Bidder of any requests for disclosure within a period of three (3) years after the announcement of the ASB. After three (3) years, any unsuccessful Proposal submitted for HCA RFP # K1807 will be disposed. Failure to so identify such materials, or failure to obtain a court order by the release date indicated in HCA's notice of request for public disclosure, will be deemed a waiver by the Bidder of any claim that such materials are exempt from public disclosure.

1.19 Procurement Authority/Method

Washington law authorizes the HCA to self-fund, self-insure, or enter into other methods of providing insurance coverage for insurance programs under its jurisdiction. Under RCW 41.05.140(1), the HCA is directed to contract for Claims payment or other administrative services for its programs. Under RCW 41.05.075(2), the HCA director is required to establish a competitive contract bidding process for Claims payment and other administrative services for the self-funded insurance coverage.

This RFP generally describes the services being solicited by the HCA; sets out criteria for evaluating factors in addition to price, including the technical capabilities and qualifications of the Bidders; and describes the format and content of submitted Proposals. The HCA reserves the right to negotiate the scope and price of the Contract that brings the "best value" to the HCA.

1.20 Mandatory Contractual Terms

By submitting a Proposal, a Bidder, if selected for Award, shall be held to all statements within the Proposal, model Contract, and oral presentation(s). This RFP and the ASB's Proposal will be made a part of any Contract resulting from this RFP.

A draft Contract included as Appendix 6, Attachment 2, will serve as the base for contract negotiations with the ASB. The Bidder must be prepared to agree to all terms of the attached draft Contract as presented or the Proposal may be rejected. Bidders must include a copy of the Contract with its Proposal that shows the changes Bidder proposes be made if it is selected as the ASB. If the Bidder fails to identify an objection to any particular term or condition, the term or condition will be deemed agreed to by the Bidder. The HCA reserves the right to discuss any Bidder proposed change to terms or conditions and to clarify and supplement such proposal. Bidders are reminded that this is a competitive solicitation for a public contract and that HCA cannot accept a Proposal, or enter into a contract, that substantially changes the material terms and specifications published in this RFP. Proposed changes to any particular term or condition of the Contract will be used to determine the responsiveness of the Proposal. Proposals that are contingent upon the HCA making substantial changes to the material terms and specifications published in the RFP may be disqualified. The HCA will consider the number and nature of the terms and conditions the Bidder is objecting to in determining the likelihood of completing a Contract with the Bidder. Unresolved issues regarding the material business terms of the Contract and project documents may affect the HCA's selection of Bidders to advance to the next stage of the procurement.

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

The services to be performed by the ASB will involve the use of information that is protected by HIPAA. As such, the ASB must agree, as a component of the final Contract, to abide by the Business Associate Agreement (BAA) included as part of the Contract.

1.21 Revisions to the RFP

The HCA reserves the right to amend this RFP at any time prior to contract award. The HCA will post any RFP amendments to WEBS. In addition to being posted to WEBS, the HCA's may also, but will not be obligated to, post amendments to its internet located at http://www.hca.wa.gov/about-hca/bids-and-contracts, and/or directly email amendments to Bidders that have expressed an interest in submitting a Proposal.

The CHA also reserves the right to request additional information to determine if the Bidder can successfully meet the requirements of the RFP.

If a conflict exists between amendments, or between an amendment and the RFP, the document last in time controls. If a conflict exists between any document posted to WEBS and any document posted to the HCA's internet site or sent directly to Bidders, the document posted to WEBS shall control. Published Bidders' questions and the HCA's official answers will be issued as an amendment to the RFP.

The HCA reserves the right, in its sole discretion, to cancel or amend this RFP at any time and for any reason.

1.22 Bidder Responsibilities

Bidders are solely responsible for:

A. Properly registering within WEBS at https://fortress.wa.gov/ga/webs; and

B. Maintaining an accurate Bidder profile in WEBS; and

C. Downloading and reviewing the full solicitation consisting of the RFP, with all exhibits, appendices, attachments, and amendments related to the RFP from WEBS.

The ASB's Proposal will be incorporated as an exhibit of the Contract. The ASB's compliance with the terms of its Proposal will therefore be a requirement of the Contract.

To ensure receipt of all solicitation documents, the RFP for this solicitation must be downloaded from WEBS. The HCA is only obligated to provide notification of amendments to the RFP by posting to WEBS. A Bidder's failure to download and review all documents posted to WEBS risks submitting a Proposal that is incomplete, inaccurate, or an otherwise inadequate. Bidders accept full responsibility and liability for failing to receive any amendments resulting from their failure to register with WEBS, or from failure to download all RFP documents, and hold the State of Washington harmless from all claims of injury or loss resulting from such failure.

SECTION 2 – MAJOR COMPONENTS OF PROPOSALS

This RFP has seven (7) major components attached as exhibits, each with a number of sub-components:

A. Exhibit 1—HCA's Health Transformation Vision

   This exhibit relates to the Bidder's expertise, experience and capability to use UMP Plans as vehicles to spread and scale the HCA's purchasing goals, clinical strategies, health transformation initiatives, and the Triple Aim.

B. Exhibit 2— Clinical Management in Care Transformation

   The Clinical Management Services component also relates to the Bidder's capability to use evidence-based guidelines (such as the Bree Collaborative recommendations) in all Clinical Management Services to support optimal health outcomes; collaborate with HCA's clinical team; proactively identify and manage Members who are at risk for health service utilization; provide Patient Decision Aids to support appropriate patient self-management; collaborate and integrate with providers and delivery systems; reduce unnecessary variation in clinical practice; and lower healthcare costs.

C. Exhibit 3— Administrative Services

   This exhibit relates to the Bidder's competence to provide a coordinated package of administrative services also relates to the Bidder's capability to complete all necessary implementation activities; to support an Open Enrollment program in advance of the scheduled 2020 plan year; and to fully assume responsibility for specified administrative services on January 1, 2020

D. Exhibit 4— Provider Network

   This exhibit relates to providing all, or selected elements of, a service delivery network covering the State of Washington, the other 49 states, the District of Columbia, and U.S. territories.

E. Exhibit 5— Contract Costs and Trend Guarantee

   This exhibit addresses how contract costs will be addressed. The HCA's objective is to achieve a cost trend better than the comparable Medicare unit cost increases, while improving the quality of care and services for its Members. The HCA will pay an Administrative Fee on a Per Subscriber Per Month (PSPM) basis for each plan year that the ASB provides services that are consistent with the scope of work described in this RFP.

F. Exhibit 6– Technical Data Requirements

   This exhibit focuses in four (4) key requirement areas: data security requirements, data transfer requirements, eligibility system requirements, and data transfer participation.

G. Exhibit 7 – Market Presence

   This exhibit relates to the Bidder's demonstrated Washington State market share, capacity, willingness and experience that enable the Bidder to effectively provide the administrative services described in this RFP and accelerate meaningful health transformation.

All components and sub-components must be adequately addressed to constitute a complete Response to the RFP. All components and sub-components will be factors in determining the ASB and Award.

For each exhibit, the Response should provide appropriate detail to describe the scope of services being proposed by the Bidder. Bidder's Response for each Key Element must address all activities and

processes necessary or incidental to the services being proposed to meet such requirement. **Unless otherwise indicated, all services, activities, and processes included in Bidder's Response must be included in the Administrative Fee proposed by Bidder in Exhibit 5.**

Each component or sub-component is presented in the following standard format:

A. *Overview*: The general description of the specific service of interest.

B. *Specific Instructions*: Specific processes or methodology to be followed by Bidder in responding to the Required Elements.

C. *Key Elements to Be Addressed*: Essential items that must be addressed in Bidder's Response that when absent may render that Response non-responsive.

D. *Required Accompanying Documents*: The specified documents needed to support Bidder's Response. Only include those documents requested by the HCA in the respective sections. Other submitted documents may not be reviewed or considered in scoring of the Proposal. Requested accompanying documents do not count against the maximum allowable number of pages set for the Bidder Proposal.

E. *Evaluation and Scoring Insight*: Key factors that will be used by the HCA evaluation teams to score the Response.

F. *Bidder Response*: Unless otherwise indicated, the form of the Response is a narrative based on specific elements listed as Key Elements, which clearly and concisely communicates the Bidder's experience and ability to meet or exceed the Key Elements. The Response should reflect the expertise, innovation, competencies, and resources that the Bidder brings to the table through the presentation of the best scope of service the Bidder is prepared to deliver within the Administrative Fee.

If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Required Element by January 1, 2020 while not negatively impacting or delaying other implementation efforts described in this RFP.

SECTION 3 – SCREENING, EVALUATION AND AWARD

3.1 Initial Screening of Bidders

A four (4) step screening process made on a pass/fail basis will be used to initially evaluate Bidder's compliance with the administrative requirements of this RFP. Passing this initial screening does not mean that the HCA has determined the Bidder or Proposal satisfies mandatory performance or functionality requirements.

A. **Step 1** is a review by the Procurement Coordinator of the Bidder's confirmation to meeting the Minimum Qualifications of this RFP provided in the Bidder's Letter of Intent. The review of the Minimum Qualifications is on a Pass/Fail basis and is not part of a Proposal's numerical scoring or ranking. If it is determined that the Bidder does not meet the Minimum Qualifications, there will be no further review of the Bidder's response. However, the HCA reserves the right at its sole discretion to waive minor administrative irregularities.

B. **Step 2** is a screening of the Proposal by the Procurement Coordinator. The Procurement Coordinator will review the Letter of Intent to determine if the Bidder has provided the required information (see Section 4). The review of the Letter of Intent is on a Pass/Fail basis and is not part of a Proposal's numerical score. The HCA reserves the right at its sole discretion to waive minor administrative irregularities.

C. **Step 3** is a review of the entire Proposal by the Procurement Coordinator to ensure that it is complete and in compliance with RFP administrative requirements, such as number/type of copies, overall format, format of Responses to each section, etc. This is also a Pass/Fail review and not part of a Proposal's numerical score or ranking. The HCA is not required to contact a Bidder for additional information if a Proposal appears incomplete, unclear, or non-compliant with RFP requirements. However, the HCA reserves the right at its sole discretion to waive minor administrative irregularities, or to contact a Bidder to clarify its Proposal.

D. **Step 4** is a review of the Master Letter of Transmittal. The review of the Master Letter of Transmittal is to ensure that all required information concerning the Bidder and the Proposal is complete. The Master Letter of Transmittal is also a Pass/Fail evaluation and is not part of a Proposal's numerical score or ranking. The HCA is not required to contact a Bidder for additional information if a Master Letter of Transmittal is incomplete or unclear. However, the HCA reserves the right at its sole discretion to waive minor administrative irregularities.

3.2 Evaluation of Proposals

Proposals that have passed all phases of the initial screening will be evaluated and scored by HCA representatives. Evaluators are under no obligation to create written notes or explanation of their scores during Proposal evaluation. Any Award will be made to the lowest responsive and responsible Bidder whose Proposal, in the sole opinion of the HCA, offers the greatest benefit to the HCA. The decision will be based on consideration of the total best value, including, but not limited to, the responsiveness of the Proposal to the requirements as set forth in this RFP, the competence and responsibility of the Bidder, quality of service, breadth and depth of offering, the strength and form of contractual commitments made by the Bidder to the HCA, and total cost. The HCA reserves the right to make the Award to the Bidder whose Proposal is deemed to be in the best interest of the HCA and the State of Washington. Hence, the HCA may choose to not award to the highest scoring or lowest-cost Proposal.

A. Written Proposal

Evaluation teams will be formed to evaluate the written Proposals. Evaluation team members will individually review each Proposal before meeting with the rest of their evaluation team to discuss the Proposals. The HCA may bring in subject matter experts (SMEs) with specific administrative, claims operations, clinical, technical, management, and/or financial backgrounds to assist in evaluating portions of the written Proposals, in determining how well each Proposal responds to the RFP exhibits, and how the Proposal and Bidder meet the needs of the HCA. Evaluation team members will take into account their own expertise and any input from SMEs to individually evaluate and score the Exhibit. It is important that each Response to the Exhibits be concise, clear, and complete, so evaluation teams understand all aspects of the Proposal without the need to refer to Responses to other Exhibits. The HCA may elect to Award a Contract at the end of the evaluation process for the written Proposals. However, the HCA reserves the right to advance Bidders to the oral presentation phase.

The scores assigned by individual team members will be used in calculating the total number of points awarded to each Bidder. Included below in Table 3.2.1 is a listing of the exhibits, weights, and the maximum points possible for each exhibit included in this RFP. Individual exhibits are categorized as either a "Non-Cost Element" or a "Cost Element." Table 3.2.2 below lists the scale of scores used by individual team members (0 – 5) and a brief statement about the general characteristics of a Proposal earning each of those individual scores.

For all Non-Cost Elements, the points awarded to a Bidder will be calculated by multiplying the scores assigned by individual evaluation team members by the weight assigned to the exhibit. These results will then be averaged across all of the evaluators for the exhibit. The sum of average points for each Non-Cost Element will be the total score for the Bidder. The maximum number of points a Bidder can earn for all Non-Cost Elements is 2,000.

Cost Elements of this RFP are NOT scored in the same manner as Non-Cost Elements. Each exhibit of this RFP that is listed as a Cost Element in Table 3.2.1 will be scored in the manner set forth in the "Evaluation and Scoring Insight" section of such exhibit. In other words, awarded points for Cost Elements are not determined by multiplying a score assigned by an evaluation team member by the weight listed in Table 3.2.1, and then summing the average of those results. **Please refer to each Cost Element exhibit for additional information on the scoring of Bidder's Response to those exhibits.** The maximum number of points a Bidder can earn for all Cost Elements is 3,000. For the Cost Elements, negative points may also be awarded. **There is no cap on the number of negative points that can be awarded for Cost Elements.** There is also no minimum score needed to advance through the evaluation process.

Each of the exhibits attached to this RFP has been assigned a weight. Those weights are included in this RFP in Table 3.2.1. A total of 2,000 points (40%) are possible for the Non-Cost Elements and 3,000 points (60%) are possible for the Cost Elements, for a total of 5,000 points available for the evaluation of the written Proposals

1. Written Proposal Scoring

Each exhibit in the RFP to be included in the written Proposal has been assigned a weight. Points will be assigned to each section based upon the average of the products of each evaluator score (0 – 5) multiplied by the weight indicated below. The weight and maximum points for each section are as follows:

Table 3.2.1

Exhibit No.	Exhibit Title	Weight	Maximum Points

NON-COST ELEMENTS			**2,000**
1	**TRANSFORMATION VISION & EXPECTATIONS**	**100**	**500**
1.1	Innovative Leadership & Administrative Support	20	100
1.2	Value-Based Purchasing	35	175
1.3	Member Engagement and Experience	15	75
1.4	Data, Reporting & Analytics	15	75
1.5	Multi-Stakeholder Quality Improvement	15	75
2	**CLINICAL MANAGEMENT**	**100**	**500**
2.1	Utilization Management	14	70
2.2	Quality & Improvement Management	20	100
2.3	Complex Case Management	14	70
2.4	Chronic Condition Management	14	70
2.5	Other Clinical Management Services	14	70
2.6	Innovations in Clinical Management	10	50
2.7	HCA Clinical & Medical Policies	14	70
3	**ADMINISTRATION SERVICES**	**100**	**500**
3.1	Medical Benefit Drug Management Program	5	25
3.2	Claims Services	9	45
3.3	Disabled Dependent Certifications	5	25
3.4	Health Technology Clinical Committee	5	25
3.5	UMP CDHP Plan Administration	5	25
3.6	ACN Administration	8	40
3.7	Appeals and Complaints	5	25
3.8	Overall Account Management Administration	8	40
3.9	Work Orders	3	15
3.10	Reporting Requirements	5	25
3.11	Member or Customer Service	5	25
3.12	Member Communications	5	25
3.13	Online Services	5	25
3.14	Conversion Offering	1	5
3.15	Implementation Plan	5	25
3.16	Administrative Performance Guarantees	9	45
3.17	Request for Renewal	3	15
	Draft Contract Redlining	9	45
4	**PROVIDER NETWORK**	**50**	**250**
4.1	Provider Network	15	75
4.2	Out-of-State Provider Network	5	25
4.3	Washington Network	10	50
4.4	Washington Provider Network Analysis	20	100
6	**TECHNICAL DATA REQUIREMENTS**	**25**	**125**

6.1	Compliance with State Data Security Requirements	7	35
6.2	Data File Transfer & Access Requirements	6	30
6.3	Eligibility Systems Requirements	6	30
6.4	Data Transfer Participation	6	30
7	**MARKET PRESENCE**	**25**	**125**
7.1	Market Presence	25	125
COST ELEMENTS			**3,000**
5	**CONTRACT COSTS AND TREND GUARANTEE**		**3,000**
5.1	Claims Re-pricing	N/A	1,250
5.2	Administrative Fee Proposal	N/A	1,000
5.3	Trend Guarantee	N/A	750
		MAXIMUM POINTS POSSIBLE	**5,000**

2. Written Proposal Scoring Methodology

Table 3.2.2		
Score	**Description**	**Discussion**
5	Far Exceeds Requirements	The Proposer has provided an innovative, detailed, efficient approach or established, by presentation of material, far superior capability in this area.
4	Exceeds Requirements	The Proposer has demonstrated an above-average capability, approach, or solution and has provided a complete description of the capability, approach, or solution.
3	Meets Requirements	The Proposer has an acceptable capability of solution to meet this criterion and has described its approach in sufficient detail to be considered “as substantially meeting the requirements”.
2	Below Requirements	The Proposer has established some capability to perform the requirement but descriptions regarding their approach are not sufficient to demonstrate the Proposer will be fully able to meet the requirements.
1	Substantially Below Requirements	The Proposer has not established the capability to perform the requirement, has marginally described its approach, or has simply restated the requirement.
0	No value	The Proposer has omitted any discussion of this requirement or the information provided is of no value.

B. Oral Presentations (optional)

HCA reserves the right to advance Bidders to oral presentation. The scores from the written Proposal **will not** carry forward to the scoring of Oral Presentations.

Topics to be addressed in the oral presentations will be based upon the written Proposals and other issues determined by the HCA in its sole discretion. The Bidders who advance to this phase of the evaluation will be provided more information. Oral presentations are expected to include Bidder participants who have both management and technical expertise to provide additional details regarding the written Proposal. The HCA expects oral presentations to be made by the Bidder's clinical, network, data, claims administration, customer service, account team, and other operations and strategic professionals who are expected to perform the services described in this RFP, including the proposed implementation team. The evaluation team may assemble with the same or additional SMEs with clinical, technical, administrative, claims operations, management, and/or financial backgrounds to determine how well each oral presentation responds to the topics to be addressed and how such presentation meets the needs of the HCA.

The evaluation team will then unanimously assign a score for each oral presentation. As with Non-Cost Elements of the written Proposal, this score will then be multiplied by the weight assigned to each element listed in Table 3.2.3 to determine the Bidder's score for such element. The Bidder's total score for its oral presentation will be some of these individual element scores.

Commitments made by the Bidder during the oral presentation will be considered binding. The HCA reserves the right to record both audio and video of the oral presentations and include such recordings as an exhibit, attachment, or schedule to the Contract.

1. References

   For Bidders who advance to oral presentations, the HCA will evaluate references provided by the Bidder in its Master Letter of Transmittal. The HCA will send each Bidder reference a questionnaire in which the references will score the Bidder and return to the questionnaire to the Procurement Coordinator. Each reference will be assigned a score on a 0 – 5 scale. The Procurement Coordinator will then determine an average score using all references received. This average will then be multiplied by the weight assigned to References in Table 3.2.3, below.

   Whether included as a key personnel reference or not, the HCA reserves the right to use its own or other organization's experience using the Bidder as a factor in evaluating the probability of success by the Bidder.

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

2. Oral Presentation and Reference Scoring

   Each element of the oral presentation has been assigned a weight. Points will be assigned to each element based upon the evaluator consensus score (0 – 5) multiplied by the weight indicated below. The weight and maximum points for each section are as follows:

Table 3.2.3

Exhibit No.	Exhibit Title	Weight	Maximum Points
NON-COST ELEMENTS			**2,000**

1	TRANSFORMATION VISION & EXPECTATIONS	100	500
2	CLINICAL MANAGEMENT	100	500
3	ADMINISTRATIVE SERVICES	100	500
4	PROVIDER NETWORK	50	250
6	TECHNICAL DATA REQUIREMENTS	25	125
7	MARKET PRESENCE	25	125
COST ELEMENTS			**3,000**
8	CLAIMS PRICING	250	1,250
9	TREND GUARANTEE	150	750
10	PSPM	200	1,000
REFERENCES		177	**885**
		Maximum Points Possible	**5,885**

3. Oral Presentation and Reference Scoring Methodology

Table 3.2.4

Score	Description	Discussion
5	Far Exceeds Requirements	The Bidder has provided an innovative, detailed, efficient approach or established, by presentation of material, far superior capability in this area.
4	Exceeds Requirements	The Bidder has demonstrated an above-average capability, approach, or solution and has provided a complete description of the capability, approach, or solution.
3	Meets Requirements	The Bidder has an acceptable capability of solution to meet this criterion and has described its approach in sufficient detail to be considered “as substantially meeting the requirements”.
2	Below Requirements	The Bidder has established some capability to perform the requirement but descriptions regarding their approach are not sufficient to demonstrate the Bidder will be fully able to meet the requirements.
1	Substantially Below Requirements	The Bidder has not established the capability to perform the requirement, has marginally described its approach, or has simply restated the requirement.
0	No value	The Bidder has omitted any discussion of this requirement or the information provided is of no value.

C. BEST AND FINAL OFFER

At its sole discretion, the HCA may elect to direct Bidder(s) to present a "best and final offer." Best and final offers, if requested, will be considered by the HCA in the final selection of the ASB.

Please note that HCA is using the expertise of the following non-state consultants in this procurement: Milliman, Inc., for actuarial and benefits consulting; Mercer as a healthcare advisory consultant in the development and evaluation of this procurement and Point B, Inc. for project management consulting services.

3.3 Notice of Award

In addition to posting on WEBS, the HCA will send an email notification to all Bidders who submitted a Proposal of the ASB decision.

The HCA reserves the right at any time, in its sole discretion to: (a) cancel the Award of the Contract, (b) Award the Contract to the next ranked Bidder, or (c) cancel or reissue this solicitation.

3.4 Debrief Procedures

Upon written request, a debriefing conference will be scheduled with any unsuccessful Bidder. The Procurement Coordinator must receive the written request for a debriefing conference within three (3) Business Days after the announcement of the ASB. The debriefing must be held within three (3) Business Days of the request. Debriefing requests must be made by email and sent directly to the HCA Procurement Coordinator listed in Section 1.11.

Discussion at the debriefing conference will be limited to the following:

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

B. Critique of the Bidder's Proposal.

C. Review of the Bidder's final score without comparison to other Bidder's Proposals.

Debriefing conferences may be conducted in-person or on the telephone, and will be scheduled for a maximum of one (1) hour.

3.5 Protest Procedures

A Bidder may submit a protest only after a debriefing conference has been both requested and held. A protest shall be filed and resolved in accordance with the following procedure:

A. Grounds for Protest

Protests may be made on only these grounds:

1. A matter of bias, discrimination, or conflict of interest on the part of an evaluator; or
2. Errors in computing scores; or
3. Non-compliance with procedures described in the RFP or DES requirements.

Protests not based on these grounds will not be considered. Protests will be rejected as without merit if they address any other issues, such as an evaluator's professional judgment on the quality of a Proposal, or the HCA's assessment of its own needs or requirements.

B. Protest Form and Content

The Bidder must ensure that the HCA receives the protest in a timely manner and that the protest is made in writing. The protest must contain the facts and arguments upon which the

protest is based, and must be signed by a person authorized to bind the Bidder to a contractual relationship. At minimum, the written protest must include:

1. The name of the protesting Bidder, its mailing address and phone number, and the name of the individual responsible for submission of the protest.
2. The RFP number and title.
3. Specific and complete statement of the action(s) protested.
4. Specific references to the grounds of protest.
5. Description of the relief or corrective action requested.

C. Protest Process

Protests must be addressed to the Procurement Coordinator. Protests may be submitted electronically via email to contracts@hca.wa.gov. The subject line of the email must contain the RFP number and title.

1. The HCA must receive the written protest within five (5) Business Days after the debriefing conference.
2. The HCA will postpone signing the Contract with the ASB until the protest has been resolved.
3. Upon the HCA's receipt of a protest, a review and investigation will be conducted by the HCA Chief Legal Officer, or their delegate, 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, the RFP and any amendments, the Proposal(s), all documents showing evaluation and scoring of the Proposals record, and any other pertinent information. A decision will be issued within ten (10) Business Days of receipt of the protest, unless additional time is needed. If additional time is needed, the protesting Bidder will be notified.
4. In the event a protest may affect the interest of another Bidder that submitted a Proposal, such Bidder will be given an opportunity to submit its views and any additional relevant information on the protest to the Procurement Coordinator.

The HCA will resolve the protest in one of the following ways:

1. Find that the protest lacks merit and deny any requested relief.
2. Find only technical or harmless errors in the acquisition process, determining the HCA to be in substantial compliance, and reject the protest.
3. Find merit in the protest and take on of the following actions:
    i. Correct errors and reevaluate all Proposals,
    ii. Reissue the solicitation document, or
    iii. Make other findings and determine other courses of action as appropriate.

D. Final Determination

The HCA protest decision is the final agency decision. No other administrative remedies will be available to, or required of, a protesting Bidder.

SECTION 4 - LETTER OF INTENT

The Letter of Intent must include the information below and be received no later than the date provided in Section 1.4, Procurement Schedule.

Information in this Letter should be placed in the following order and using the same format/headings:

A. **Company Information**:

   1. Bidder Name
   2. Proposal Contact
   3. Address
   4. Telephone Number
   5. Email Address
   6. Washington UBI

   In the instance of a planned joint Proposal from two (2) or more parties, identify the Prime Bidder and all other parties included in the Proposal. The contact, address, telephone and email information is only required for the Prime Bidder.

B. **Authorized Representative.** Bidder will appoint an Authorized Representative to speak on behalf of the Bidder for all matters relating to this procurement. The HCA will not recognize any other persons as representing the Bidder during the procurement process unless written designation is received in advance.

C. **Key Subcontractors**. The identification of anticipated Key Subcontractors in the Letter of Intent is informational only for the purpose of identifying potential conflicts of interest. Identifying potential key Subcontractors does not obligate the Bidder to include those Subcontractors in the final Proposal.

D. **Certification of Minimum Qualifications**. Bidder must certify they meet the minimum qualifications listed in Section 4.3 and provide supporting documents.

E. **Signed DSA.** This is required in order for the HCA to provide data necessary to complete Exhibits 4.4, 5.1, and 5.2. A copy of the DSA form is provided as Form A in Appendix 7 of this RFP.

SECTION 5 – MASTER LETTER OF TRANSMITTAL

This is a cover letter to the Proposal that provides Bidder-specific information, and acknowledges the receipt of all parts of the RFP and any amendments thereto. A single Master Letter of Transmittal covering all exhibits should be prepared on Bidder letterhead and signed by an individual who is authorized to commit the Bidder to the services and requirements as stated in the Proposal. The Master Letter of Transmittal must include the following information in the following order:

A. Information about the Bidder, including the following:

   1. The Bidder's business name, address, telephone number, email address (if any) and fax number.
   2. The legal form of the bidding entity (sole proprietorship, partnership, corporation, etc.) and the year the entity was substantially organized as it now exists.
   3. The name, address, email address, and telephone number any sole proprietor, partners, or principal officers, as appropriate.
   4. The name of the person who will have primary contact with the HCA in carrying out the Bidder's responsibilities if awarded the Contract.
   5. The name and address of the entity that receives legal notices for the Bidder.
   6. Bidder's statewide vendor number issued by the Washington State Office of Financial Management.

B. Bidder's Federal Employer Tax Identification Number and a completed IRS W-9 form. If the Proposal is being submitted in partnerships or with joint Bidders or Subcontractors with one (1) or more entities, identify each other entity and their primary responsibilities if Bidder is selected as the ASB. Also include the following:

   1. Length of Subcontractor relationship with the RFP responder
   2. Core Financial information about the Subcontractor (i.e. financial rating from S&P or Moody's, etc.)
   3. How long the Subcontractor has been in existence and whether it is a parent or subsidiary of other companies

C. Attach as a separate document, an Executive Summary of the Proposal (no more than a single-sided page).

   D. Five (5) references for which the Bidder has performed similar work during the past five (5) years. For each reference, include a brief description (no more than three (3) single-sided pages) of the work and contact information. At least one of these references must be from an entity that had been a client for the Bidder but for whom the Bidder is no longer providing services. At least two (2) references should have at least 20,000 Covered Lives or be the largest accounts held by the Bidder.

E. Provide a statement affirming that by submitting a Proposal to this solicitation, the Bidder and any Key Subcontractors represent that they are not in arrears in the payment of any obligations due and owing the State of Washington, including the payment of taxes and employee benefits.

F. Provide the financial information as instructed below to provide assurance to the HCA that the Bidder is a financially stable, viable entity which will be fully able to meet all of its

obligations under any resulting Contract. Financial information that provides third party assurances, such as an audited financial statement, is encouraged. Bidder must submit:

1. Most recent certified financial statements in customary form and quarterly reports to shareholders, if any, for the current fiscal year as required by the Securities and Exchange Commission; **OR**
2. Most recent financial statements reviewed by an independent, third-party, Certified Public Accountant (CPA) and quarterly reports to shareholders, if any, for the current fiscal year as required by the Securities and Exchange Commission; **AND**
3. In addition to the financial statements, the Bidder must submit one (1) copy of an A.M. Best Insurance report for the bidding entity. The report must bear a date not more than 90 Days prior to the submittal date of the Proposal.

G. In the case of a Bidder that is the subsidiary of another entity, all information, including financial reports and references, submitted by the Bidder shall pertain solely to the Bidder. If separate financial documents are not available, provide a letter from the parent entity certifying the financial status of the subsidiary and acknowledging the parent entity's assurance of support.

The HCA reserves the right to require any Bidder to provide additional information necessary for the HCA to determine the financial integrity and responsibility of such Bidder.

H. Describe any litigation and/or government action, including OIC fines, against the bidding entity's license or the license of any sub-entities of the Bidder, or government action or government litigation against the bidding entity directly related to the performance of any of the administrative services contained in this RFP, in the past six years.

I. Conflict of Interest Information:

1. If any employees or officers of the Bidder or Key Subcontractors' employees or officers who shall provide services under the Contract were employed by the State of Washington during the last two (2) years, state their positions within the Bidder, their proposed duties under any resulting Contract, their duties and position during their employment with the State and the date of their termination from State employment. If a decision regarding conflict of interest has been obtained from the State Ethics Board, submit the decision.
2. If any owner, officer or key employee of the Bidder is related by blood or marriage to any employee of the HCA or member of the Public Employees Benefit Board or has a close personal relationship to same, identify all the parties, identify their current or proposed positions and describe the nature of the relationship.
3. If the Bidder is aware of any other real or potential conflict of interest, the Bidder must fully disclose the nature and circumstances of such conflict.
4. If, after review of the information provided, the HCA determines that a potential conflict of interest exists, the HCA may, at its sole option, request a change in personnel assigned to the account or disqualify the Bidder from participating in this procurement. Failure to fully disclose any real or potential conflict of interest may result in the disqualification of the Bidder or the termination for default of any Contract with the Bidder resulting from this procurement with the Bidder.

J. Bidders must indicate whether they have had a contract terminated for default since January 1, 2011. Termination for default is defined as a notice to stop work due to the Bidder's non-performance or poor performance, where the issue of performance was either not litigated

due to inaction on the part of the Bidder, or litigated and determined that the Bidder was in default.

If the Bidder has had a contract terminated for default since January 1, 2011, the Bidder must submit full details including the other party's name, address and telephone number. The Bidder must specifically grant the HCA permission to contact any and all involved parties and access any and all information the HCA determines is necessary to satisfy its investigation of the termination. The HCA will evaluate the circumstances of the termination and may, at its sole discretion, disqualify the Bidder from participating in this procurement.

K. A red-lined copy of the draft Contract (Appendix 6, Attachment 2) identifying issues or proposed alternate text that reflects the actual content of the Bidder's Proposal (see Section 1.20).

L. Completed Diverse Business Inclusion Plan. Bidders will be required to submit a Diverse Business Inclusion Plan, included as Appendix 7, Form E, Diversity Business Inclusion Plan, with its Proposal. In accordance with legislative findings and policies, the State of Washington encourages participation in all contracts by firms certified by the Washington State Office of Minority and Women's Business Enterprises (OMWBE) (see, Chapter 39.19 RCW), or by the Washington State Department of Veterans Affairs (see, RCW 43.60A.200), and for firms qualifying as Washington Small Businesses (see, RCW 39.26.005). Participation may be either on a direct basis or through the use of Subcontractors. However, no preference on the basis of participation is included in the evaluation of Diverse Business Inclusion Plans, and no minimum level of participation is required as a condition for receiving an Award. However, the HCA does have the following agency goals:

    1. 10% participation by Minority Owned Business
    2. 6% participation by Women Owned Business
    3. 5% participation by Veteran Owned Business
    4. 5% participation by Small Businesses

M. A copy of the Certification and Assurances signed by a person authorized to bind the Bidder to a Contract. A copy of this form is provided in as Appendix 7, Form D.

N. Certification that Bidder's Responses to Exhibits 4.4, 5.1, and 5.2 have been submitted to Milliman.

EXHIBIT 1 HCA HEALTH TRANSFORMATION VISION

Overview

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

A. Move state-financed health care, and work in tandem with other major purchasers and payers to move the commercial market, to outcome-based payments;

B. Build healthier communities through a regional approach that fosters links between communities and clinical care; and

C. Integrate physical and behavioral health services so that health care focuses on the whole person.

Healthier Washington has invested heavily statewide in foundational infrastructure and resources to directly support and accelerate the three focus areas and enhance overall system performance in the following ways:

A. Fostering a culture of quality and price transparency to enable providers and communities to benchmark performance against their peers and measure overall health system performance.

B. Engaging individuals and families in their health and health care by providing tools, resources and training.

C. Building ACHs to facilitate local linkages between communities and clinical care to address Social Determinants of Health.

D. Supporting transformation efforts by assisting providers with their transition to Value Based Payment.

E. Enabling regional health data capabilities, including analytic tools, interoperable systems and standardized measurement strategies to improve population health.

F. Supporting workforce capacity and flexibility by encouraging team-based approaches and supporting strategies that allow practitioners to work at the top of their license, effectively and efficiently.

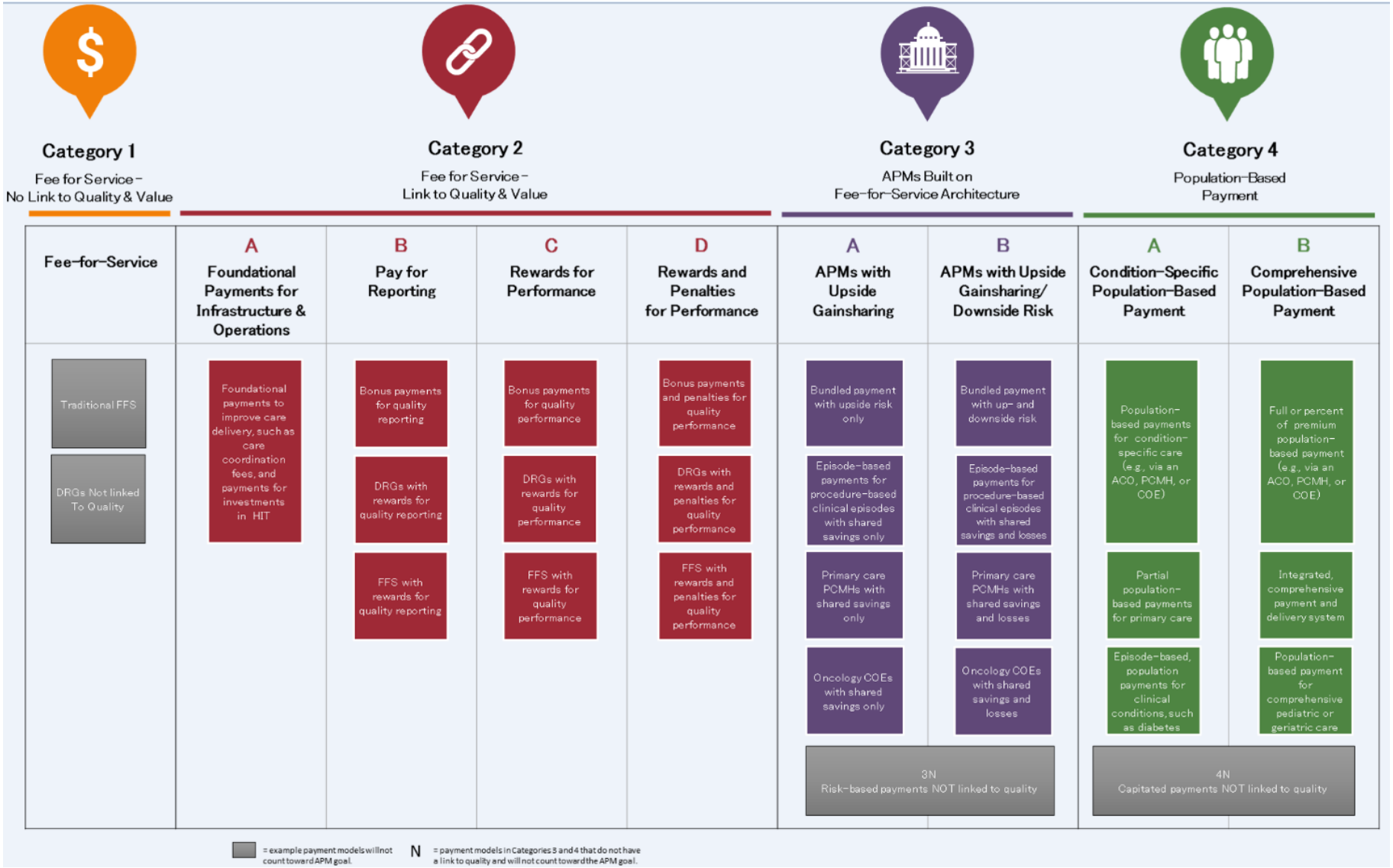
Paying for Value – The HCA's Purchasing Strategy

The HCA is the largest health care purchaser in Washington State, providing care for over 2.2 million Washingtonians through Apple Health (Medicaid) and the Public Employees Benefits Board (PEBB) program. Annually, the HCA spends $10 billion dollars between the two programs.

"Paying for Value" is a core strategy of the Healthier Washington initiative, which charts a bold course for transforming the way health care is delivered and paid for in Washington State. Under RCW 41.05.021, HCA is required "to increase the use of value-based contracting, alternative quality contracting, and other payment incentives that promote quality, efficiency, cost savings, and health improvement, for Medicaid and public employee purchasing". 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."

Under its Paying for Value strategy, the HCA has pledged that 90% of HCA provider payments under Apple Health and the PEBB program will be linked to quality and value by 2021 (as defined by the CMS LAN Alternative Payment Model categories 2c - 4b; see Chart 1, below).

Chart 1: CMS Framework for Value-based Payments or Alternative Payment Models (CMS LAN APM)



For more information, see CMS LAN APM Framework White Paper, go to: https://hcp-lan.org/workproducts/apm-whitepaper.pdf

Updated Health Transformation Vision: HCA Value-based Roadmap

By changing how health care is purchased, the HCA will support new models of care that drive toward population-based care while fundamentally changing how health care is provided. The HCA produced the HCA Value-based Roadmap in June 2016 to articulate its updated purchasing vision. This document brings together major components of Healthier Washington and other health transformation projects into one approach.

The HCA Value-based Roadmap is built on the following principles:

A. Reward the delivery of patient-centered, high value care and increased Quality Improvement.

B. Reward performance of the HCA's Medicaid and PEBB program health plans and their contracted health systems.

C. Align payment and delivery reform approaches with CMS for greatest impact and to simplify implementation for providers.

D. Improve outcomes for patients and populations.

E. Drive standardization based on evidence, including best-practice recommendations from the Bree Collaborative.

F. Increase long-term financial sustainability of state health programs.

G. Continually strive for the Triple Aim.

The HCA Value-based Roadmap also articulates the following elements of the HCA's vision to align the delivery of health care throughout HCA programs by the end of 2021:

A. HCA programs implement Value Based Payment arrangements according to a unified purchasing philosophy;

B. HCA's purchasing business is entrusted to accountable delivery networks and plan partners; and

C. HCA exercises significant oversight and quality assurance over its contracting partners and implements corrective action as necessary.

The HCA cannot achieve health transformation alone. The HCA desires an ASB who can assist in reaching the HCA's goals and is dedicated to radically transforming their own business strategies to align with the HCA's efforts. The ASB must be poised to send one consistent message to the Washington marketplace in the pursuit of achieving the Triple Aim.

The ASB must possess the experience and knowledge to provide the following capabilities under this Contract:

A. Provide leadership and health transformation expertise and administrative capabilities to continuously innovate UMP products to adapt to health transformation strategies.

B. Design, implement and administer Value Based Payment models to support new models of care delivery, including administrating and offering an ACO product for their commercial Book-of-Business that aligns with the core components of UMP Plus.

C. Offer novel Member education and engagement tools and strategies to support appropriate self-management.

D. Possess sophisticated data, reporting and analytic expertise, services and capabilities to produce ad-hoc analyses for the HCA, providers, and other stakeholders.

E. Participate in multi-stakeholder Quality Improvement and transparency initiatives.

Exhibit 1.1 Innovative Leadership & Administrative Support

Overview

The health care industry is changing rapidly. If current delivery and payment reforms are successful, Washington State's health care delivery and reimbursement systems will be drastically different when the ASB begins to provide administrative services under the Contract in 2020. In addition, the HCA's health transformation vision and goals will have evolved to reflect the needs of our reformed health system.

The HCA seeks an ASB that shares its health transformation vision and goals and is strongly positioned to move the entire Washington health care market toward the Triple Aim. It must be able to operate in two disparate systems at the same time – a fee-for-service system where volume of services is rewarded, and a Value Based Payment system where value is rewarded and whole-person care is optimized.

The ASB's Executive Leadership and Management team, including but not limited to its Chief Medical Officer, must have the intellectual capital and expertise to be a committed partner with the HCA, ready to help the HCA realize its health transformation vision and purchasing goals while offering creative ideas and strategies. The ASB's operational staff and systems must have the experience, system capacity, capability and flexibility to operationalize the HCA's customized approach and vision while adapting to innovation and transformation initiatives quickly.

The ASB is required to possess:

A. A visionary Executive Leadership and Management team with the attributes as described above.

B. An organizational commitment to actively support and participate in statewide health transformation efforts, including Healthier Washington.

C. A commitment to and experience supporting linkages between communities and clinical care to address Social Determinants of Health.

D. A commitment to spread and scale the HCA's clinical policies, care transformation vision and Value Based Payments, as well as foundational elements of the ACNs, in its Book of Business.

E. A commitment to provide and coordinate customized reporting of UMP Plan offerings to HCA leadership at quarterly meetings on care transformation activities, Value Based Payment updates and other reporting, as requested by the HCA.

F. Experience designing and implementing new models of care that drive toward population-based care for Members, entire Book-of-Business and other purchasers.

G. A commitment to and experience in deploying strategies that improve patient education and self-management.

H. Executive endorsement of community-wide transparency efforts on quality, utilization, pricing, and sharing medical Claims data, including metrics related to price and quality.

I. Flexible Claims and payment systems that can support and adapt to innovative strategies and new financial reimbursement models.

J. Benefit design expertise that accelerates new models of care.

K. A commitment to facilitate conversations between the HCA and providers.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

Describe the Bidder's:

A. Executive leadership structure.

B. Vision for health transformation, progress made to date, and future tasks.

C. Vision for Washington State's health care system in 2025. Include what the organization is currently implementing to achieve that vision.

D. Past, current and future strategies to evolve the Bidder's business model to prepare for new delivery and payment models. Include specific examples, including how Social Determinants of Health will be addressed.

E. Past and current experience working with other public and private payers to accelerate health care transformation.

F. Experience working with large, self-funded, public- and private-sector clients. Address the organization's approach to implementing purchaser(s) customized programs and policies, and experience providing benefit design advice.

G. Plans to incorporate elements of the HCA's health transformation vision across its Book-of-Business.

H. Experience developing and supporting strategies to improve access and quality of care for a culturally and linguistically diverse patient population.

I. Involvement and experience with the following initiatives, agencies and/or organizations:

    1. Washington state legislative efforts on health care.

    2. Local, regional, statewide or national health transformation efforts (not including Healthier Washington).

J. Proposed approach to partnering with the HCA leadership and staff in the PEB and Clinical Quality Care Transformation (CQCT) Divisions to continuously innovate and improve programs for Members.

Required Accompanying Documents

Include examples of standardized reporting of the performance of UMP Plans that would be shared with HCA Executive Leadership on a semi-annual basis. Include Care Transformation reports that

(1) detail provider network progress of implementation of Bree Collaborative Best Practice recommendations, and (2) track achievement of primary care clinics' progress toward achieving new NCQA PCMH certification standards for the ACO product offered to its Book-of-Business.

Evaluation and Scoring Insight

Preference will be given to responses that are detailed, concise and articulate Bidder's ability to meet the Key Elements.

Bidder Response

Not to exceed eight (8) pages, excluding Required Accompanying Documents.

Exhibit 1.2 Paying for Value through Value Based and Alternative Payment Models

Overview

The HCA expects that 90% of HCA provider payments under state-financed health care programs, and 50% of provider payments in commercial health care arrangements, will be linked to quality and value by 2021, as defined by Categories 2c through 4b in Chart 1, CMS LAN APM, above.

In order to send a consistent signal to the marketplace and providers across Washington state, the HCA expects that the majority of payment strategies, whether implemented by the HCA directly through its own purchasing or through HCA health program partners (providers and health plans), will include all elements mentioned in Exhibit 1.2.2, below.

Exhibit 1.2.1 Support of Value Based and Alternative Payment Models

Overview

The HCA seeks an ASB that can develop, implement and administer a broad range of Value Based Payment and alternative payment models, and work with other payers. The HCA has developed and is in the process of implementing, several strategic Value Based Payment initiatives in Medicaid and the PEBB, one of which is the Centers of Excellence (COE) program.

The HCA has a bundled payment program through a COE for total joint (knees and hips) replacement (TJR) available to UMP Classic and UMP CDHP members, starting in January 2017 (the TJR COE Program). The TJR COE Program is a comprehensive program that covers services related to TJRs, including but not limited to pre-surgical consultations, hospitalization, surgery, and post-surgical management. Members will work with a team of professionals at a third party administrator, Premera Blue Cross, and a designated COE, Virginia Mason Medical Center, to ensure that all aspects of treatment are consistent with Bree Collaborative recommendations.

In the COE model:

A. The COE bears the cost of complications from sub-optimal clinical outcomes, and ensures all aspects of treatment are consistent with Bree Collaborative recommendations.

B. The COE assumes financial risk for preventable surgical complications and infections.

C. The COE's clinical team—including physicians, hospitals and others involved in TJRs—coordinates patient care and encourages Shared Decision Making with each patient.

D. The HCA pays a single amount prospectively agreed to by the provider and the HCA for each clinical episode of care, called a "bundled payment."

E. Services covered under the COE model may be covered in full for qualifying Members enrolled in UMP Classic or UMP CDHP.

The HCA is actively working to expand the COE program to cover additional health care services, such as maternity care, spine fusions, low back pain and cardiac care, in accordance with Bree Collaborative Alternative Payment Model recommendations, LAN recommendations, and other best practice recommendations. If the ASB demonstrates the capacity and capabilities to administer bundled payments and COE activities, then it may be required to administer the COE and bundled payment program.

Throughout the length of this contract, the HCA will continue to design and implement Value Based Payment strategies through its own purchasing and through multi-payer efforts consistent with CMS LAN APM Categories 2c through 4b (see Chart 1 above). Some payment strategies may include pilot projects or additional plan offerings within the PEB Division, and may not require competitive procurement.

The ASB must:

A. Commit to lead and pay providers using Value Based Payment arrangements in CMS LAN APM Categories 2c through 4b (see Chart 1 above) for its Washington State Book-of-Business as well as the UMP Plans.

B. Administer different types of Value Based Payment and alternative payment models in different plan offerings in Washington State, including UMP Plus.

C. Demonstrate its knowledge, experience and capability to implement bundled payments to support a COE program for purchasers in Washington State and achieve the following tasks:

    1. Enter into a BAA and data sharing agreement with each third-party COE program administrator.

    2. Participate in meetings or collaborations with each COE program administrator and the HCA to support development, implementation and administration of the COE program, including benefit design.

    3. Administer other COE and other bundled payment programs as they roll out geographically across the State and for different medical procedures or conditions.

    4. Evaluate the impact and results of COE and other bundled payment programs in terms of quality outcomes and patient experience when administered by the ASB.

D. Provide, support and/or administer newly emerging forms of Value Based Payment strategies while offering suggestions on other forms of Value Based Payment strategies that have been proven to be successful.

E. Commit to participate in multi-payer initiatives and data sharing.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to be Addressed

Describe the Bidder's:

A. Experience administering or implementing Value Based Payment arrangements to providers using arrangements in CMS LAN APM Categories 2c through 4b (see Chart 1 above) (excluding ACOs). Include its process for selecting provider groups or delivery systems for these current Value Based Payment arrangements, including the assessment of clinical, operational and financial capabilities.

B. Lessons learned and best practices used for developing, implementing and monitoring Value Based Payment arrangements, and how lessons learned have been applied to new payment initiatives.

C. Process for monitoring and implementing emerging forms of Value Based Payments.

D. Approach to aligning benefit design with new models of payment and care.

E. Experience participating in multi-payer efforts to accelerate Value Based Payment efforts.

F. Experience modifying its current Claims system to support new payment methodologies, including working with and customizing payment programs for large self-funded purchasers.

G. Vision and plan to expand Value Based Payment strategies in its Book-of-Business.

Required Accompanying Documents

Bidder must provide a completed Paying for Value Survey included with this RFP in Appendix 6, Attachment 24.

Evaluation and Scoring Insight

Scoring will take into account the Bidder's knowledge and experience designing and administering Value Based Payments (as defined in CMS LAN APM Categories 2c through 4b), implementing and managing COE models for health care services in accordance with the Bree Collaborative and other best practice recommendations, including LAN, and participating in multi-payer efforts.

Bidder Response

Not to exceed five (5) pages, excluding Required Accompanying Documents.

Exhibit 1.2.2 Offering Accountable Care Organization Product

Overview

The ASB must offer an ACO product (or equivalent) aligned to Category 3b on the CMS LAN APM to its Book-of-Business, effective January 1, 2020, including:

A. Upside and downside risk in alignment with a quality improvement model that leverages the Common Measure Set.

B. Standardized care based on the Bree Collaborative recommendations and other best practice recommendations identified by the HCA.

C. Enhanced Member services (e.g., expanded clinic hours, dedicated call line for Members, e-consults).

D. Quality, cost and utilization data provided to providers on a timely basis.

E. Benefit design packages or recommendations that provide financial incentives for appropriate care (e.g., primary care use, encourage in-network care, discourage out-of-network care).

F. Eighty percent of participating Primary Care clinics that achieve NCQA PCMH Level III recognition or equivalent (as determined solely by the HCA) by the end of 2021.

G. Promotion of the ASB's ACOs to other purchasers.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to be Addressed

A. Organization and Governance

1. Briefly describe the Bidder's current and past ACO products, including names and locations of delivery systems, geographic locations (regional and statewide) participating in the ACO, and enrollment numbers as of July 1, 2016.
2. Describe criteria used to identify, evaluate, and select delivery systems.
3. Describe the Bidder's ACO organizational structure, the roles of executive leadership and participating delivery systems leadership.

B. Administration and Network Development

1. Provide examples of how the Bidder has demonstrated willingness to share and collaborate with ACOs and/or other delivery systems, including delegation of care management and administrative functions.
2. Describe the Bidder's approach to effective contracting outside the ACO network, with the goal of promoting well-coordinated care for patients that produces quality outcomes at affordable prices.
3. Describe its plan to expand ACO products into its Book-of-Business. Specify the timeline for expanding and offering ACO products into as many Washington counties as possible.

C. Care Transformation

1. Describe how the ACO currently does or will promote and advance patient-centered care and the provision of Primary Care.
2. Describe how the ACO will incorporate Bree Collaborative recommendations and other best practice recommendations. Specify how the Bidder will align or incorporate other innovative purchasing concepts such as COEs within its ACO.
3. Explain how the Bidder will meet the HCA's expectation of 80% of participating Primary Care clinics, for the fully-insured book-of-business ACO products, achieving NCQA PCMH Level III recognition or equivalent (as solely determined by the HCA) by the end of 2021.

D. Payment and Risk Arrangements

1. Describe if and how the Bidder provides payment arrangements to enable provider organizations to provide non-visit based care (e.g. telehealth and email), non-physician care where appropriate, specialty consultation without requiring an office

visit, home and community-based services and supports, and Care Coordination including proactive outreach to patients within defined population.

2. Describe the financial risk arrangements and results of current or past ACOs (e.g., improved quality and/or decreased costs) and what future enhancements might be included.

E. Patient Engagement Tools and Patient Experience

1. Describe the Bidder's patient-facing website. Include whether it includes quality information and a cost calculator with the following functions:
    i. Cost information that considers patients' benefit designs related to copays and cost sharing, coverage exceptions and service limits.
    ii. Pharmacy benefits, accumulated deductibles and out-of-pocket maximums.
    iii. Medical costs searchable by procedure, drug and episode of care, that include both professional and facility fees.
    iv. Cost comparisons of alternative treatments aligned to Patient Decision Aids for preference-sensitive treatments.
    v. Cost comparisons for physicians, hospitals, ambulatory surgery centers and diagnostic centers linked to quality data on the Member website.
2. Describe Bidder's approach to enhancing patient experience. Include rationale for this approach.
3. Describe the activities and dedicated resources the Bidder uses to promote its ACO product, including patient education and communication.
4. Describe if ACO product includes "hard enrollment" where patients are required to prospectively select the ACO and affiliate with a Primary Care team and/or clinic within the ACO.

F. Data Reporting to Providers

1. Describe the Bidder's approach to sharing data with ACOs and integrating data across the ACO and non-ACO care delivery sites on a timely basis to facilitate effective patient care.
2. Describe the data analytics tools and reports provided to the ACOs.
3. Highlight how the data and data systems are managed to reliably produce information. Also, describe how the ACO assesses and responds to the ongoing data and reporting needs of the ACO.

G. Purchasers

1. Describe how the Bidder will promote the products to its Book-of-Business and purchaser clients, including a timeline for offering the ACO to self-insured markets other than the UMP Plans by January 1, 2020.
2. Address how it will work with purchasers to ensure benefit design supports and incentivize appropriate health-seeking behaviors.
3. Describe how it will provide and/or coordinate routine, standardized reporting of ACO performance to purchasers.

Required Accompanying Documents

The Bidder must provide:

A. A letter from an actuary that reports and certifies the most current year-end enrollment, by state, for each ACO product offered by the Bidder. If the Bidder is not currently serving patients through an ACO, then state that the Bidder does not currently serve patients through an ACO.

B. A description of the process for selecting provider groups or delivery systems for ACO arrangements, including how the Bidder assesses the clinical, operational and financial capabilities of such groups or systems.

C. A description of the oversight of ACO arrangements that monitor for quality of care, adherence to evidence-based guidelines, and enhanced patient experience.

D. A description of lessons learned and best practices used when developing, implementing and monitoring ACO arrangements.

E. Information on the performance of ACO products, including finance, clinical quality and patient experience, for all ACOs offered for at least three (3) years.

Evaluation and Scoring Insight

Preference will be given to Bidders who have:

A. A current ACO: an ACO product that is currently serving patients in Washington State.

B. Network development: a process for selecting network providers that includes an effective assessment of the clinical, operational and financial capabilities of providers.

C. Network geography: a network that adequately serves a broad geographic area within Washington State with further preference given to a network that adequately serves all Washington counties.

D. Risk sharing: an ACO that uses clinical accountability and upside/downside financial risk to drive quality of care and an efficient cost trend.

Bidder Response

Not to exceed ten (10) pages, excluding Required Accompanying Documents.

Exhibit 1.3 Member Engagement and Experience

Overview

The HCA believes that people who are informed and engaged in their own health are more likely to make appropriate decisions regarding the use of health care resources. Therefore, Member engagement is at the heart of HCA health transformation strategies. The HCA's vision of Member engagement involves several strategies, including but not limited to:

A. Offering innovative Patient Decision Aids that are culturally and linguistically appropriate so Members can make meaningful care choices.

B. Providing Patient Decision Aids that allow Members to learn about treatment options when engaged in Shared Decision Making on which treatment to seek.

C. Participation in creating and updating care plans that are shared with Members and their family.

D. Providing cost and quality transparency tools that empower Members to make cost-effective selections for health care services.

The following is a description of tools and resources the ASB will offer to all UMP Plan Members:

A. Shared Decision Making

Washington leads the nation in promoting Shared Decision Making and creating a certification process for Patient Decision Aids. Washington state law recognizes that certification plays a significant role in assuring the quality of Patient Decision Aids used by consumers, providers and payers. The HCA began accepting Patient Decision Aids for certification in April 2016. A list of certified Patient Decision Aids is available at http://www.hca.wa.gov/about-hca/healthier-washington/patient-decision-aids-pdas. The ASB must support and encourage Shared Decision Making through its provider agreements, Member communications, and Member resources.

B. Member Website

The ASB must offer a functional and timely Member website that is optimized for mobile/tablet access as well as desktop use. This must include, but not be limited to, the following interactive tools and information:

1. Cost calculator to help Members understand out of pocket costs before care is received.
2. Cost information that considers Member benefit designs relative to copays and cost sharing, coverage exceptions and service limits, pharmacy benefits, accumulated deductibles and out-of-pocket maximums.
3. Medical costs searchable by procedure, drug and episode of care that include both professional and facility fees.
4. Cost and outcome comparisons of alternative treatments linked to shared decision-making tools.
5. Cost, quality and outcome comparisons for physicians, hospitals, ambulatory surgery centers and diagnostic centers linked to quality data as much as possible.
6. Up-to-date list of providers and their locations.
7. Important insurance documents such as Explanation of Benefits (EOBs), COCs, and Summaries of Benefits and Coverage, that clearly differentiates between the UMP Plans. The website must include a process for paper copies of these documents to be requested and provided.

C. Multichannel Communications

The ASB must provide Members the ability to communicate electronically via email and/or text reminders. In addition, Members must be able to conduct transactional activities such as managing their insurance accumulators via the website or applications.

D. Communication Tools and Resources

1. In order to provide customized experiences for Members, the ASB must offer multiple channels for Member communication, including but not limited to telephone, in-person and online communication as well as chat, instant messaging and texting.
2. Medical records that patients and other authorized individuals are allowed to read are an important aspect of patient-centered care. When used properly, they let patients see themselves through the eyes of their caregivers and give them insight

into diagnoses and treatment options. The ASB must promote the use of electronic health records (EHR) among providers and enable Members to access their own records (clinician chart notes, visit summaries, lab results, etc.) to help them take an active role in their own care.

3. In addition to being able to access medical records, Members must be able to conduct insurance and health care related transactions using innovative technology. To that end, the ASB must enable Members to communicate with their health plans through electronic means, schedule appointments with providers, request prescription refills, and communicate with providers online or through telehealth services.
4. A growing number of patients are seeking expert medical opinions (EMO), particularly in specialties such as oncology, and a growing number of online services are offering second opinions. The ASB must have the capability to offer Members an online EMO or second opinion option.
5. One of the greatest health care challenges for Members is managing billing and insurance systems to ensure that bills are accurate and appropriate payments are made. The ASB must offer assistance with these challenges to help Members manage their health care bills.

E. Tools and Resources for Self-Management

1. The ASB must offer, or work with the HCA's wellness vendor so it can offer Members the ability to monitor and track their own participation in activities related to wellness, including diet and nutrition, exercise and weight loss, and tobacco cessation activities.
2. There are a growing number of online tools that enable Members to participate in classes, utilize health coaches, and manage aspects of their health related to chronic disease. The ASB must offer Members the ability to manage chronic diseases in an evidence-based way that is convenient and customizable to their needs.
3. The ASB must provide support for a culturally and linguistically diverse Membership as well as reasonable accommodations for communications that are consistent with ADA requirements for all Member-oriented tools.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

Describe the scope, thoroughness and transparency of the Bidder's member experience and engagement tools:

A. Experience with and approach to supporting and encouraging the use of Shared Decision Making tools in provider agreements, patient communications and patient resources. If

Bidder does not use Shared Decision Making tools, describe how these will be incorporated into future plans.

B. The features and capabilities of patient-oriented websites, including desktop and mobile optimization.

C. The types of interactive cost and quality transparency tools available to patients through patient-oriented websites, including whether or not they include the following features:

    1. Customized cost calculator based on patient's benefit design, including coinsurance and service limits, pharmacy benefits, deductibles and out-of-pocket limits.
    2. Searchable database of medical costs by procedures, drugs and episodes of care.
    3. Cost and quality comparisons for alternative treatments based on Shared Decision Making tools.
    4. Cost and quality comparisons for physicians, hospitals, ambulatory surgery centers and diagnostic centers.

D. Methods offered to patients to communicate with the Bidder, including the types of transactional activities patients can conduct via website.

E. Provision of an up-to-date list of providers and locations as well as important insurance documents to patients, including the types of informational resources that are typically available online.

F. Methods offered for patient communication including telephone, in-person and online communication as well as chat, instant messaging and texting.

G. Methods used to promote the use and availability of EHRs among providers, patients, and other appropriate parties.

H. The promotion of tools and applications that make it easier for patients to conduct health care related transactions, including the ability to:

    1. Schedule appointments online.
    2. Request prescription refills online.
    3. Communicate with a provider online.
    4. Conduct physician appointments over the phone or online (telehealth services).

I. The EMO service for patients.

J. The method used to assist patients in managing billing and insurance issues with providers.

K. The support provided for a culturally and linguistically diverse patient population and how the Bidder complies with ADA requirements in all communication methods.

L. Current tools and resources for self-management, and how they can integrate with an outside wellness program.

Required Accompanying Documents

None.

Evaluation and Scoring Insight

Scoring will take into account Responses that include detailed descriptions of the following:

A. Demonstrated experience offering Shared Decision Making tools (e.g., Patient Decision Aids) to patients.
B. A robust website for Members that includes interactive cost and quality transparency tools, self-management tools, wellness information, cost information that considers Members' benefit design relative to different services,
C. Multiple communication mediums offered to patients to contact customer service for general and billing questions, communicate with a provider, etc.
D. Patient services are culturally and linguistically appropriate
E. Capability to integrate self-management patient tools and resources with an external wellness program.

Bidder Response

Not to exceed six (6) pages, excluding Required Accompanying Documents.

Exhibit 1.4 Data, Reporting and Analytics

Overview

Data is key to achieving and supporting value-based care and payment. The HCA needs timely reports on UMP Plan and provider performance to actively inform and adjust purchasing strategies; providers need access to timely, accurate and actionable data at the group/provider/patient level (quality, patient experience, utilization and cost data from HCA vendors) to facilitate effective patient care and conduct population health analytics; and health plans need data to inform business decisions and provide feedback to providers. Functional, comprehensive reporting systems are necessary to support and integrate data and provide meaningful reports.

The HCA seeks an ASB who:

A. Has the ability to provide both standard and ad hoc customized reports to the HCA on UMP Plan quality, cost and utilization performance, Member reported outcomes, provider performance, and population health measures, and a detailed reporting system (standards and staffing structure) and processes in place, including an approach to developing, testing, modifying and finalizing reports.

B. Has a current Claims data system that can process and support current and new Value Based Payment arrangements.

C. Has robust technology and core systems in place to accept, store, process and validate data from various sources (e.g., claims, clinical data from EHRs, and other HCA vendors).

D. Has capacity and expertise coordinating and integrating data sets across those sources (e.g., clinical, claims and data from HCA vendors).

E. Coordinates with other HCA vendors at the Member level Claims data, Member communication, behavioral outreach, wellness programs and benefits, and other programs. HCA data vendors may include but are not limited to the UMP PBM, and outsourced wellness programs.

F. Has a client- or purchaser-facing data warehouse that can be used by at least ten (10) HCA employees who produce reports for Claims and enrollment.

G. Possesses detailed reporting capabilities to report measures from the Common Measure Set and HEDIS measures for provider groups, including quality, claims, Member reported outcomes, and hybrid measures. The measures will be based on standards created at the

state and national level, and the data will be configured in accordance with the applicable specifications.

H. Has experience, knowledge and expertise providing appropriate data and routine, standardized reporting on provider performance regarding various clinical and quality metrics, including Patient Reported Outcomes, patient experience and population health. This reporting must be understandable and accessible to providers and provider groups.

I. Will provide UMP Plan-specific HEDIS data to the HCA and/or its business associates.

J. Will provide data and/or analytical support as specified by the HCA from community transparency initiatives (see, Exhibit 1.5) and the system for measuring the HCA's progress on core processes and key outcomes, called “Results HCA.”

K. Will submit data using the NCQA or URAC Interactive Data Submission System (IDSS) or other NCQA-approved methods.

L. Will encourage provider participation in Washington State’s Clinical Data Repository and Health Information Exchange.

M. Uses innovative, state-of-the-art risk adjustment approaches in data work.

N. Ensures all information sharing is in full compliance with HIPAA and other applicable regulations, with information and reporting structured to meet the needs of Members, providers, the HCA, the community, and other identified stakeholders.

Specific Instructions

The Bidder’s Response must demonstrate strong knowledge and experience, while affirming the organization’s ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder’s management’s assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

Describe the scope, thoroughness, and transparency of the Bidder’s capability to meet the HCA’s reporting and data management needs regarding its:

A. Current Claims system and its capability and capacity to support Value Based Payment and alternative payment models.

B. Core data system used for accepting, storing, processing and validating Claims, clinical data (e.g., data from registries and EHRs) and data from HCA vendors, including data flows and processes.

C. Experience with and capacity to integrate and harmonize data from various data sources. Describe approach to data flow, processes and staffing.

D. Requirements for providers in supplying necessary information for all quality measures for all plans, including quality measures from the Common Measure Set that are encounter-based, hybrid, Patient Reported Outcomes, clinical information from EHRs, and others.

E. Experience and reporting capabilities for all UMP Plans for HCA selected quality metrics from the Common Measure Set and HEDIS measures (including Claims, Patient Reported

Outcomes, and hybrid measures), financial measures, and patient experience. Include experience and capability to provide such reports, including:

1. Bidder's approach to data flow processes.
2. Bidder's approach to receiving and managing data from EHRs.
3. Staffing.
4. Core reporting systems, structures and standards.
5. Approach to testing, modifying and finalizing reports that ensure timely and accurate reporting.

F. Experience calculating quality measures and providing data and analytic reports to providers. Include examples of reports, frequency of delivery of data and reports, and technical assistance offered to providers to integrate data into workflows.

G. Experience providing customized reports to purchasers on plan portfolio performance.

H. Strategies and approaches to integrate data from outside vendors, such as an outside pharmacy benefit manager and ACOs. Include details of the clinical referral processes between vendors and an illustration of data flows and information sharing.

Required Accompanying Documents

Provide:

A. Data flow processes from Claims systems to reporting systems and outputs.

B. Diagrams for core reporting systems, structures and standards.

Evaluation and Scoring Insight

Preference will be given to Responses that include detailed descriptions of the following:

A. Demonstrated experience offering Shared Decision Making tools (e.g., Patient Decision Aids) to members.
B. A robust website for members that includes interactive cost and quality transparency tools, self-management tools, wellness information, cost information that considers members' benefit design relative to different services.
C. Multiple communication mediums offered for members to contact customer service for general and billing questions, communicate with a provider, etc.
D. Services are culturally and linguistically appropriate for members.
E. Capability to integrate self-management member tools and resources with external wellness program admissions for wound infection, thrombophlebitis, etc.

Bidder Response

Not to exceed six (6) pages, excluding Required Accompanying Documents.

Exhibit 1.5 Multi-Stakeholder Quality Improvement and Transparency Initiatives

Overview

The HCA places a high priority on community partnerships and multi-stakeholder efforts with the specific purpose of working collaboratively across the community to increase the quality of health care in Washington State. It also values aggregated community and statewide measurement and

reporting initiatives aimed at improving transparency of quality, utilization and price, as these efforts are key to accelerating health transformation efforts.

The HCA actively participates in numerous community initiatives and expects its partners to participate and contribute data to the community efforts listed below.

The ASB must actively participate and encourage their contracted providers to participate, in the following community initiatives during the term of the Contract, starting on or before January 1, 2020:

A. Washington Health Alliance (WHA) – a leading nonprofit health system improvement in Washington. Located in Seattle, the WHA brings together health care stakeholders to create a high-quality, affordable system for the people of Washington state. The WHA also produces and shares the most reliable data on Health Care Quality and value in the state to help providers, patients, employers and union trusts make better decisions about health care. More information is available at www.wahealthalliance.org.

B. Bree Collaborative – a multi-stakeholder, Governor-appointed group working to improve the quality, health outcomes and cost effectiveness of care in Washington. The Bree Collaborative produces best practice recommendations for health care services that experience a high variation of care delivery, are frequently used but do not lead to better care or patient health, or that experience patient safety issues. More information is available at www.breecollaborative.org.

C. Accountable Communities of Health – regional health collaboratives that bring together leaders from multiple health sectors with a common interest in improving health and health equity throughout the state. As ACHs align resources and activities they improve whole person health and wellness. Nine ACHs serve the entirety of Washington State, the boundaries of which align with Medicaid Regional Service Areas. More information is available at www.hca.wa.gov/hw.

D. National Business on Health e-Value8™ Initiative – a transformational resource that helps purchasers and employers measure and evaluate health plan performance. The WHA sponsors a biannual e-Value8™ which is supported by the HCA. More information about e-Value8™ is available at www.nbch.org/evalue8.

In addition, the ASB must provide a copy of Claims data for the UMP Plans and its Book-of-Business to the following community transparency initiatives:

A. WHA Community Checkup (per requirements established by the WHA)

B. Fred Hutchinson Institute for Cancer Outcomes Research

C. All-Payer Claims Database (APCD) (when operational)

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

A. For WHA committees, the Bree Collaborative, and ACHs or other community organizations, please describe the following:
    1. Specific roles.
    2. Length of participation.
    3. Staff level (e.g., executive level, staff, etc.).
    4. Committee participation, both current and past.
    5. Approach to encouraging provider and hospital participation.
    6. Approach to monitoring provider and hospital participation in community initiatives.

B. Describe how the Bidder will permit access to and use of enrollment and price data at the HCA's discretion.

C. Describe current or past participation on other health care community initiatives in Washington State such as those described in this Exhibit.

D. Provide a "Yes" or "No" Response to each question listed in Table 1.5.1 below, and include the completed table with Bidder's Response to this Exhibit.

Table 1.5.1

TOPIC	RESPONSE (Yes/No)
Did the Bidder participate in data submission with Book-of-Business for the WHA Community Checkup project in 2016?	
Has the Bidder submitted data on Book-of-Business to Fred Hutchinson Institute for Cancer Outcomes Research in the past?	
Did the Bidder participate in an NBCH e-Value8™ survey as a PPO in 2016 in Washington or another U.S. market?	
Will the Bidder participate in an NBCH e-Value8™ survey as a PPO in 2020 in Washington or another U.S. market, and will share results with the HCA?	
Will the Bidder agree to respond affirmatively to all WHA invitations to participate in the e-Value8™ survey as a Washington PPO during the term of the Contract?	
Will the Bidder commit resources toward ACHs and other Healthier Washington programs and initiatives without charging additional fees beyond the PSPM?	
Will the Bidder submit appropriate data for its entire Book-of-Business to the APCD?	

Will the Bidder agree to encourage self-funded purchaser clients to submit their data to the APCD?	

Required Accompanying Documents

None.

Evaluation and Scoring Insight

Preference will be given to Bidders willing to engage on all levels of community collaboration, which includes submitting Book-of-Business and UMP Plan data to community transparency initiatives and HCA business partners.

Bidder Response

Not to exceed six (6) pages, excluding Required Accompanying Documents.

EXHIBIT 2 CLINICAL MANAGEMENT IN CARE TRANSFORMATION

Overview

HCA is fundamentally changing how health care is paid for by adopting Value Based Payments. Value Based Payments will require changes in how care is delivered. To be successful, new care models will create a high-performing delivery system where:

A. Care is managed optimally within the primary care setting using evidence-based principles based on the Patient Centered Medical Home (PCMH) and the Chronic Care Model.

B. Care is managed in accordance with evidence based guidelines, including but not limited to the Bree Collaborative Best Practice recommendations.

C. Continuous Quality Improvement is practiced by health plans and providers, including participation in peer and community Quality Improvement efforts.

D. Care is delivered using an interdisciplinary care team approach with the Primary Care provider serving as the team leader of all appropriate disciplines, supported by an integrated and comprehensive plan of care for each patient.

E. Physical health and Behavioral Health care is integrated while incorporating both medical conditions and Social Determinants of Health.

F. Performance is measured and reported using quality measures from the Common Measure Set, as well as Patient Reported Outcomes, patient experience and provider experience measures. (For more information on the Common Measure Set, please go to http://www.hca.wa.gov/about-hca/healthier-washington/performance-measures).

The vision of a high-performing delivery system in Washington State outlined above will take years to achieve. During the transition, the ASB is expected to provide a menu of Clinical Management Services to support providers in Washington State, including the following:

A. Utilization Management

B. Quality Management and Improvement

C. Complex Case Management

D. Chronic Condition Management

E. Other Clinical Management Services, such as Consumer Support Services

F. Clinical Management Innovations.

The HCA desires an ASB that can offer Clinical Management Services to support the following elements:

A. Use of evidence-based medicine and Bree Collaborative best practice recommendations, including integrated physical and Behavioral Health services.

B. Alignment with NCQA or URAC standards, and compliance with the UMP Plan coverage, reimbursement, and benefit provisions defined in the applicable COC.

C. Inclusion of programs and services provided to the ASB's Book-of-Business within the PSPM. This will include all Clinical Management Services and related or similar

programs and services, such as Utilization Management, Quality Management, Quality Improvement, and Case Management services.

D. Incorporation of Social Determinants of Health by partnering with local Accountable Communities of Health.

E. Incorporation of condition-specific Clinical Management Services and programs, including, but not limited to, maternity and high risk pregnancies, radiology, medical infusion, Autism, transgender, and other programs offered in the Book-of-Business (all programs will be included within the proposed PSPM).

F. Utilization review processes, including prior authorization and concurrent review.

G. The Bidder will not contract out integrated Behavioral Health management services.

H. Medical expertise provided through at least one (1) ASB Medical Director to support the Washington State Health Technology Assessment program, the Washington State Prescription Drug Program, and other HCA-identified performance improvement efforts as they relate to the UMP Plans and HCA delivery system purchasing strategies.

I. Medical imaging management program for the UMP Plans that is in compliance with Washington State Health Technology Clinical Committee (HTCC) determinations. This program will include prior authorizations and clinical edits within the Claims systems.

J. HCA approved application and implementation of HTCC determinations as set forth in the applicable implementation plan in the Operations Manual.

K. Adherence to a documented process, subject to the HCA's review and approval, that uses HCA-determined clinical criteria, guidelines, protocols, and/or other tools (e.g., HCA medical policy, Bree Collaborative, HTCC, ASB's medical policy) to accurately determine the medical necessity of health care services, equipment, and supplies.

L. Collaboration with local medical and health care communities, associations, and societies during the development and implementation of medical policies, for both Book-of-Business medical policies and HCA custom policies.

M. Participation in the Practice Transformation Support Hub, a Healthier Washington initiative that provides technical assistance and support to providers through their transition to Value Based Payments.

The ASB's administrative responsibilities to support Clinical Management Services will include:

A. Providing HCA with an annual written description of its Medical Management programs that has been approved by ASB's medical director for its Book-of-Business by May 1. The HCA will inform the ASB which programs will go into effect by work order, ninety (90) Days before implementation.

B. Notifying the HCA of changes in medical policy that materially affect UMP Plan payments at least thirty (30) Days before making the change.

C. Notifying providers of changes in medical policy that materially affect UMP Plan payments at least ninety (90) Days before making the change.

D. Accepting and following all the HCA's coverage and medical policies, including policies based on the determinations of the HTCC.

Exhibit 2.1 Utilization Management

Overview

The HCA desires a utilization management program that incorporates State endorsed Bree Collaborative recommendations, evidence-based guidelines, Office of the Insurance Commissioner (OIC) timeframes for reviews and Appeals, UMP Plan coverage and benefit provisions, Shared Decision Making tools, and NCQA or URAC standards. The ASB must use HCA-promulgated evidence-based medical policies and guidelines as well as available Bree Collaborative recommendations in the Utilization Management decision-making processes. The HCA expects the ASB to use its own clinical policies and procedures if the HCA does not have a custom clinical policy or procedure. The HCA requires the ASB to conduct Utilization Management for physical health and Behavioral Health, and the HCA also requires that Utilization Management reviews be conducted for inpatient and outpatient/ambulatory health care services. The HCA requires the ASB to provide pre-service (also called preauthorization and prior authorization), concurrent (also called continued stay), and retrospective reviews for medical necessity.

Any Utilization Management programs the ASB provides to its Book-of-Business must be offered to the HCA at no additional cost, but must first be approved by the HCA before being implemented. The ASB will update the HCA quarterly on all Clinical Management programs, including, but not limited to, UM programs. All HTCC decisions must be implemented through medical policies (e.g., pre-authorization and hard-coded edits). HTCC decisions may not align with current medical policies of the ASB.

The ASB must provide UM programs that support evidence-based practice, monitor for medically necessary services, facilitate timely referrals for other services, implement Shared Decision Making tools, and support positive patient and provider experiences. The HCA is also interested in how the ASB will appropriately delegate and monitor UM functions to provider groups, healthcare delivery systems, and ACOs.

The HCA requires the ASB to provide a robust UM program that:

A. Utilizes ASB's fully-insured book-of-business evidence-based medical policies, unless the HCA requires use of customized medical policies (such has gender dysphoria or HTCC), as well as available Bree Collaborative recommendations.

B. Meets or exceeds the OIC timeframes for reviews and Appeals.

C. Possesses Quality Management and Quality Assurance methods and programs to promote adherence to and incorporate the UM processes listed below across its fully-insured book-of-business, including predictive modeling and Expert Medical Opinion (EMO), also called "second opinion."

D. Develop and implement care management strategies to incent care delivery from both a medical condition and a social determinants perspective.

E. Includes UMP coverage and benefit provisions.

F. Meets or exceeds NCQA or URAC standards.

G. Monitors for medically necessary services by providing pre-service (also called preauthorization and prior authorization), concurrent (also called continued stay), and retrospective reviews for medical necessity.

H. Facilitates timely referrals for other services.

I. Includes UM for physical health and Behavioral Health.

J. Ensures UM reviews are conducted for inpatient and outpatient/ambulatory healthcare services.

Specific Instructions

The Response must explain how the Bidder's proposed Utilization Management program achieves the following goals:

A. Reducing medically unnecessary care.

B. Supporting timely and appropriate health care services for the right care for the right patient at the right time at the right level of care.

C. Reducing administrative burden.

D. Facilitating appropriate and timely referrals to other benefit programs (e.g., complex Case Management).

E. Supporting patient safety and quality of care.

F. Supporting Shared Decision Making.

G. Improving patient and provider satisfaction.

The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

Provide a written description of the proposed Utilization Management program that incorporates State endorsed guidelines (e.g., Bree Collaborative or HTCC recommendations), other evidence-based guidelines, OIC timeframes for reviews and Appeals, Shared Decision Making, UMP Plan coverage and benefit provisions, and NCQA or URAC standards. Respond to the following:

A. *Utilization Management Structure*

1. Describe the Bidder's organizational approach and philosophy.
2. Describe and identify any Subcontractors the Bidder uses for UM.
3. Describe the Bidder's years of experience in providing UM.
4. Describe the volume of reviews for the last five (5) years, including types of reviews (i.e., prospective, concurrent, retrospective, etc.), health care services reviewed, and review outcomes (i.e., approved, denied, partial approval/partial denials) for UM.
5. Describe the volume of Appeals for the last five (5) years, including percentage of denials appealed, and number and percentage of Appeal outcomes (upheld, overturned or partially upheld/partially overturned).
6. Describe the number and volume of UM reviews by channel of submission (i.e., phone, mail, fax or internet).
7. Describe the volume of Auto Adjudicated reviews (i.e., reviews not handled by a person but entirely adjudicated based on systems logic and edits).

8. Describe the background of Bidder's clinical leaders responsible for the UM program, such as Medical Director/Clinical Director and Operational Director of Utilization Management.
9. Describe the number, qualifications, roles, and functions of Bidder's clinical and non-clinical team members.
10. Identify the specific location (city and state) of Bidder's UM operations, if any, including the identification of U.S.-based and any off-shore based operations.
11. Describe the number and qualifications of clinical peer reviewers.
12. Describe the Bidder's information technology platform, including but not limited to the Web-based review platform used for UM.
13. Describe the telephone system that supports the Bidder's UM program.
14. Describe how the Bidder's systems and/or reporting integrate with other health management programs.
15. Describe how the Bidder's UM program incorporates State-endorsed Bree Collaborative recommendations, evidence-based guidelines, OIC timeframes for reviews and Appeals, UMP Plan coverage and benefit provisions, shared decision making tools, and NCQA or URAC standards.
16. Describe how the Bidder will delegate and monitor UM functions to provider groups, health care delivery systems and ACOs.

B. Process

1. Describe the clinical guidelines and criteria the Bidder uses, including Bree Collaborative recommendations.
2. Describe the channels of communication used for receiving and processing UM review requests, such as telephone, fax, internet, etc.
3. Describe your process for reviewing health care services when clinical guidelines/criteria are available.
4. Describe the process for reviewing health care services when there are no clinical guidelines/criteria (e.g., potentially experimental or investigational healthcare services).
5. Describe the Bidder's process and timeframe when a case does not meet clinical review guidelines/criteria.
6. Describe the Bidder's process for pursuing cases when information necessary to conduct the review is missing.
7. Describe the Bidder's process for Web-based review submissions, including the historical proportion of reviews submitted in this manner.
8. Describe any specific processes for the review of Behavioral Health services.
9. Describe any specific processes for the review of inpatient/acute health care services.
10. Describe any specific processes for the review of ambulatory healthcare services.
11. Describe any specific processes for the review of services provided by COEs.

12. Describe the Bidder's process for detecting and addressing potential quality of care/patient safety issues (e.g., premature discharge).
13. Describe the process for notifications when there is a denial.
14. Describe the process for notifications when there is an Appeal.
15. Describe the Bidder's preadmission counseling process.
16. Describe the discharge planning process.
17. Describe the post-discharge follow-up process.
18. Describe the Bidder's process for referrals to other services, such as complex Case Management and EAP services.
19. Describe the process for incorporating EMO into the review process.
20. Describe the process for proactively identifying providers who adhere to clinical guidelines/criteria so that those providers have a significant reduction in their review volumes.
21. Describe the Bidder's credentialing process for clinical/medical directors, clinical peer reviewers, and all other licensed clinical reviewers.
22. Describe the process for delegating UM functions to provider groups, healthcare delivery systems, and ACOs.
23. Describe the Bidder's Quality Assurance and Quality Improvement processes.

C. Outcomes

1. Provide the percentage of reviews completed within the OIC specified timeframes for the last five (5) years.
2. Provide the percentage of reviews denied for medical necessity for the last five (5) years.
3. Provide the percentage of reviews denied for reasons other than medical necessity (e.g., lack of information, administrative denials, etc.) for the last five (5) years.
4. Provide the percentage of cases referred for other health management programs, including complex Case Management, EAP, etc., for the last five (5) years.
5. Describe the Bidder's methodology for calculating Return on Investment (ROI) and/or Value on Investment (VOI) for UM.
6. Describe and show calculations for the Bidder's ROI and/or VOI statistics for the last five (5) years for UM.

D. Other Questions

1. Describe the Bidder's vision for the future of UM, including the roles of health plans and providers.
2. Describe the Bidder's experience delegating UM responsibilities to primary care clinics and delivery systems that have demonstrated expertise and capability to take on care management responsibilities. Address how the Bidder appropriately delegates and monitors UM functions to provider groups, healthcare delivery systems, and ACOs.

3. Describe the Bidder's condition-specific services or programs as listed above or for other programs offered in Book-of-Business.

Required Accompanying Documents

Submit the following documentation:

A. One (1) example each of the Bidder's current 2017 UM Program Description and 2016 UM Program Evaluation. The program description and evaluation must be for the Washington State market, if available.

B. Two (2) examples of a summary UM authorization and denial report produced for purchasers. The reports must be for the Washington State market, if available.

C. Provide one (1) page overviews of each Clinical Management program, condition-specific program, Utilization Management program, or Case Management program that the Bidder offers to its self-insured and fully-insured commercial populations. Include a summary of such program, outreach methods, and identification of members, percent of commercial population enrolled, how ROI is calculated, what current ROI is on the program.

D. Two (2) examples of decision-making guidelines developed by the Bidder, including a link to online medical policies.

E. UM authorization letter templates sent to patients with identified customizable fields. Provide two (2) letters for each of inpatient hospitalization and durable medical equipment or supplies, for a total of four (4) letters.

F. UM denial letter templates sent to Members with identified customizable fields identified. Provide two (2) letters for each of inpatient hospitalization and durable medical equipment or supplies, for a total of four (4) letters.

Evaluation and Scoring Insight

Preference will be given to a UM program that addresses all UM elements, goals, and aims; does not subcontract out UM programs; and has demonstrated financial, clinical, and satisfaction results. The HCA wants strong evidence of improved Member outcomes, improved utilization metrics, and appropriate decreases in clinical and administrative costs. The HCA will look favorably on established and fully integrated UM programs that are flexible, have experience in the Washington medical community, and promote the HCA's reimbursement methods for value based purchasing.

Bidder Response

Not to exceed sixteen (16) pages, excluding Required Accompanying Documents.

Exhibit 2.2 Quality Management and Improvement

Overview

The HCA desires a robust Quality Management and Improvement (QMI) program that incorporates best practices in Health Care Quality. This includes QMI as it relates to administrative services, such as Claims administration and customer service. A QMI program should help Subscribers receive high quality care in the right setting and achieve optimal health outcomes while receiving timely and accurate information about their benefit program and support for self-management.

The HCA is also interested in how the Bidder involves contracted providers and other suppliers into the QMI program. The Bidder must describe how it incorporates providers and other suppliers into an integrated QMI program that enables Members to have positive experiences with all services. The HCA is also interested in how the Bidder incorporates QMI into Clinical Management programs. The Bidder must describe how it uses QMI tools, resources, and processes to support the achievement and maintenance of quality in all aspects of administrative and Clinical Management Services described in this RFP.

Any QMI program the Bidder provides to their Book-of-Business, must be offered to the HCA at no additional cost, but must be approved by the HCA before being implemented. The ASB will update the HCA quarterly on all Clinical Management programs, including, but not limited to, its QMI programs.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

Please respond to each of the following items:

A. Describe the Bidder's QMI program, including its governance, scope, measurable goals and objectives, staffing structure, and staff responsibilities.

B. Describe the Bidder's specific QMI efforts related to non-clinical administrative services, such as Claims administration, provider contracting, and customer service. What are the key performance indicators for those non-clinical administrative services? Describe how any suppliers or Subcontractors are involved in the QMI program for non-clinical services.

C. Describe the Bidder's specific QMI efforts related to Clinical Management Services, such as Utilization Management, Case Management, and chronic condition management. What are the key performance indicators for those Clinical Management Services? Describe how providers and other interested parties are involved in the QMI program for Clinical Management Services.

D. Describe the specific QMI tool or methodology is used in the Bidder's QMI program, such as Lean; Plan, Do, Study, Act (PDSA); or Human Factors. Include how the tool or methodology is deployed.

E. Provide a summary of the Bidder's QMI activities in the Washington market, or one alternate market, that demonstrates improvement in coordination or management of individuals with chronic medical and Behavioral Health care conditions as a result of the Bidder's QMI process. What data, information, or deficiencies supported the change effort? What actions were taken to address data, information, or deficiencies? What were the structural changes, quantitative and qualitative process improvements and Member outcomes from these change efforts? What additional actions were taken to reinforce change (both structural and procedural) once outcomes were achieved? What is the Bidder's role in relation to providers?

F. Describe the Complaint processes from initiation all the way through resolution. Describe how Complaints are incorporated into the overall QMI program.

G. Describe what specific actions are taken to address common grievances and Complaints.

Required Accompanying Documents

A. Submit an example of an annual QMI program description and program evaluation within the Washington State market only. If a Washington market program is not available, the Bidder may submit one from an alternate market that is comparable to Washington's market.

B. Submit an example of an annual QMI work plan within the Washington State market. If a Washington market program is not available, the Bidder may submit one from an alternate market that is comparable to Washington's market. Describe the outcomes achieved as a result of measureable goals and objectives identified in the annual work plan.

C. Submit a report for 2016 Complaints for a comparable client. At a minimum, the report should list common categories of Complaints, including a category for quality of care; number of Complaints by category, and the rate of Complaints per category, per 1,000 Members.

D. Describe specific actions taken to address common grievances and Complaints.

E. Submit the results for a recent 2016 or 2015 CAHPS adult survey composite category, preferably in the Washington market, for a comparable client. Compare reported results to current commercial plan National CAHPS Benchmark Database (NCBD) commercial benchmarks results, measured at the 90th percentile. Describe specific actions taken to address any underperforming composite measures.

Evaluation and Scoring Insight

Preference will be given to a Bidder who can demonstrate a comprehensive, integrated, and impactful QMI program that addresses improvement in all administrative and Clinical Management Services. Preference will also be given to a Bidder who can demonstrate active and meaningful involvement from the providers in the QMI program.

Bidder Response

Not to exceed sixteen (16) pages, excluding Required Accompanying Documents.

Exhibit 2.3 Complex Case Management

Overview

The ASB must use HCA's evidence-based medical policies and guidelines when available as well as available Bree Collaborative recommendations in the Case Management care planning and decision-making processes. The ASB must use its own criteria for complex Case Management when there are no HCA criteria. The HCA requires the ASB to conduct complex Case Management (also called catastrophic Case Management) for physical health and Behavioral Health, and the HCA also requires that complex Case Management services be provided for patients receiving inpatient and outpatient/ambulatory healthcare services.

The HCA expects that the ASB's complex Case Management program will be able to achieve the following goals:

A. Reduce medically unnecessary and avoidable care.

B. Support timely and appropriate health care services, i.e. the right care for the right patient at the right time with the right level of care.

C. Support optimal Member self-management and Shared Decision Making.

D. Address Social Determinants of Health as part of the care planning process.

E. Incorporate physical health and Behavioral Health into the care planning process.

F. Reduce provider administrative burden.

G. Facilitate appropriate and timely referrals to health care and other benefit programs (e.g., wellness programs).

H. Support patient safety and quality of care.

I. Improve patient and provider satisfaction

Any Complex Case Management programs the ASB provides to its Book-of-Business must be offered to the HCA at no additional cost, but must be approved by the HCA before implementation. The ASB will update the HCA quarterly on all Clinical Management programs, including but not limited, to complex Case Management programs.

Specific Instructions

A. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020.

B. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

Provide a Response to each of the following Key Elements:

A. *Structure*

1. Describe the Bidder's organizational approach and philosophy for complex Case Management.
2. Describe and identify any Subcontractors used for complex Case Management.
3. Provide how many years of experience the Bidder has in complex Case Management.
4. Describe the Bidder's complex Case Management service delivery model.
5. Describe the volume of cases actively enrolled in complex Case Management over the last five (5) years.
6. Describe the communications channels available for interaction between patients/families and providers, including telephone, email, chat, text messaging, etc.
7. Describe the background of the Bidder's clinical leaders, such as Medical Director/Clinical Director and Operational Director.
8. Describe the number and qualifications of clinical case managers and non-clinical staff members.

9. Identify the specific location (city and state) of your complex Case Management operations, including the identification of U.S. based and off shore operations, if any.
10. Describe the number and qualifications of clinical specialists for clinical consultations, including physicians and Behavioral Health practitioners.
11. Describe the information technology platform used for complex Case Management, including but not limited to any Web-based platform.
12. Describe the telephony system that supports complex Case Management.
13. Describe how the Bidder's systems and/or reporting integrate with other health management programs.
14. Describe the outcomes achieved for the Bidder's Book-of-Business.

B. Process

1. Describe the Bidder's complex Case Management protocols, assessment tools, and other resources used in the Case Management process.
2. Describe the Bidder's ability to perform on-site visits and embed case managers within larger health systems.
3. Describe the Bidder's inclusion and exclusion criteria for potential candidates for complex Case Management.
4. Describe the process and timeframe for case identification from sources such as the UM process, predictive modeling, etc.
5. Describe the process of screening and outreach to potential candidates for complex Case Management.
6. Describe the process for obtaining missing telephone numbers, emails, and other contacts for potential complex Case Management candidates.
7. Describe the assessment tool used to determine patient acuity level.
8. Describe the Bidder's process for assigning patients to clinical case managers.
9. Describe the process and timeframe from initial patient contact to obtaining consent to assessment to complex Case Management care plan finalization.
10. Describe the role and function of the non-clinical support team members in the complex Case Management process.
11. Describe the role and function of the clinical case manager.
12. Describe the role and function of clinical specialists (including physicians and Behavioral Health specialists).
13. Describe the tools and resources used by the clinical case manager throughout the complex Case Management process, such as motivational interviewing and Patient Activation Measure (PAM®).
14. Describe the processes and tools used to identify and address Social Determinants of Health.
15. Describe the process and timeframe for distributing the complex Case Management care plan to patients/family members, providers, and any others.

16. Describe the tools and resources used for patient education and Shared Decision Making.
17. Describe the tools and processes used for transitions of care, from discharge planning to post-discharge follow up processes.
18. Describe the Bidder's process for referrals to other services, such as wellness programs.
19. Describe the Bidder's credentialing process for all licensed clinicians, including Clinical/Medical Directors and clinical case managers only as it relates to complex Case Management.
20. Describe the Bidder's complex Case Management closing criteria and processes, including notifications to the patient, family, providers, and any others.
21. Describe the process for handling Complaints regarding complex Case Management services.
22. Describe the process for delegating complex Case Management functions to provider groups, healthcare delivery systems, and ACOs.
23. Describe the Quality Assurance and Quality Improvement processes for this program.

C. *Outcomes*

1. Describe the percentage of patients with outreach/engagement who actually enrolled in Case Management for the last five (5) years of the total Book-of-Business.
2. Describe any survey of patients who are in complex Case Management, the percentage of patients where care plans were developed and distributed within 30 Days of initial contact with the patient for the last five (5) years.
3. Describe the percentage of enrolled patients who rank complex Case Management satisfaction in one of the top two satisfaction levels for the last five (5) years.
4. Describe the percentage of patients who have been enrolled in complex Case Management who have increased their level of patient activation or patient engagement (e.g., PAM® level) for the last five (5) years.
5. Describe the percentage of enrolled patients filing Complaints regarding complex Case Management services for the last five (5) years.
6. Describe the percentage of cases referred for other health management and wellness programs for the last five (5) years.
7. Describe the Bidder's methodology for calculating ROI and/or VOI.
8. Describe the Bidder's ROI and/or VOI statistics for the last five (5) years.
9. Describe outcomes for quality and cost for Book-of-Business complex Case Management for the last five (5) years.

Required Accompanying Documents

A. Submit an example of the Bidder's complex Case Management assessment tool that addresses Social Determinants of Health, Bree Collaborative recommendations, and physical health and Behavioral Health aspects.

B. Submit an example of the Bidder's complex Case Management satisfaction tool or similar tool.

C. Submit an example of a quarterly summary complex Case Management report.

D. Provide two (2) Case Management summaries:

   1. One case with a member with a primary Behavioral Health condition, including Case Management assessment, care plan, Case Management interventions for both Behavioral Health and physical health issues, and a description of the outcomes from the Case Management interventions.

   2. One case with a member with a primary physical health condition, including Case Management assessment, care plan, Case Management interventions for both Behavioral Health and physical health issues, and a description of the outcomes from the Case Management interventions.

Evaluation and Scoring Insight

None.

Bidder Response

Not to exceed sixteen (16) pages, excluding Required Accompanying Documents.

Exhibit 2.4 Chronic Condition Management

Overview

The HCA requires a chronic condition management program that is embedded whenever possible into Primary Care practices. The management program should demonstrate how it incorporates the tenets of the Chronic Care Model and Patient Centered Medical Home (PCMH). The ASB must use HCA evidence-based medical policies and guidelines, when available, as well as available Bree Collaborative recommendations in the chronic condition management care planning and decision-making processes. The ASB must use its own criteria for chronic condition management when there are no HCA criteria. The HCA requires the ASB to conduct chronic condition management for physical health and Behavioral Health.

Any chronic condition management programs the ASB provides to its Book-of-Business, must be offered to the HCA at no additional cost, but must be approved by the HCA before implementation. The ASB will update the HCA quarterly on all Clinical Management programs, including but not limited to chronic condition management programs.

The Bidder must provide chronic condition management programs for UMP Plans, grounded in the tenets of the Chronic Care Model, evidence-based practice, patient self-management and Shared Decision Making, facilitate timely and appropriate referrals for physical health and Behavioral Health services, coordinates care across the healthcare delivery system, and provide positive patient and provider experiences.

The ASB will provide a chronic condition management business function that identifies Members with multiple, persistent, severe healthcare needs to ensure:

A. Incorporation of the tenets of the Chronic Care Model and PCMH. If telephonic process is used, please describe how the Bidder works with patient's Primary Care team to integrate as much as possible.

B. Incorporation of Social Determinants of Health, patient self-management, and Shared Decision Making into care planning processes.

C. Improved Care Coordination across health care delivery system and positive Member and provider experiences, this includes integration between the ASB, complex Case Management team and the patient's Primary Care team to facilitate a comprehensive patient care plan.

D. Development, implementation, and revision of a comprehensive care plan.

E. Optimal clinical outcomes for Member self-management and Shared Decision Making.

F. Support timely and appropriate health care services for the right care for the right patient at the right time with the right level of care.

G. Reduction in medically unnecessary care and administrative burden.

H. Timely and appropriate referrals for physical and Behavioral Health services as well as other benefit programs.

I. Support of patient safety and quality of care, and improvement of Member and provider satisfaction.

J. Proactive identification of Members at risk for health service utilization in order to implement interventions at the earliest possible time to enhance outcomes and effectiveness.

K. Cost containment to the extent consistent with the above.

The HCA requires the ASB to provide:

A. A documented process that accurately identifies the Member population eligible and most likely to benefit from chronic condition management.

B. A process for designing and implementing individualized treatment plans and distributing those plans within thirty (30) Days of initial contact with the Member.

C. Effective use of the full array of benefits and network providers available.

D. Coordination with other HCA vendors available through the UMP Plan to achieve integrated care.

E. Reporting of detailed program statistics to the HCA, as requested, including disease type, chronic care manager work, outcomes, and other information as determined by the HCA.

F. Ability to manage specific service types under the chronic condition management program, including inpatient chemical dependency and mental health care.

G. Application of COC provisions that require Members to be in chronic condition management before the UMP Plan covers certain services or conditions.

Specific Instructions

A. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020.

B. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

Provide a Response to each of the following Key Elements:

A. *Structure*

1. Describe the Bidder's organizational approach and philosophy for chronic condition management.
2. Describe and identify the provider groups, delivery systems, and ACOs that the Bidder has delegated for the provision of chronic condition management.
3. Describe the Bidder's on-site (i.e., non-telephonic) chronic condition management service delivery model.
4. Describe your chronic condition management service delivery model that is telephonic and integrated with the patient's Primary Care provider or team.
5. Describe the communication channels available for interaction between patients/families and providers, including telephone, email, chat, text messaging, etc.
6. Describe the number of staff, and staff per 1,000 Members, and qualifications of licensed chronic condition managers and non-clinical staff members.
7. Describe how the chronic condition management systems and/or reporting integrate with the Bidder's other health management programs.
8. Describe the chronic conditions that are included in this program.

B. *Process*

1. Describe chronic condition management protocols, assessment tools, and other resources the Bidder uses.
2. Describe the Bidder's inclusion and exclusion criteria for potential candidates for chronic condition management.
3. Describe the Bidder's process and timeframe (starting with case identification) to provide chronic condition management services.
4. Describe the process for screening and outreach to potential candidates.
5. Describe the process for obtaining missing telephone numbers, emails, and other contacts for potential chronic condition management candidates.
6. Describe the assessment tool the Bidder uses to determine patient acuity level.
7. Describe the Bidder's process for assigning patients to chronic condition managers.
8. Describe the process and timeframe from initial patient contact to obtaining consent to assessment to chronic condition management care plan finalization.
9. Describe the role and function of non-clinical support team members in the chronic condition management process.
10. Describe how the Bidder's clinical team is specifically trained to address the chronic conditions they manage, including the role and function of the clinical chronic condition manager, and the role and function of clinical specialists (including physicians and Behavioral Health specialists).

11. Describe the tools and resources used in the chronic condition management process, such as motivational interviewing and PAM®.
12. Describe the processes and tools the Bidder uses to identify and address Social Determinants of Health.
13. Describe the Bidder's process and timeframe for distributing the chronic condition management care plan to the patient/family, providers, and any others.
14. Describe the tools and resources used for patient education and Shared Decision Making.
15. Describe the Bidder's process for referrals to other services, such as wellness programs.
16. Describe the process for detecting and addressing potential fraud, waste, and/or abuse.
17. Describe the Bidder's credentialing process for all licensed clinicians, including clinical/medical directors and clinical chronic condition managers.
18. Describe the Bidder's chronic condition management closing criteria and processes, including notifications to the patient, family, providers, and any others.
19. Describe the process for handling Complaints regarding chronic condition management services.
20. Describe the process for delegating chronic condition management functions to provider groups, health care delivery systems, and ACOs.
21. Describe your Quality Assurance and Quality Improvement processes for this program.

C. Outcomes

1. Provide the percentage and number of patients who engaged through outreach and enrolled in chronic condition management over the last five (5) years in each chronic condition management program.
2. Provide the percentage of patients where care plans were developed and distributed within 30 Days of initial contact with the patient in the last five (5) years.
3. Provide the percentage of enrolled patients who rank chronic condition management satisfaction in one of the top two satisfaction levels in the last five years.
4. Provide the percentage of patients who have been enrolled in chronic condition management who have increased their level of patient activation or patient engagement (e.g., PAM® level) in the last five (5) years.
5. Provide the percentage of enrolled patients who filed Complaints regarding chronic condition management services in the last five (5) years.
6. Provide the percentage of cases referred for other health management and wellness programs in the past five (5) years.
7. Describe the Bidder's methodology for calculating ROI and/or VOI.
8. Provide the Bidder's ROI and/or VOI statistics for last five (5) years.

Required Accompanying Documents

A. Submit an example of the Bidder's chronic condition management assessment tool that incorporates the Chronic Care Model, PCMH, Social Determinants of Health, and physical health and Behavioral Health aspects.

B. Submit an example of the Bidder's chronic condition management satisfaction tool or similar tool.

C. Submit an example of a quarterly summary chronic condition management report.

D. Provide two (2) chronic condition management summaries:

1. One (1) case with a member with a primary Behavioral Health condition, including chronic condition management assessment, care plan, chronic condition management interventions for both Behavioral Health and physical health issues, and a description of the outcomes from the chronic condition management interventions.

2. One (1) case with a member with a primary physical health condition, including chronic condition management assessment, care plan, chronic condition management interventions for both Behavioral Health and physical health issues, and a description of the outcomes from the chronic condition management interventions.

Evaluation and Scoring Insight

The Bidder must present an on-site chronic condition management program that incorporates embedded teams, whenever possible, into Primary Care practices. The Bidder must incorporate the Chronic Care Model into the provision of chronic condition management services. Preference will be given to a chronic care management program that addresses all elements, goals, and aims and has demonstrated financial, clinical, and satisfaction-related results. The HCA wants strong evidence of improved Member outcomes, improved access to appropriate health care services, and increase in clinical appropriateness. The HCA will look favorably on established and fully-integrated chronic care management programs that are flexible, have experience in the Washington medical community, and promote the HCA's reimbursement methods for Value Based Purchasing. Preference will be given to a Bidder that offers telephonic chronic care management program that is integrated with the patient's Primary Care team.

Bidder Response

Not to exceed sixteen (16) pages, excluding Required Accompanying Documents.

Exhibit 2.5 Other Clinical Management Services

Overview

The HCA is looking for an ASB who offers additional Clinical Management Services that can augment the Clinical Management programs previously described. These other Clinical Management Services should align with NCQA or URAC standards as well as UMP Plan coverage and benefit provisions while supporting evidence-based care and health supports. Other Clinical Management Services should incorporate the Bree Collaborative recommendations, other state endorsed guidelines, and other nationally-recognized evidence-based guidelines. These other Clinical Management Services should provide support and tools

to Members and providers on the appropriate use of health care services based on the guidelines cited above. Tools could include support for issues relating to Claims, clinical, benefits, and/or patient navigation services, decision support for health conditions including preference-sensitive conditions.

Specific Instructions

A. The Bidder's Response must explain how these proposed other Clinical Management programs achieve the following goals:
    1. Supporting optimal patient self-management and shared decision making.
    2. Addressing Social Determinants of Health into the care planning process.
    3. Incorporating physical health and Behavioral Health into the care planning process.
    4. Reducing administrative burden.
    5. Facilitating appropriate and timely referrals to health care and other benefit programs (e.g., wellness programs).
    6. Supporting patient safety and quality of care.
    7. Supporting timely and appropriate health care services for the right care for the right patient at the right time with the right level of care.
    8. Improving patient and provider satisfaction.

B. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020.

C. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

Provide a written description of the proposed other Clinical Management Services that incorporate State-endorsed guidelines (e.g., Bree Collaborative recommendations), other evidence-based guidelines, UMP Plan coverage and benefit provisions, patient self-management, Social Determinants of Health, Shared Decision Making tools and resources, and NCQA or URAC standards. Respond to the following questions:

A. Describe other Clinical Management Services that might apply to Members.

B. Describe the structure, including the qualifications and number of staff and other resources, for each of the other Clinical Management Services.

C. Describe the information technology infrastructure/platform for the other Clinical Management Services (e.g., systems used and how they integrate with each other, claims vs. clinical).

D. Describe how these other Clinical Management programs have impacted costs, quality, and patient and provider satisfaction.

E. Describe how these other Clinical Management Services interact, coordinate, and integrate with Utilization Management, complex Case Management, and chronic condition management.

F. Describe how these other Clinical Management Services optimize the use of technology (e.g., email, chat).

G. Describe the appropriate sub-population for each of the other Clinical Management Services offered by the Bidder.

H. Describe how the other Clinical Management Services will coordinate and communicate with provider delivery system, provider group, and/or ACOs.

I. Describe the Bidder's Quality Assurance and Quality Improvement processes for these programs.

J. Describe the Bidder's methodology for calculating the ROI and/or VOI.

Required Accompanying Documents

Provide sample reporting for all other Clinical Management Services, including a report showing that displays the ROI and/or VOI.

Evaluation and Scoring Insight

The HCA is looking for a Bidder who has implemented other Clinical Management Services that helped to reduce costs, improve quality, and support positive Member and provider experience. The HCA seeks an ASB with other Clinical Management Services that are tested and proven in its Book-of-Business. The HCA is also looking to see if and how the Bidder can propose other Clinical Management programs that are appropriate and applicable to the HCA population.

Bidder Response

Not to exceed seven (7) pages, excluding Required Accompanying Documents.

Exhibit 2.6 Innovations in Clinical Management

Overview

The HCA is interested in an ASB that uses a systematic approach for identifying and implementing innovations in the delivery, management, and payment of health care services. The HCA anticipates changes in Clinical Management over the course of the Contract term due to a number of reasons, including the following factors:

A. Changes in financial reimbursement models;

B. Adaptation and use of technology; and

C. Implementation of new evidence-based clinical practices.

The HCA seeks an ASB who is committed to on-going health innovation, especially as it impacts Clinical Management, in order to leverage technology, human resources, emerging financial reimbursement strategies, and evolving evidence-based care delivery models.

Specific Instructions

A. The HCA is looking for a Bidder who has demonstrated experience in identifying and implementing innovations in Clinical Management. The Bidder should describe experiences from previous innovation projects, including successes and lessons learned.

B. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in

the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020.

C. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

Provide a written description of how the Bidder meets the requirements above, as well as the following Key Elements:

A. Describe the Bidder's historical experience with identifying and implementing health innovations related to Clinical Management programs.

B. Describe the Bidder's philosophy and guiding principles for health innovation.

C. Describe the established health innovation structure, including staff and other resources, created and dedicated to health innovation.

D. Describe the Bidder's process for on-going health innovation, particularly Clinical Management innovation.

E. Describe applicable experience with health innovation in Washington State, particularly with Clinical Management programs.

F. Describe how the Bidder involves providers, plan sponsors, patients, and other stakeholders in health innovation initiatives.

Required Accompanying Documents

A. Submit a case study of a health care innovation that was developed and implemented, including the financial, clinical, and satisfaction outcomes.

B. Submit the Bidder's innovation plans for 2017 through 2020, including specific involvement and impact on Clinical Management programs.

Evaluation and Scoring Insight

Preference will be given to Bidders who have experience identifying and implementing health care innovation, especially with state government agencies, and preferable within Washington State. Bidders should demonstrate a long term commitment to on-going, systematic health care innovation.

Bidder Response

Not to exceed five (5) pages, excluding Required Accompanying Documents.

Exhibit 2.7 HCA Clinical and Medical Policies

Overview

The ASB will be required work closely with the HCA Chief Medical Officer and the HCA's Clinical Quality Care Transformation (CQCT) Division to develop, implement, and manage customized HCA medical polices, such as the HCA's transgender policy, as well as determinations made by the Washington State Health Technology Clinical Committee (HTCC). UMP Plans are required by law to use HTCC's criteria when deciding whether certain technology is medically necessary and to implement HTCC determinations in a way that is not

more restrictive or more liberal than HTCC determinations allow (see, RCW 70.14.120(1)). All HTCC determinations and reports requested by the HCA will be implemented within the PSPM.

At a minimum, the ASB is expected to:

A. Assist in the development of customized medical policies, including drafting policies according to high-level direction and within timelines and approval criteria provided by the HCA.

B. Develop pathways for implementing each HCA medical policy, including, but not limited to the development of:

    1. Coverage or benefit updates;
    2. Target dates for implementation of new policies (often the start of the next plan year);
    3. Care management, clinical guidelines, tools, and criteria, including procedure and diagnostic codes requiring prior authorization;
    4. Claim system modifications, including UMP Plan-specific covered and non-covered procedure codes;
    5. Staff training that ensures consistent application of HCA clinical policies; and
    6. A web-based approach for submitting reviews and receiving Utilization Management review decisions, including Auto Adjudicated review processes.

C. Implement medical necessity criteria, technology coverage and reimbursement in accordance with the implementation strategies and time-frames established by the HCA CQCT Division, as described in this Section 2.7 of this RFP.

D. Create detailed implementation plans (including procedure and diagnostic codes) for each determination that must meet the approval of the HCA Medical Director.

E. Implement all HTCC decisions through medical policies (e.g., pre-authorization and hard-coded edits).

F. Participate in HCA activities to affirm the Bidder's conformance to policies, including audits.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

Submit detailed and specific Responses that address the Bidder's experience or plans to meet the following Key Elements:

A. Describe the Bidder's experience implementing customized medical policies for a self-insured client.

B. Describe the Bidder's experience implementing HTCC coverage decisions or other similar decisions for self-insured plans.

C. Describe the Bidder's proposed approach to developing pathways for implementing customized medical policies.

Required Accompanying Documents

None.

Evaluation and Scoring Insight

Preference will be given to Bidders who have experience adapting to and implementing customized medical policies, and have an existing structure and processes for such implementation.

Bidder Response

Not to exceed five (5) pages, excluding Required Accompanying Documents.

EXHIBIT 3 ADMINISTRATIVE SERVICES

Overview

The Bidder is to develop a separate technical Proposal for each of the administrative services contained in Exhibits 3.1 through 3.17 and review and agree to the administrative Performance Guarantees listed in Exhibit 3.16. The Bidder must address each administrative service as a required element of the full package, follow all instructions, address each of the required elements, and include all required accompanying documentation. All administrative services required or proposed in response to Exhibits 3.1 through 3.15 must be included in the Administrative Fee Per Subscriber Per Month (PSPM) Proposal presented in Exhibit 5.2.

Each administrative service response must stand on its own merits in terms of addressing the scope of the topic and will be scored independent of other Responses. Do not refer to other administrative service Responses or information provided in other Proposal sections as supporting information. The HCA is under no obligation to consider information that is not contained in the specific administrative service Response being evaluated.

Specific Instructions

For each of the following administrative services, the Proposal should provide appropriate detail to describe the scope of service being offered. The description for each service must address all activities and processes, including all Quality Assurance and Quality Improvement activities necessary to operate the service in a manner that effectively and efficiently delivers high quality outcomes.

Evaluation and Scoring Insight

The HCA values responses that communicate the Bidder's capabilities and capacity relative to the size and complexity of all the UMP Plans, and the HCA's status as a public sector self-insured PPO. Responses must acknowledge and address the Bidder's flexibility to comply with unique requirements imposed by Washington State laws, administrative rules, and policies.

Exhibit 3.1 Medical Benefit Drug Management Program

Overview

The HCA desires an ASB with a robust Medical Benefit Drug Management Program (MBDMP) with the following elements:

A. Strategically aligned with the outpatient pharmacy benefit administered by the UMP PBM.

B. Claim payment integrity, Rebate negotiation, invoicing, and collection for Medical Drugs;

C. A medical infusion site of care management for infused Medical Drugs and includes a quality and cost assessment for infusion facilities;

D. An evidence-based Utilization Management program to ensure that each use of a Medical Drug is for its FDA-labeled indication and dose and for which there is good clinical evidence.

E. Clinically appropriate, safe, and cost-effective "medical preferred drug list" that is consistent with either the Washington Preferred Drug List, the UMP wrap-around preferred drug list maintained by the UMP PBM, or use the medical preferred drug list provided by the HCA.

F. Medical Drug coverage policies should be designed to ensure the most cost-effective drug is used to treat each condition, which may be a self-administered drug (injectable or oral), that is would be covered under the outpatient pharmacy benefit.

Specific Instructions

A. Provide a written response that demonstrates the Bidder's ability to meet all required elements of the MBDMP listed below or describe the reasons any required element cannot be met or will be delayed and for how long.

B. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020.

C. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

A. Utilization and Preferred Drug Management—ensuring the safe and appropriate use of high-cost specialty drugs. Describe the Bidder's Utilization Management approach to drugs covered under the medical benefit. In the description, please address the following:

1. How the Bidder's clinical policies are developed and what resources are used. Include the role of the Bidder's medical and pharmacy director in establishing clinical policy.
    i. How policies ensure the drugs are used for the appropriate FDA-approved diagnosis(-es) at the appropriate dose, frequency and duration of therapy.
    ii. How policies ensure the most cost-effective drug is prescribed and administered. Explain how a preferred drug is selected when multiple drugs are available within a therapeutic class (e.g. IVIG, oncology, filgrastim, growth hormone, etc.).
    iii. How changes to the medical preferred drug list are communicated to members and the local medical community.
    iv. The Bidder will be required to make specific coverage criteria available for prescribers and Members as set forth in RCW 41.05.074. Describe how the Bidder will meet this obligation.
    v. Provide specific examples of the clinical pathways the Bidder recommends implementing that involve pharmaceuticals (e.g., oncology, hemophilia, HAE etc.). For example, if Bidder currently provides these services for other clients, describe how those services are provided.
2. Describe the prior authorization process, including approvals, denials and Appeals.
    i. Describe how the Bidder will collaborate with the UMP PBM to enforce step-therapy protocols that require a self-administered drug, covered under the pharmacy benefit, be used prior to an infused drug.
    ii. Describe how the Bidder will monitor ongoing Clinical Management performance.

iii. Describe the Bidder's electronic platform that providers can access to obtain a coverage decision for medications that require pre-authorizations.

3. Describe how the Bidder will inform the HCA about new drugs coming onto the market. Include what the Bidder will provide regarding industry benchmarks and advanced information on new drugs including cost projections and coverage recommendations including a plan-specific economic analysis of coverage options for new therapies with high cost.

B. Fee Schedule Management and Payment Integrity - Verifying that Claims are paid at the contracted rate and improving opportunities to collect Rebates. Describe how drugs are reimbursed under the medical benefit. In your description, please address the following:

1. Describe the Bidder's basis for reimbursement for Medical Drugs (e.g. Average Wholesale Price, Average Sales Price, Wholesale Acquisition Cost, etc.)? If the Bidder does not currently reimburse based on a discount off of Average Wholesale Price or Wholesale Acquisition Cost, describe its openness to doing so for this Contract.

2. Describe the pre-payment Claim processing edits the Bidder utilizes to ensure that drugs are used for the appropriate FDA-approved diagnoses at the appropriate dosages, frequency, and duration.

3. Describe the Bidder's ability to adjudicate Medical Drug claims using NDC codes and base reimbursement and Member cost share on the NDC codes rather than J-codes.

C. Medical Drug Site of Care Management – Re-directing patients to the lowest-cost and most appropriate medication(s) channel. Describe the Bidder's site-of-care management program. In the description please address the following:

1. Describe how providers purchase drugs within the site-of-care program.

2. If Bidder requires providers to purchase from a single specialty pharmacy, describe the basis of reimbursement to that pharmacy. If contracted, detail how the HCA will be billed. Will it be the same amount paid to the specialty pharmacy?

3. PEBB has a preferred specialty pharmacy through its PBM. Would the UMP be able to require providers to purchase Medical Drugs from that specialty pharmacy?

4. Describe how the Bidder will manage where the drugs are given for infusions.

D. Plan Design – Demonstrate the ability to administer the UMP plan design for Medical Drugs consistent with the UMP out-patient pharmacy benefit. Recent legislation requires Health Plans to have the same out-of-pocket costs in the medical and pharmacy benefit for cancer drugs. The HCA desires a flexible system that allows for the administration of different cost-sharing for drugs based on their "preferred" status to align with the out-patient pharmacy benefit (e.g. Tier 1 has a 10% coinsurance with a maximum per Claim cost of $25; Tier 2 has a 30% coinsurance with a maximum per Claim cost of $75; Tier 3 has a 50% coinsurance with no maximum except for specialty drugs, but exception policies apply in certain circumstances). Please describe your ability to administer such a program.

E. Rebate Management – The HCA desires a Rebate management program that is transparent, auditable, and passes 100% of all Rebates to the HCA. Describe the Bidder's Rebate management program. In the description, please address the following:

1. Describe the Bidder's ability to negotiate Rebates with third parties that are specific to the HCA Preferred Drug List and are not dependent on the Bidder's Book-of-Business market share or PDL.

2. Describe the Bidder's ability to disclose Rebate terms prospectively to enable the HCA to make informed benefit design decisions.
3. Describe the Bidder's ability to negotiate Rebates and discount units with pharmaceutical manufacturers for drugs covered under the medical benefit based on the Bidder's wrap around medical preferred drug list.
4. Confirm that the Bidder will pass 100% of the Rebates, discounts, incentives or other credits however characterized to the HCA for any of its plans administered by the Bidder, with respect to utilization of any Medical Drugs by Members on which Rebates are or will be paid.
5. Provide the HCA with quarterly Rebate reports detailing the total amount of Rebates submitted on behalf of the Plans for each pharmaceutical company. These reports shall break down the Rebate submission by pharmaceutical company, drug product by NDC, and Claim count.
6. Confirm that the Bidder will provide the HCA monthly Rebate payments.
7. Describe the type of drugs for which the Bidder has secured Rebates, including multi-source brand, single source generic or any other unique designations.
8. Confirm that the Bidder will allow the HCA or its delegates to review contracts with manufacturers and data specific to the administration of the plans upon request. Bidder shall permit the HCA or its delegate to audit records and pharmaceutical manufacturer contracts for compliance with the terms of the Contract. Provide a copy of any confidentiality agreement the Bidder will require the HCA, or their delegates (e.g. independent auditor/s) to sign in order to audit records including invoices to third parties, financial transactions between Bidder and third parties, and third party Contracts.
9. Describe the Bidder's knowledge and experience with performance based risk sharing agreements. Note any performance-based risk sharing agreements with any manufacturers at this time.

F. Describe how the Bidder's pharmacy team will interact, collaborate, and communicate with the UMP PBM to manage total drug costs.

G. Describe how the Bidder's pharmacy team will monitor adherence for drugs administered for chronic conditions administered under the medical benefit.

H. The ASB will be required to routinely coordinate with the UMP PBM. This will include regular joint participation in clinical strategy meetings, sharing of patient and Claim information by both parties to coordinate care of Members as needed and will support data analysis of both the ASB and the UMP PBM as directed by the HCA. Execution of a BAA and/or Data Sharing Agreement with the UMP PBM will be required under the Contract. The ASB will be required to take a data file from the UMP PBM and complete data analysis such as UMP Plan-specific HEDIS reporting for the HCA at least monthly. It is expected that the ASB will store this PBM data with the medical data, but keep it firewalled from the rest of the Book-of-Business data. Data analysis will be included in the PSPM under the data analytics FTE under Account Management in Exhibit 3.8.1. Describe how the Bidder will comply with this requirement.

I. Describe the Bidder's knowledge and experience with performance based risk sharing agreements, including current agreements with manufacturers.

Required Accompanying Documents

A. Submit sample monthly Rebate remittance documentation.

B. Submit a copy of the confidentiality agreement the HCA or delegated professional auditor must sign to review Rebate contracts and processes.

C. Submit a sample report demonstrating the Bidder's ability to report Rebates by manufacturer and product at the National Drug Code (NDC) level.

Evaluation and Scoring Insight

Points will be given for each of the following factors and value will increase in relation to the number of included factors.

A. An evidence-based Utilization Management program including step therapy for oral and infused drug options;

B. An effective site of care management process

C. Bidder's description of their Rebate program for Medical Drugs;

D. The Bidder's ability to negotiate UMP specific Rebates with third parties, including details about the Bidder's significant market presence to negotiate competitive Rebates.

E. Transparency of Rebate process and payments to Members and the HCA

F. Willingness to coordinate with the UMP PBM and the HCA on clinical strategies and patient care management for optimal patient outcomes.

Bidder Response

Not to exceed twelve (12) pages, excluding Required Accompanying Documents.

Exhibit 3.2 Claims Services

Overview

The Claims Payment Service must be fully operational on January 1, 2020 including the ability to Auto Adjudicate 70% of non-Medicare Claims and process 85% of non-Medicare Claims electronically. The ASB will not be responsible for paying Claims for dates-of-service prior to January 1, 2020. However, the ASB will be responsible for loading hearing aid accumulators from the prior administrative services contract.

The ASB must be able to perform the following types of Claim payment processes beginning January 1, 2020 based on UMP Plan designs:

A. Pay its Washington State network hospitals, facility and professional and Ancillary Provider Claims based on the terms of ASB contracts with those providers. This may require UMP-specific rates within such contracts.

B. Pay out-of-state network facility and professional provider Claims based on the terms of ASB's contracts with those providers. This may require UMP-specific rates within such contracts.

C. Process out-of-country Claims at in-network rates for Members, including expected translation services.

D. Process out-of-network Claims at lower non-network reimbursement rate based on the UMP plan design.

E. Process payments for COEs or bundled payments as the HCA requests.

Specific Instructions

Each Response to the exhibits below must be separate, stand-alone narratives and will be scored independent of the content of the other Responses.

Exhibit 3.2.1 Claims Payment Services General Requirements

Overview

The Bidder is to describe in detail the scope of service to be provided to comply with the required elements under a single Administrative Fee for each UMP Plan.

The HCA desires an ASB that can perform the following general required elements:

A. Support and implement HCA strategic initiatives and demonstration projects such as ACNs, COE contracting, Healthier Washington, bundled payments, tiered hospital networks, Value Based Payment contracts, episode of care reimbursements and other value-based payment initiatives sanctioned by the HCA for Members and across the ASB's Book-of-Business.

B. Pay the ASB's contracted network of hospitals, professional providers and other non-hospital providers based on the specified payment methodologies, as defined by the HCA Value-based Roadmap.

C. Administer Value Based Payment or alternative payment models.

D. Administer, create, implement and manage payment to providers for ACNs.

E. Administer the UMP benefit design in 2020 similar to that described in the 2017 UMP Certificate of Coverage (Appendix 6, Attachments 4 – 7).

F. Adjudicate all U.S. and Foreign Claims and Washington Tribal Clinic Claims as in network that cover all active, COBRA, and retiree Members in accordance with plan benefits in the applicable Certificate of Coverage. This excludes retail, mail-order, and specialty pharmacy Claims.

G. Subcontract for some services with specific vendors upon HCA request, for services such as Diabetes Control and Prevention Programs, or a specific HSA Trustee.

H. Provide a structured, adequately staffed U.S.-based claims office that delivers a consistently high degree of Claims payment accuracy and timeliness as measured by the Performance Guarantees.

I. Include all Claims and provider networks in one resource enabling Members to receive EOBs, access Claims information (electronic and paper based), and search for providers.

J. Perform other Claims-related functions necessary to provide a complete administration of Claims service.

K. Provide a credit balance recovery service and quarterly reports thereof.

L. Provide fraud, waste, and abuse (collectively called program integrity) awareness, detection, and recovery services and at least monthly reports thereof.

M. Collect information from Members via mail at least annually, after Open Enrollment (mailed concurrently with welcome packets), about other health insurance coverage in order to help with the administration of Coordination of Benefits.

N. Pay or administer incentives identified by HCA for Member completion, or participation in HCA-sponsored wellness or disease management activities, such as SmartHealth. HCA will

inform the ASB via the eligibility file which UMP Classic or UMP Plus Subscribers receive a reduction in their annual deductible, and which UMP CDHP Subscribers will have an incentive added to their HSA. This will include Subscribers who earned their wellness incentive for the year in which they enroll in Medicare mid-year (February 2 – December 31). The ASB will participate in HCA-requested data exchanges with the wellness vendor(s) through the Work Order process as necessary.

O. Track and resolve incomplete or pended Claims using an automated process and within designated timeframes.

P. Provide a fully operational Claims payment service on January 1, 2020 that includes the ability to accurately electronically process 85% of all non-Medicare Claims.

Q. Provide a corrective action plan for resolution of Claims adjudication issues, including Member eligibility, referral, authorization, Coordination of Benefits, third-party liability, subrogation, fraud, overpayments, or workers' compensation information, within fifteen (15) Days of receipt of such issue.

R. Provide a controlled process for printing checks and EOBs, sending payment data to the provider within ten (10) Business Days of the check printing, and handling check reconciliation and offering electronic funds transfer to providers.

S. Before Claims payment is made, perform all authorization processes or edits to Claims administration, such as prior authorization, based on Book-of-Business medical polices, HTCC determinations, UMP Plan exclusions, and other HCA custom medical policies.

T. Provide services for Claim adjudication, Appeals/Complaints management, reports and customer service for all Claims for dates-of-service during the term of the Contract, including all run-out claims for sixty (60) months after termination, at no PSPM or additional payment.

U. Provide internal audit, training and performance management programs to ensure consistency and accuracy of Claims processing, coverage decisions, customer service, and administrative performance.

V. Make benefit revisions and update the Claims system to pay accordingly on sixty (60) Days' advance notice from the HCA. The HCA has final authority for benefits administration and Claims payments.

W. Resolve issues with Claims requiring additional information for proper adjudication, including:

    1. Member eligibility
    2. Referral
    3. Authorization
    4. Coordination of benefits
    5. Third party liability
    6. Workers' Compensation information

X. Provide Claims adjudication services that cover all active, COBRA, and retiree Members in accordance with UMP Plan benefits in the applicable COC.

Y. Apply standard Coordination of Benefits rules for all Medicare retiree and other Medicare-primary Members' Claims (ESRD, etc.), consistent with Washington State insurance regulations in chapter 284-51 WAC. The ASB must use Medicare crossover claims for all

available facility (Part A) and non-facility (Part B) Claims, including paid in full crossover Claims.

Z. Coordinate benefits with other group health insurance entities using a non-duplication of benefits method of coordination for active Members and non-Medicare retiree Members.

AA. If requested in the future, apply non-duplication of benefits approach for all Medicare retirees upon sixty (60) Days' notice from the HCA.

BB. Accept PEBB eligibility data in the format provided by HCA.

CC. Use only Washington licensed clinicians when the need for consultation arises during any part of the claims administration process. While these licensed clinicians may be geographically located throughout the United States, each must be licensed in Washington.

The HCA requires an ASB that can perform the following services regarding erroneous payments:

A. If the HCA or the ASB determines that any payment made by the ASB under this Contract should not have been paid, or was paid in a larger amount than it should have been, such as a payment for more than the correct amount, or to or on behalf of a non-enrolled person, or otherwise in error, the ASB will diligently attempt to recover that payment. The ASB will have six (6) months from the date it discovers such erroneous payment to recover those amounts. As set forth in the Operations Manual, the ASB will (1) review its payments to discover any erroneous payments or overpayments at least monthly, and (2) use only lawful means to seek to collect those payments. The ASB will report to the HCA any known money paid out on quarterly bases for any erroneous payments or overpaid claims.

B. The ASB will keep the HCA informed as to the methods being used to recover erroneous payments and the status of such efforts. The ASB is not always required to take legal action to attempt recovery. However, if the HCA determines that legal action should be taken, the HCA may request the ASB to file a claim in the name of the HCA.

C. Overpayments and erroneous payments as a result of ASB fraud or gross negligence, or a result of fraud by someone acting as an employee or agent of the ASB or a Subcontractor, will not be considered Claims costs and the HCA will not provide reimbursement. Other overpayments and payments in error that are not recovered will remain as Claims costs.

D. Any money recovered by the ASB will be credited to the HCA at the time of such recovery.

E. The ASB will correct underpayments within three (3) business days of becoming aware of them.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

A. Describe how the Bidder will meet all the required elements above. The Response must fully describe providers, hospitals, ambulatory surgical center provider, and Ancillary Providers Claims payment systems that will be used for the UMP Plans. Include how accuracy will be ensured when coordinating payment policies for each of the different UMP Plan networks.

B. Describe how customizable the Bidder's Claims systems are, and how the systems would accommodate customized Claims payments or changes for such items as HTCC determinations. What is the Claims payment system you would be paying the UMP Plan claims from? How long has it been in use? Are there plans to switch systems? How would current system adjudicate Claims for incentive programs similar to SmartHealth? Is there a different system for claims analysis versus financial analysis?

C. Describe the claims service center where UMP Plan Claims would be adjudicated. Include the number of employees dedicated to the UMP Plan account, and whether such employees only adjudicate Claims or if they also perform other duties (such as customer service). Where is the center located? How long has it been in service? Are other self-insured or fully-insured clients' claims serviced there? How many clients does that service center serve? Where is the back-up claims service center?

D. Describe the Bidder's ability to process Claims for all active, COBRA, and retirees, including Medicare retirees, in accordance with plan benefits as noted in the COCs. The Bidder must also process all Medicare COB Claims in accordance with WAC 284-51.

E. Describe program integrity and recovery services, including the prevention and detection of fraud waste and/or abuse. Include elements of investigation; collaboration with local and national fraud law enforcement, prosecutors, and recovery services; and information about the type and amount of recoveries in each calendar year from 2013 through 2015 in Washington State or a similar market. Describe how Claims involving fraud, waste, and/or abuse were identified, as well as the steps taken in the of recovery process. Also describe the process of how Claims were written off, if ever (including any dollar thresholds for write-off) for Bidder's Book-of-Business.

    1. Describe the Bidder's relevant program integrity experience, including:

        i. Fraud, waste and abuse detection and prevention services and activities (collectively called program integrity) the Bidder's organization has provided as a TPA.

        ii. Whether these services pertained to member or provider program integrity, or both.

        iii. Number of cases investigated and the number referred elsewhere for further investigation and/or prosecution in the last three (3) years.

        iv. The outcomes achieved, including the amount of related recoveries, if any, during each of the last three (3) years.

        v. Articulate the Bidder's level of ongoing commitment to cost containment through fraud, waste, and abuse detection and prevention.

        vi. How the Bidder's organization has cooperated and collaborated with external investigators, law enforcement, prosecutors, and others involved in fraud and abuse detection, prevention, and prosecution.

    2. Describe the Bidder's investigation capability and expertise, including the following:

i. Experience with audits, analytics, site visits, record reviews and other methods.

ii. Available data systems and resources.

iii. Education and training initiatives.

iv. Policies and disciplinary guidelines.

v. Dedication to continuous monitoring and reporting.

vi. Process for referring credible allegations of fraud to external entities similarly charged with detecting and preventing fraud and the improper payments that result.

vii. Process for handling fraud allegations, from receipt to resolution or referral.

viii. How allegations are tracked and followed-up.

3. Describe the Bidder's erroneous payment identification and recovery services, including:

   i. How the Bidder's organization handles payments identified as improper.

   ii. Address whether or not identified improper payments are reported and recovered and if so, by what means and in what timeframe.

   iii. How the Bidder collects other coverage information from members for Coordination of Benefits.

Required Accompanying Documents

None.

Evaluation and Scoring Insight

Proposals will be scored based on the demonstrated ability to meet the listed specifications on January 1, 2020.

Bidder Response

Not to exceed ten (10) pages, excluding Required Accompanying Documents.

Exhibit 3.2.2 Provider Claims Payment Services in Washington

Overview

The Bidder is to describe the system it will use to electronically pay Claims beginning January 1, 2020 for its proposed Washington State provider network (hospitals, professional providers, ambulatory surgical centers, and Ancillary Providers) based on the terms of the Bidder's contracts with those providers.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements

by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

The Bidder's Response must fully describe the Claim payment system for its entire Washington State provider network that will be used for the UMP Plans.

A. Describe the processes and third party responsible for processing the Bidder's Claims if providers are outside the Bidder's service area. Include how these processes differ from Claims processed within the Bidder's service area.

B. Detail which elements remains in the primary control of the Bidder if/when it uses Subcontractors to process Claims. These may include elements such as Utilization Management, reimbursement arrangements and rates, Appeals, documentation and pre-authorization.

C. Indicate if all of the Bidder's Washington State provider network contracts are held by the Bidder, or if they are held under a Subcontractor or affiliate. For contracts held under a Subcontractor or affiliate, list all counties where the Subcontractor holds these contracts.

D. Describe the Bidder's approach to alternative payment models, including a description of how these models impact traditional policies, procedures, and processes or a split or subcontracted network within Washington State.

E. Describe the Bidder's standard facility, professional, ancillary and ASC payment policies. Provide a description of how the networks and provider search tools are kept updated, and the timelines associated with those tasks.

Required Accompanying Documents

A. Provide the Bidder's professional fee schedule for 2016. The Bidder's fee schedule for 2020 will be posted on the UMP website for transparency and updated each year.

B. Provide a Claims processing flow chart for Medicare-primary, and UMP Plan primary plans, including details from receipt of Claim to issuance of payment and EOB for a typical clean Claim. If any Claims are processed by Subcontractors, include separate flow charts for those entities.

C. Indicate contract terms (capitated, Fee-for-Service, bundled, DRG, shared risk, RBRVS, Per Diem and APC, etc.), category of services covered (PCP, SCP, X-ray/Lab, OP, IP, etc.) and percentage of contracts as total dollars in Washington State for each provider category (inpatient, outpatient, professional, Ancillary, ASC, and other) for all provider contracts within Washington State.

Evaluation and Scoring Insight

Preference will be given to Bidders who coordinate payment policies between Claims submitted under the Bidder's own Washington State provider network and networks contracted by affiliates or Subcontractors so that policies and covered services are applied consistently for all Members.

Bidder Response

Not to exceed five (5) pages, excluding Required Accompanying Documents.

Exhibit 3.2.3 Out-of-State Providers Claims Payment Services

Overview

The HCA desires an ASB that can provide a robust national provider network with seamless integrated payment systems for Members who reside or travel outside of Washington State.

The HCA requires the ASB to perform the following services:

A. Pay Claims arising outside the Bidder's Washington service area through ASB's Book-of-Business contracts.

B. Provide a substantially similar network adequacy within the United States as it does for Washington State.

C. Process out-of-country Claims at network rates using currency conversion rates in effect on the date of service, and provide translation services for those Claims at no additional charge to the Member.

D. Process out-of-network Claims at lower non-network reimbursement rate based on the UMP Plan design.

E. Provide adequate access to providers for covered services for all UMP Plans.

F. Process payments for COEs or bundled payments as the HCA requests.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

The Bidder's response must describe the system it will use to electronically pay Claims beginning January 1, 2020 for its proposed out-of-state provider network. It must fully describe any separate system it will use based on provider type (e.g., hospital, professional provider, ambulatory surgical center provider and/or Ancillary Provider) or geographic location of those providers, including translation services for Foreign Claims.

A. Provide a list of subcontracted providers, if any, used to process Claims.

B. Include if all of the Bidder's out-of-state provider network contracts are held by the Bidder, or if any are held under a Subcontractor or affiliate. For contracts held under a Subcontractor or affiliate, include all states where the Subcontractor holds these Contracts.

C. Provide alternative payment models for out-of-state providers, including a description of how these models impact traditional policies, procedures, and processes.

D. Provide an out-of-state network that meets substantially similar network adequacy standards as those set forth in Exhibit 4.4.

Required Accompanying Documents

A. Include a Claims processing flow chart for Medicare-Primary, UMP Primary including details from receipt of Claim to issuance of payment and EOB for a typical clean Claim. If any Claims are processed by Subcontractors or affiliates, Contractor must include separate flow charts for those entities.

B. Provide a list of all states and territories other than Washington where the Bidder paid 1,000 or more Claims per month in 2015.

C. Provide the total number of Claims paid for services outside the United States in 2015.

D. Provide the total number of Claims that required translation in 2015, and how translation services were provided (e.g., in-person, telephone, video).

Evaluation and Scoring Insight

Preference will be given to Bidders who can demonstrate a coordinated Claims payment system with the capacity to pay a significant number of out-of-state and international Claims. Robust translation services will also be favorably considered.

Bidder Response

Not to exceed five (5) pages, excluding Required Accompanying Documents.

Exhibit 3.2.4 Claims Subrogation Service

Overview

The HCA desires an ASB that will:

A. Identify and pursue opportunities in which a party other than the HCA might have primary financial obligations with regard to Claims submitted to UMP during the term of the Contract. The HCA will notify the ASB of post-pay recovery opportunities of which it has actual knowledge. The ASB will not be required to pursue or recover any specific opportunity, nor will the HCA be required to conduct any inquiry or investigation to determine if any opportunity exists. The HCA does not pay for third party liability Claims covered under workers' compensation. Work related illness and injury claims are excluded services under all UMP Plans.

B. Investigate whether any such recoveries are possible for all Claims involving the following sources:

   1. Motor vehicle accidents.
   2. Property Casualty/Homeowner insurance liability.
   3. Subrogation settlements.
   4. Other situations where a party other than HCA is liable.

C. Remit or issue a credit to the HCA for all amount(s) recovered, less the proposed fee for subrogation activities as stated in Appendix 6, Attachment 27.

D. Pursue subrogation opportunities existing as of the effective date of termination of the Contract, both before and after the end of any run-out period. The ASB shall pursue such recoveries only as long as it determines such recoveries are active and viable. The ASB shall continue to provide the HCA with quarterly reporting during the run-out period. Any additional reporting provided to the HCA after the end of the run-out period is subject to mutual agreement.

E. Offset payments due from Members and/or recipients against unpaid Claims, if permissible under HCA policies communicated to the ASB in advance, and under applicable law and regulations.

F. Remit recoveries and report to HCA accounting any withheld fees on at least a monthly basis.

The ASB will provide a quarterly report of post-pay recovery activities in a format specified by the HCA. This report will be delivered to the HCA Contract manager forty-five (45) Days after the end of each quarter.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

A. Describe the subrogation process used by Bidder. Note whether this is an internal function or if it is subcontracted to an outside vendor.

B. If subcontracted, identify the Subcontractor and its process. Confirm its willingness and ability to comply with the testing process required in Appendix 5 for OCIO security standards in order to receive Claim files.

Required Accompanying Documents

Provide a sample copy of typical monthly or quarterly subrogation report for clients.

Evaluation and Scoring Insight

Preference will be given to a detailed explanation of the internal or subcontracted process that indicates a robust process for pursuit of third-party payers, representation of HCA settlement interests and recovery of HCA funds.

Bidder Response

Not to exceed five (5), excluding Required Accompanying Documents.

Exhibit 3.2.5 One Resource for Provider and Claims Information for Members

Overview

The HCA desires an ASB that can describe how all Claims and UMP Plans provider network searches will tie into one resource so Members can receive EOBs and Claims information both electronically and on paper. In the response, include if any Member resources are provided by Subcontractors, and if so, how long these relationships have been in place.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the

Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

The Bidder's response must describe:

A. How the Bidder will provide an online resource by which Members can access Claims information, such as EOBs, maximum out-of-pocket status, deductible status; search for providers; estimate costs; provider quality tool; become engaged and educated in their care; and other features as requested by the HCA.

B. Include details of all Claims administration activities subcontracted to other entities or affiliated companies who would not be a party the Contract with the HCA. Include a description of any customer service staffing or process differences between the Key Elements addressed in Exhibits 3.2.1, 3.2.2, 3.2.3 and 3.2.4. Describe how EOBs are processed for Medicare-Primary Members and if there is clear reconciliation for Members on each EOB. Include whether the EOB displays the final member responsibility net of Medicare-Primary payments and any COB savings applied to the current Claim transaction.

C. Include the name and location any Subcontractors or affiliates that provide contracted networks or Claim systems and/or perform Claim processing services to fulfill the requirements of the Contract.

D. Include samples of or links to the online resource for cost transparency tools, provider search tool screens, and medical policies for UMP Plans. Provide link or attachment that shows these services.

Required Accompanying Documents

A. Provide the following sample EOBs

    1. Primary plan EOB
    2. Medicare primary claim EOB

B. Include an electronic resource link and a dummy login and password credential so HCA evaluators can test the capabilities of the resource.

Evaluation and Scoring Insight

Preference will be given to Bidders who can show a seamless Member experience for provider search and customer service nationwide. Bidders who use one system for Claims and EOBs are ideal. For Bidders who process some Claims through subcontracted systems, show how quality, timeliness and Member questions are handled to maintain consistency.

Preference will be given to Bidders who can communicate a detailed plan that describes how all tools are integrated into one online resource for Members.

Bidder Response

Not to exceed three (3) pages, excluding Required Accompanying Documents.

Exhibit 3.3 Disabled Dependent Certifications

Overview

The ASB must be able to process Disabled Dependent Certifications and meet notification and processing requirements established by the HCA. While the authority for determining eligibility for these certifications is exclusively with the PEBB, the ASB is expected to perform the clinical components of the certifications.

The governance, timeline, and processing guidelines are listed in the Table 3.3 below. Additional information about disabled Dependent certification can be found at the following websites:

http://app.leg.wa.gov/WAC/default.aspx?cite=182-12-260

http://app.leg.wa.gov/WAC/default.aspx?cite=182-12-262

http://www.hca.wa.gov/assets/pebb/Policy_36-1.pdf

Table 3.3: Timeline to Enroll Disabled Dependent:

	Event	Time Allowed for Member to Return Forms	Description of Timeline
Initial Certification	New employee enrolling a Disabled Dependent age 26 or older	31 Days	The form must be received by his or her employer no later than thirty-one Days after the employee becomes eligible for PEBB benefits.
	New retiree enrolling a Disabled Dependent age 26 or older	60 Days	The form must be received by the PEBB Program no later than sixty Days after the employee's employer paid or COBRA coverage ends.
	New COBRA, Leave Without Pay, or Continuation Coverage Subscribers enrolling a Disabled Dependent age 26 or older	60 Days	The form must be received by the PEBB Program no later than 60 Days after the employee's employer paid coverage ends.
	Current employee enrolling a Disabled	60 Days	The form must be received by his or her

	Event	Time Allowed for Member to Return Forms	Description of Timeline
	Dependent following the Dependent's 26th birthday		employer no later than sixty Days after the last Day of the month in which the child reaches age 26.
	Current retiree enrolling a Disabled Dependent following the Dependent's 26th birthday	60 Days	The form must be received by the PEBB Program no later than sixty Days after the last Day of three month in which the child reaches age 26.
	Current COBRA, Leave Without Pay, or Continuation Coverage Subscriber enrolling a Disabled Dependent following the Dependent's 26th birthday	60 Days	The form must be received by the PEBB Program no later than 60 Days after the last Days of the month in which the child reaches age 26.
Re-certification	Child currently enrolled as a Dependent with a disability that needs to recertify	60 Days	The form must be received by the Bidder no later than 60 Days from the date on the 90 Day recertification letter.
Open Enrollment	Current employee enrolling a Disabled Dependent age 26 or older during Open Enrollment	Last Day of the annual Open Enrollment period.	Forms must be received by his or her employer no later than the last Day of the annual Open Enrollment.
Special Open Enrollment	Current employee enrolling a Disabled Dependent over age 26 due to a qualifying event under special open enrollment rules	60 Days	The forms must be received by his or her employer no later than sixty Days after the event that creates the special open enrollment.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

The Bidder's response must:

A. Describe the Bidder's certification process

B. Describe the Bidder's Appeals process.

C. Describe what modifications would need to take place in order to align the Bidder's standard Book-of-Business processes with the HCA processes.

D. Describe how the Bidder completes the following items:

1. Date stamps all incoming documents.
2. Processes new certifications upon receipt of the initial Disabled Dependent certification form.
3. Processes re-certifications.
4. Adheres to the processes that ensure timely notices are sent to the Subscriber
5. Provides a determination notification to Subscribers.
6. Provides a clear appeals process for certification denials based on clinical reasons.
7. Expedites certification or recertification forms sent by the HCA for Members with an Appeal (for the termination of coverage for their Disabled Dependent due to untimely submission of the form) overturned by the PEBB Appeals committee.
8. Provides reports to the HCA.
9. Provides all documents used to correspond with Member upon request.

Required Accompanying Documents

Include a flow chart of Disabled Dependent processes for Book-of-Business members.

Evaluation and Scoring Insight

Preference will be given to Bidders who submit documents and processes showing how their Book-of-Business processes could be modified to accommodate HCA processes.

Bidder Response

Response shall not to exceed seven (7) pages, excluding Required Accompanying Documents

Exhibit 3.4 Health Technology Clinical Committee

Overview

Under RCW 70.14.080 through 70.14.130, the Washington State Legislature established a process to review health technologies. The Health Technology Clinical Committee (HTCC), governed under chapter 70.14 RCW, determines the conditions, if any, under which specific health technologies (including medical devices, procedures, and diagnostic tests) will be included as a covered benefit in health care programs of participating agencies; and if covered, the criteria which the participating agency administering the program must use to decide whether the technology is medically necessary. Participating state agencies include the HCA, the Department of Labor and Industries, and the Department of Social and Health Services.

Under RCW 70.14.120(1), the HCA is required to implement HTCC coverage determinations in the UMP Plans. The HCA and any TPA do not have discretion to deviate from HTCC coverage determinations unless such determination conflicts with another federal or state legal requirement. Because there is no discretion on the part of the HCA or UMP, the ASB cannot implement a medical policy that results in either more permissive or less restrictive coverage or medical necessity criteria than HTCC's determination.

The UMP Certificate of Coverage requires the UMP to follow coverage decisions made by the HTCC. If the HTCC has determined that a service or treatment is not covered, the Plan will not cover the service and the service is deemed not medically necessary, even if the Member's provider considers it medically necessary. If the Committee has determined that a service or treatment may be covered, then it will be covered only in cases where it meets the Committee's specific coverage criteria because those criteria must be used for determining medical necessity.

Implementation by the UMP of HTCC coverage determinations are done individually with involvement of the HCA Medical Director. HTCC coverage determinations may be implemented mid-year or at the start of the next Plan year. The ASB will be responsible for implementing HTCC coverage determinations consistent with the HCA's directions and while working with the HCA on an implementation plan, which may include provider and/or Member notice. HTCC determinations can be viewed at http://www.hca.wa.gov/about-hca/health-technology-assessment/health-technology-reviews

HTCC Meetings

The HTCC committee meets approximately six (6) times each year to discuss the new topic and vote on draft decisions. The ASB Clinical Programs Manager will be required to attend these meetings.

The Health Technology Assessment (HTA) State Agency Medical Directors meetings consist of the participating agency Medical Directors, the HCA HTA Program Managers, and other work group members. The group meets once a week to discuss current and upcoming topics, review reports and, discuss data, etc. The ASB's Clinical Programs Manager for UMP will be required to attend these meetings.

The following HCA meetings require participation from the ASB:

A. The HCA Clinical Meeting
    1. Occurs every other week.
    2. Meeting agenda is led by the ASB Clinical Programs Manager.
    3. Clinical issues are discussed and tracked by the ASB in a "clinical action log."

4. Discussed issues include: program updates or concerns, clinical programs, any specific Member question or complaint, HTCC decisions that are active and pending, etc.

B. HTCC Medical Director Meetings between the ASB and HCA

1. Occurs once per month.
2. Meeting agenda is led by the ASB Clinical Programs Manager.
3. Discussed topics include: HTCC decisions, pending decisions, reviews, implementation plan and/or concerns.
4. Facilitates final approval for HTCC implementation in the UMP Plans (written documentation is sent via email to the HCA Medical Director and ASB Medical Director for signature).

C. Clinical Strategy Workgroup Meeting

1. Occurs one week prior to the Clinical Strategy Leadership meeting.
2. Medical Directors need not attend.
3. Meeting agenda will be led by the ASB Clinical Programs Manager.
4. The HCA and ASB teams will weigh in on issues to be discussed at the Clinical Strategy Leadership meeting.

D. Clinical Strategy Leadership Meeting

1. Occurs once per month.
2. Meeting agenda is led by the ASB Clinical Programs Manager.
3. Standing agenda items include: Bree updates, Monthly Book-of-Business Medical Policy Updates, Program updates, and HTCC initiatives.

The ASB's Clinical Programs Manager shall maintain an HTCC coverage determination documentation spreadsheet and will update it as new information is received. The ASB will share this worksheet with the HCA on a monthly basis to be received by the last Day of the month for HCA approval. Some examples of what this spreadsheet will include are:

A. Topic name
B. Implementation date
C. Affected codes
D. Non-covered codes
E. Covered codes
F. Procedure and DX codes requiring prior authorization
G. Target date

The ASB shall develop and maintain an implementation plan for each HTCC decision and store those within the Master Grid. The Master Grid shall include final approved HTCC decisions and must be updated by the ASB and sent no later than October 31 of each year.

Newly added or changed HTCC coverage determination procedures shall be documented and incorporated into this manual by the HCA Senior Account Sponsor(s) no later than September 30

each year. The procedures include, but are not limited to updated timelines, work-flow, and documentation.

The HCA must approve of all documents and templates related to implementation of HTCC decisions.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

The Bidder's Response must:

A. Confirm in writing the Bidder's commitment to follow the decisions of the HTCC even if such decisions are in conflict with then current Bidder guidelines, medical policies, or medical necessity criteria.

B. Confirm in writing the Bidder's commitment to develop documentation methods to add or modify (if updated) HTCC coverage determination procedures.

C. Describe how this work would be resourced and outline the processes the Bidder would follow to implement HTCC decisions.

D. Describe the types of customized medical policies currently implemented for other self-insured clients.

E. Confirm in writing the Bidder's commitment to actively participate, attend, and contribute to the HTCC meetings described in this section.

F. Confirm the Bidder can do all of the above requirements and list any that cannot be met.

Required Accompanying Documents

None.

Evaluation and Scoring Insight

The HCA requires the ASB to fully comply with the requirements of the HTCC. The ASB must collaborate with the HCA in development of any benefit updates, clinical guidelines, UM decision-making guidelines and Claim edits required by the ASB to implement HTCC determinations.

Bidder Response

Not to exceed eight (8) pages, excluding Required Accompanying Documents.

Exhibit 3.5 UMP CDHP Plan Administration

Overview

The ASB shall partner with the HCA to administer a High Deductible Health Plan with a linked Health Savings Account (HSA) for eligible Members, as required by statute.

Responsibilities of the ASB

A. The ASB will fulfill all obligations and duties for UMP CDHP as are required for the administration of UMP Classic, as well as the additional obligations and duties described herein.

B. The ASB will administer an integrated IRS-qualified CDHP/HSA. It will engage an HSA Trustee to administer the HSA, but the ASB will still be responsible for the administration and assumes full responsibility for HSA Trustee performance. The ASB is responsible for implementation, including all processes, procedures, and systems necessary for an effective date for UMP CDHP of January 1, 2020. The ASB will engage proactively with all stakeholder groups, including but not limited to PEBB, the UMP PBM, and the HSA Trustee.

C. The ASB will send representatives to all Open Enrollment benefit fairs. Benefit fair representatives will be trained in the details of plan benefits, HSA accounts, and salient issues that affect Members.

D. Upon HCA approval, the ASB will pass all UMP CDHP/HSA Member eligibility information to the HSA Trustee, complying with federal and state privacy laws and eligibility audit standards. The ASB will be required to collect and retain authorization from Members to transfer Claims information to the HSA Trustee.

E. The ASB will collaborate with the UMP PBM to pass shared accumulator information for Member deductible and out-of-pocket maximum at least once per Day.

F. The ASB will develop, design, print, and distribute the documents listed below, in coordination with the HSA Trustee and the HCA. All communications must be approved by the HCA prior to being sent to Members.

    1. CDHP/HSA education materials for use at benefit fairs (such as UMP Plan summaries, descriptions, and summaries of benefits and coverage) and in welcome packets (such as ID Cards, quick tips on how to use each UMP Plan, and information on how to access COCs.

    2. Customized online information about the UMP CDHP, including COCs in a format that complies with the ADA, how to reach ASBs and HSA Trustee customer service, as well as access to consumer education tools that help Members estimate their costs for services and choose between the UMP CDHP or UMP Classic plans.

    3. UMP CDHP Certificate of Coverage.

G. The ASB will provide parallel reports that mirror all standard and custom reports required, including monthly and quarterly status reports and reporting on performance metrics.

Services to be performed by a Qualified HSA Trustee (HCA may require this to be HealthEquity)

A. Account Administration

The ASB will require the HSA Trustee to:

    1. Accept enrollment files via FTP and/or online submission process. New Member accounts will be set up within two (2) Business Days of receipt of file.

    2. Accept employer contributions from the HCA via secure protocols. Deposits will be available to Members within one (1) Business Day.

    3. Accept Member discretionary contributions via payroll deduction in the form of data files from employing agencies using accepted secure protocols. Member contributions must be accessible in their account within one (1) Business Day.

4. Accept Member contributions via Member's online accounts or paper check. Funds must be available to Member within one (1) Business Day of transaction of receipt.
5. Notify Members if annual contributions are anticipated to exceed IRS maximum contribution amounts, based on the combination of employer contribution, SmartHealth Financial wellness incentives, and Members voluntary contributions.
6. Provide employer with notification of completed files within one (1) Business Day of receipt.
7. Provide paper and electronic statements to Members.
8. Provide paper tax reporting to Members for IRS form 1099.
9. Provide mutual funds for Members with a minimum balance of $2,000.
10. Follow eligibility audit procedures with the ASB as specified and approved by the HCA.
11. Escalate to the ASB any concerns about the benefit coverage design of the UMP CDHP and/or qualified expenses eligible for HSA reimbursement.

At the HCA's request, the ASB will transfer the HSA Trustee administration via a direct HCA contract and then mandate cancelling the ASB's HSA Trustee.

B. Fulfillment

The ASB will require the HSA Trustee to:

1. Send 95% of debit cards/welcome kits within five (5) Business Days of account activation, completing 100% sent within seven (7) Business Days.
2. Send 95% of replacement cards within five (5) Business Days of request, completing 100% sent within seven (7) Business Days.
3. Provide customizable welcome packet materials to be reviewed and approved by the HCA.

C. Customer Service

The ASB will require the HSA Trustee to:

1. Provide twenty-four (24) hour per Day, seven (7) Days per week live customer support for 365 Days each year.
2. Provide 98% call resolution within two (2) Business Days.
3. Answer 80% of calls within thirty (30) seconds or less.
4. Offer an average call abandonment rate of less than five percent (5%).
5. Provide a reimbursement process for paper/electronic submissions within three (3) Business Days.
6. Assist the ASB in providing quarterly reporting on all metrics above, to be completed within forth-five (45) Days after the quarter ends.

D. Employer Support

The ASB will require the HSA Trustee to:

1. Provide live employer support from at least 7:00 a.m. through 6:00 p.m. Pacific Time (PT), Monday through Friday.

2. Electronic access to view and download reporting to manage the employee card program.
3. Manage an employer portal that provides access to reporting on employee activity, and offers the ability to make adjustments to individual accounts.
4. Make an Account Manager available to the HCA for escalated issues.
5. Coordinate between HCA and the ASB customer service including warm transfers and escalation processes.
6. Collaborate with the HCA to develop and revise enrollment and contribution processes as needed, including processes for payroll deductions and employer contributions.

E. Custom Website/Online Account

The ASB will require the HSA Trustee to:

1. Provide Members with twenty-four (24) hours per Day, seven (7) Days per week access to online accounts that provide HSA balance, access to Member's medical Claim information, and the ability to pay Claims using HSA funds online.
2. Maintain a customized website that is mobile-optimized, includes employer co-branding, and provides tools and consumer education materials that help Members get the most utility from their HSA.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

A. Describe how the current HSA vendor integrates with Bidder's systems. Include how Claims are transferred and secured so only the Member (and not the Subscriber) can see details of the Claims. Include how this is done for Dependents aged 18 and under.

B. Include if the Bidder is required to use a certain HSA vendor for other self-insured clients. If not currently required to do so, describe how the Bidder will contract with HCA's required HSA vendor. Describe how the Bidder will ensure that all Subcontractors comply with customer service, reporting and other requirements.

C. Describe how the Bidder will comply with the requirements above. Include the bidder's current rate of compliance with those requirements for other self-insured clients who have and HDHP/HSA plan.

D. Describe any fees or penalties that could be charged to Members, such as minimum balance.

Required Accompanying Documents

None.

Evaluation and Scoring Insight

Preference will be given to Bidders who fully comply with the requirements of UMP CDHP. The Bidder must collaborate with the HCA in its development of any benefit updates, Claim transfers, use of Subcontractors, or other elements utilized in implementation of UMP CDHP or HSA recommendations.

Bidder Response

Not to exceed five (5) pages, excluding Required Accompanying Documents.

Exhibit 3.6 ACN Administration

Overview

In 2015, PEBB contracted directly with two (2) ACNs – Puget Sound High Value Network and University of Washington Accountable Care Network - to offer UMP Plus to non-Medicare Members starting in 2016. UMP Plus is currently available to Members in the 5-county Puget Sound region. Both ACNs will expand to be offered in additional counties in 2017, and the HCA will continue to work with both networks to expand into additional counties. The HCA reserves the right to add future ACNs at its sole discretion.

UMP Plus consists of these five foundational elements:

A. Shared financial (upside and downside) and clinical risk between the HCA and ACNs, with quality measures from the Common Measure Set.

B. Care Transformation strategies, including achievement of NCQA PCMH standards and implementation of Bree Collaborative recommendations.

C. Member experience and member access standards for timely and appropriate care, including offering extended primary care hours and a dedicated Member call line.

D. Timely data on Members' utilization shared with ACNs to assist with managing care.

E. Benefit design strategies to incent members to use primary care and receive coordinated care within the ACN.

Under UMP Plus the current UMP TPA provides administrative (claims adjudication) functions, provides data to both networks, and manages the ACN Ancillary Provider network.

For more details on UMP Plus, a redacted copy of the ACN contracts can be found here: http://www.hca.wa.gov/about-hca/healthier-washington/paying-value.

There are currently two (2) types of Members for these ACNs:

A. Designated Members: Those who select and enroll in a UMP Plus Network. They live in a Washington state county served by a UMP Plus Network.

B. Attributed Members: Members in UMP Classic or UMP CDHP that attribute to one of the ACNs. The ASB provides the algorithm for attributing a UMP Classic or UMP CDHP Member to one of the ACNs based upon commonly received services in that network. Attributed Members need not live in a UMP Plus county.

The ACNs accept upside and downside risk on the delivery of health care services performed for Designated Members. For Attributed Members, ACNs have upside risk only in gain sharing. The financial reconciliation of the ACN's performance for Designated Members and gain sharing for Attributed Members is administered by the HCA, with support from the HCA's consulting actuary. Financial reconciliation is calculated using both cost and quality measures.

All ASB contracted providers must be preferred providers for the UMP Plans, therefore the ASB may be asked to add providers to its Preferred Provider network. Each ACN is comprised of two (2) sets of providers:

A. Core providers such as primary care physicians, physician specialists, clinics and hospitals

B. Ancillary providers such as therapists, chiropractors, and Behavioral Health providers.

Currently, when core providers contract with a UMP Plus network, they adopt the contractual requirements of the ACN and must be located in or near the counties served. The ACN Ancillary Provider network is comprised of selected ACN Affiliate Provider types. If an ACN Affiliate Provider type is selected for the ACN Ancillary Provider network, then all UMP preferred providers of that type are included in the UMP Plus ACN Ancillary Provider network. For example, every physical therapist who is a UMP preferred provider is an ACN Ancillary Provider for the UMP Plus networks. The ACN Ancillary Provider network extends to all Washington State counties and may even extend to counties the ACN does not serve.

The ASB shall pay UMP Plus Claims and provide customer service for Claims payment. It shall also provide and maintain a provider search tool as well as data reporting that assists daily operations and care delivery while supporting analytics and the financial reconciliation for the UMP Plus networks.

Responsibilities of the ASB

The ASB will be responsible for all of the obligations and duties described below:

A. Benefits Administration:

1. Conduct ongoing sharing, testing, maintenance, enhancements, and auditing, in accordance with the schedule of eligibility reporting requirements included in the Contract.
2. Coordinate with the HCA to develop additional ACN contracts or amend current ACN contracts in a way that is consistent with the ASB's role as TPA of all UMP Plans.
3. Work in good faith with the HCA and the ACNs to resolve any issues that arise in a timely manner.
4. Administer UMP Plus provider network and Claims payment for each ACN as well as a wrap-around ACN Ancillary Provider network that may differ for each ACN, but in both cases must be present in all 39 Washington State counties, and may be updated during the plan year, and at a minimum, annually.
5. Contract with all ACN Partner Providers and ACN Affiliate Providers.

B. ASB Communications:

1. Write, design, print, and distribute the documents and tools listed below, in coordination with the HCA:
    i. UMP Plus education materials for use at benefit fairs
    ii. Welcome Packets and other UMP Plus specific materials, when requested by the HCA fifteen (15) Days in advance of mailing.
    iii. Customized UMP Plus ID Cards for each ACN with HCA approved logos and contact information for each ACN.
    iv. Annual COCs for each ACN.

v. For each ACN, build and maintain a search tool that lists all in-network provider functions in the manner listed below:

a. Content must be updated to stay consistent with provider credentialing and new files from all the ACNs.

b. The search tool must provide separate search functionality for the current plan year and the upcoming plan year in support of Open Enrollment. It must also clearly identify the availability of both functions to Members.

c. The Bidder will use best efforts to integrate all search tools together for a seamless user experience when the ACNs expand geographic areas.

d. Provide the HCA with custom links for provider search tools for UMP Plus website, as well as HCA maintained websites such as for the UMP Plans and the PEBB.

2. Send specialized representatives (excluding Account Managers) to all PEBB Open Enrollment benefit fairs. Benefit fair representatives will be trained by the ASB in the details of UMP Plus benefits as well as any benefit design differences from other Health Plans. ASB representatives will collaborate with the PEBB and HCA staff when necessary to provide service at benefit fairs.
3. Provide Health Literacy information and a cost-calculator, supplied to the ASB by the HCA in a coordinated fashion with the provider search tool.
4. Provide the HCA with custom links for provider search tools for ACN websites.
5. Provide customized web site(s) upon HCA request with HCA requested branding that provides customer education tools for consumer education materials to help Members get the most utility from the site, subject to HCA review and approval.
6. Annually review, report, and recommend enhancements to search technology, processes, provider content, organization and display of the content, and implement those recommendations and enhancements adopted by the HCA
7. Coordinate with the HCA on a due date for submitting draft communications for the next plan year that provides the HCA with reasonable time to review and provide reasonable comments. All communications must be approved by the HCA before October 15 of the preceding plan year. The ASB will collaborate with the HCA on communications.
8. Provide a customer call center specializing in benefit design questions regarding UMP Plus.
    i. Answer 80% of calls within thirty (30) seconds or less.
    ii. Maintain an average call abandonment rate of less than 5%.
9. Provide quarterly reporting on all metrics above to be completed by forty-five (45) calendar Days after the quarter ends.
10. Collaborate with the HCA on other communications.

C. Network Administration:

1. Adding or removing providers to a clinically integrated network and/or adding or removing or updating information on a ACN Partner or ACN Affiliate Provider Tax Identification Number (TIN)
    i. ASB will not unreasonably withhold inclusion of an ACN provider from being an ASB in-network provider. Providers must go through a regular credentialing process.
    ii. Administer the ACN out of network consent process as documented within the ACN operations manual. This process may be different for each ACN. HCA will accept a monthly provider TIN Roster from each ACN that adds or removes provider TINS from UMP Plus.
2. Update the UMP Plus website and network status for payment within thirty (30) Days of receipt if providers are already credentialed with the ASB.
3. Follow Bidders credentialing process, for providers not credentialed. Once credentialed, provider is approved, and will be added to the website and monthly provider TIN Roster and have an updated network status.
4. HCA will approve providers before each monthly roster and the UMP Plus account manager will be responsible for those approvals.
5. The ASB will expand network geography anywhere within Washington State each year as requested by the HCA.

D. Data and Reporting:

1. Transmit all UMP Plus Member eligibility information, Utilization Management reviews, and Claims information to each ACN or data intermediaries, complying with federal and state privacy laws, confidentiality agreements and the HCA audit standards to enable the ACNs to send out ACN Welcome Packets to new UMP Plus Members. Data files shall include all information needed for mailings and to be sent monthly or weekly, with dates to be specified by the HCA.
2. Maintain compliance with any data extract and confidentiality agreement between the ACN data intermediary, the ACN provider, and the Bidder, and provide the HCA with amended and updated versions of any such agreement.
3. Maintain a Secure File Transfer Protocol (SFTP) site with ACNs and any data intermediaries.
4. Process files within agreed to timelines of data specifications. All monthly reports will be transmitted by the 25th of the following month.
5. Complete eligibility and Claims implementation and testing as specified and approved by the HCA on mutually agreed upon dates but not more frequently than once per year. After testing is complete, for the next year, eligibility and Claims data will be delivered to the HCA or third party on mutually agreed upon dates and frequencies.
6. Provide vendor data integration and reporting, risk score methodology, Primary Care provider election (if the HCA requires it), and EHR reporting requirements.
7. Troubleshoot data reporting issues to resolution with UMP Plus networks, data intermediaries, consulting actuaries for the HCA, and the HCA.

E. Operational Requirements

1. Provide an additional program manager to support new implementation of additional networks or current ACN expansions. This program manager will attend as-needed and on-going HCA/ACN meetings as requested by the HCA.
2. Perform all administrative activities necessary to launch an ACN, collaborate on drafting and reviewing the procurement, and review procurement documents to safeguard against operational gaps or inconsistencies in such administrative services.
3. Perform all administrative activities necessary to remove an ACN.
4. Participate in the development and review of operational processes to perform the necessary functions of the ACN program. The ASB shall:
    i. Support the development and implementation of processes that specify the responsibilities and actions of a UMP Plus Plan, the HCA, and the ASB.
    ii. Support the development and implementation of the UMP Plus financial reconciliation process to include developing data reports and supplying those
    iii. Support the HCA's monitoring of ACN financial and care transformation performance as specified in contracts with each ACN.
    iv. Coordinate the implementation and performance of care management and/or coordination programs so the programs align with similar programs performed by the ACN for the Attributed and Designated Member populations. If requested by the HCA, the ASB shall discontinue Case Management and Utilization Management programs for ACNs and the PSPM for such services would then be deducted from the Administrative Fees.
    v. Provide the same standard and custom reports noted in the Agreement, including monthly and quarterly status reports and reporting on performance metrics.
    vi. Maintain all data reporting in Exhibit 3.10, and transmit the HCA UMP Plus Data and Reporting Inventory to the ACNs and the data intermediaries or the HCA directly, as indicated.
    vii. Add and remove providers from the UMP Plus networks on a monthly basis as outlined in Attachments 18 and 22 of Appendix 6.
    viii. Add ACN data to monthly data files to the HCA actuary or a third party as requested by the HCA.
    ix. Administer the provider consent process for non-network and out-of-network providers as described in Attachment 16 of Appendix 6, Network Consent Process for Non-Network and Out of Network providers.
    x. Execute a three-party data sharing and confidentiality agreement with each of the ACNs and data intermediaries within three (3) months of the Contract signing and update as necessary.
    xi. Administer or modify benefits, services or networks as directed by the HCA within thirty (30) Days of written request.
    xii. Add ACN Ancillary Providers in a network from the current TPA's provider network. A list of provider types will be provided by the HCA annually and the geographic region of an ACN's ancillary network may change. The ASB will include those provider types within the ancillary in-network providers for the

UMP Plus Plans. These ACN Ancillary Provider networks may be different for each ACN and different for each county served by an ACN. The ASB will need to include all ACN Ancillary Providers within provider search tools and ACNs, and HCA will have authority to approve or delete such inclusions.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

A. Describe how the Bidder will comply with the requirements above, including how these requirements are different from other ACO products the Bidder currently administers for both fully insured and self-insured purchasers.

B. Include any current reporting the Bidder does for other ACN purchasers.

C. Describe how the Bidder will comply with the data inventory and amount of time needed to build such reporting.

D. Confirm that the Bidder will sign a three-way data sharing agreement between Bidder, ACN and data intermediary.

E. Confirm in writing the Bidder's commitment to the willingness and ability to support the ACNs and other new forms of care delivery and reimbursement methodologies.

F. Confirm in writing the Bidder's commitment for its Clinical Management team to coordinate with the ACN's clinical team including co-management, referrals and hand-offs, information/data sharing, etc.

G. Describe the Bidder's experience providing data flows and reports with stand-alone, provider-led Accountable Care Organizations. For example, the Bidder will be required to provide timely data including eligibility, Claims, and encounter data files and reports to the ACOs and HCA's consulting actuary to support the quality and cost metrics that comprise the financial reconciliation.

H. Describe how the data provided to an ACO will align with the data sent to the HCA's consulting actuary and confirm that the data will differ only to the degree necessary to comply with legal requirements or to support of different business practices accepted by the HCA.

Required Accompanying Documents

None.

Evaluation and Scoring Insight

Preference will be given to Bidders who have current capacity to support ACN administration over Bidders who are willing to develop a similar capacity. The HCA will look favorably on a Bidder's ability to:

A. Perform activities that directly serve Members such as websites, online provider search tools, and Member communication.

B. Describe successful previous experiences in supporting ACN administration.

C. Perform care management activities that align with ACN care transformation activities.

D. Establish and maintain the network of providers.

E. Provide data files and reporting that support financial monitoring and the efficient delivery of high-quality health care services.

Bidder Response

Not to exceed twelve (12) pages, excluding Required Accompanying Documents.

Exhibit 3.7 Appeals and Complaints

Overview

The HCA requires an administrative service to administer, document, and track first- and second level Appeals, Independent Review Organization (IRO) requests, pre-authorizations, Complaints, and related issues, and to process associated correspondence in compliance with all applicable laws. The UMP Plans, as noted in other sections of this document, are not ERISA plans, but state-sponsored health plans subject to applicable provisions of Washington law, including RCW 41.05.017, which includes part of the Washington State Health Care Patient Bill of Rights.

The HCA reserves the right to customize all Appeals and Complaints communications and processes.

Requirements: All Levels of Appeals

The ASB must:

A. Provide Appeals administration for medical necessity as well as Contractual issues.

B. Administer, document and track first-level Member Appeals, Complaints (also known as grievances) and related issues.

C. Notify the Member in writing within seventy-two (72) hours, of receipt of an oral or written request for Appeal of an adverse benefit determination as defined in RCW 48.43.005.

D. Answer first-level Appeals and Complaints within thirty (30) days of receipt, unless an extension is granted by the Member or is otherwise permissible under Washington state regulations.

E. Process associated correspondence in compliance with all applicable laws for patient privacy and promptness.

F. Comply with the Appeals processes and coverage provisions of the COC and Washington State Health Care Patient Bill of Rights, as described in RCW 41.05.017, as well as other applicable law.

G. Customize standard Appeals, pre-authorizations, and other related materials as directed by the HCA. All denials of coverage will contain a description of the Appeal process within the document. This includes excluded services, pre-authorizations, HTCC determinations and others, as directed by the HCA.

H. Administer, document and track Expedited Appeals or IROs, as described in the COC, as well as any other Appeals that are required by law to be resolved within a shorter time.

I. Notify Members of Appeal rights for all denials, including denials of reimbursement, prior authorization or non-covered benefits.

Requirements: Second-Level Appeals, and Requests for Independent Review

The ASB must:

A. Administer, document, and track second level Member Appeals.

B. Notify the Member that the second level Appeal was received within seventy-two (72) hours of receipt.

C. Answer second level Appeals will be within thirty (30) Days of receipt unless an extension is granted by the Member or otherwise permissible under Washington State regulations.

D. Administer, document and track Independent Review Requests (as defined in the COC).

E. Follow the Independent Review Organization (IRO) process required by Washington State law utilizing the Washington certified IROs sequentially.

F. Clearly and accurately note whether the IRO request is for a review of medical necessity, contract review of an excluded service, and/or denials based on a HTCC coverage determination.

G. Complete and send to the IRO all independent review requests within three (3) Business Days of receipt.

H. Give the HCA copies of each IRO decision within seven (7) days of the final IRO decision. Independent review decisions are considered final and binding for that specific review only.

I. Notify Members of Appeal rights for all denials, including about denial of reimbursement or prior authorization or non-covered benefits.

Requirements: Expedited Appeals

There are two parts to the Expedited Appeals process: (1) first-level Appeal, and (2) Independent Review. If the Health Plan denies coverage for services and the provider determines that taking the usual time allowed could seriously affect a Member's life, health or ability to regain maximum function, or would subject the Member to severe pain that cannot be adequately managed without the disputed care or treatment, the provider can initiate an Expedited Appeal. The ASB will decide on the Expedited Appeal within seventy-two (72) hours of the request. The ASB will report the number of Expedited Appeals requested each quarter (or monthly, if requested by the HCA), including information about requests determined not to be urgent, requests denied, and requests approved.

Requirements: Member Materials

A. The ASB will customize standard Appeals-related materials as directed by HCA.

B. The ASB will document, track, and respond to member Complaints within thirty (30) Days.

Requirements: Response

If a Member submits a written Complaint, the ASB will provide that Member with a written response, or a verbal response by telephone when requested by the Member.

The ASB must have a process in place to achieve full compliance with the above requirements.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a

description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

A. Provide an overview of the entire Appeal process. Include how Appeals are received, how decisions are made, which people (state their titles and qualifications) are involved in making decisions, completion timelines, how and when Members are notified that their Appeals have been received and their results, and in which circumstances the HCA would be notified.

B. State if pre-authorization request denials can be appealed. Include if this is standard or customizable for self-insured clients. If pre-authorization request denials can be appealed, explain how and when members are notified of their Appeal rights and given an example of the notice language.

C. State if a denial of a non-covered service can be appealed, if this is standard or customizable for self-insured clients.

D. Provide an overview of the Complaint process. Include how a Complaint is received, how Complaints are differentiated from Appeals, how decisions are made, which people (state their titles and qualifications) are involved, completion timelines, how and when members are notified that their Complaints have been received and their results, and in which circumstances the HCA would be notified.

E. Describe the responsible department for processing Appeals and its location (e.g., locally or nationally). If Appeals will not be handled locally, describe how processes will be coordinated to assure compliance with applicable timelines defined by the Washington Patient Bill of Rights and other HCA requirements.

F. Describe how grievance and Appeal information is used. Explain how such data informs the Bidder's business processes, such as staff training, Utilization Management decision-making and member experience (data collection or improvement activities). Provide two (2) examples. Describe how data is used to improve performance of network-provider feedback and training.

G. Describe the methods for communicating member rights and responsibilities information to members and providers.

H. Describe the roles, responsibilities, titles, credentials (including types of licenses and certifications held by clinicians), and processes associated with medical necessity Appeals.

Required Accompanying Documents

A. Include an example of an Appeal response letter, indicating the areas available for customization.

B. Include an example of the Appeal process used with a self-insured customer demonstrating adherence to timelines, customization of letters, and specific results in performing the process.

C. Include a recent quarterly report of first and second level Appeal results that show the number and percentage of Appeals overturned at each level. Provide a similar report of IRO results.

D. Describe how Appeal results are used to improve Claim processing, Member service and prior authorization processes when the ratio of overturned Appeals is high in a particular area or for a specific benefit.

Evaluation and Scoring Insight

Preference will be given to Bidders who have a process in place that meets the HCA requirements for managing Appeals and Complaints and tracking of each level of Appeal, preauthorization denial, and Complaints and ensures data sharing between the HCA and the Bidder.

Bidder Response

Not to exceed eight (8) pages, excluding Required Accompanying Documents.

Exhibit 3.8 Overall Account Management Administration

Overview

The HCA desires an ASB with a solely dedicated Account Management administrative service team located in Washington State that is proficient in coordinating resources and services to meet all Contract requirements and Performance Guarantees, and is responsive to HCA requests for support and coordination. Further, the HCA desires an Account Management team that is well prepared to deal with situations outside the realm of normal operations in ways that (a) rapidly respond to and resolve problems regardless of causation (acknowledge receipt of email and ETA within 24 hours and provide the HCA with a 24-hour phone line for urgent issues), (b) minimize negative direct impacts to Members and providers, and (c) are sensitive to the economic and political environment associated with UMP as a public Health Plan serving Members of state and local legislative, executive and judicial branches of government and faculty and staff of institutions of higher education. The solely dedicated Account Management team may be required to travel to in-person meetings as required by the HCA. Only experienced ASB employees shall be utilized on the Account Management Team, as they will each need a robust understanding of the ASB's processes the ASB's processes before working on this account. The HCA has the authority to require replacement of team members at its discretion and will be part of the interview process for team members when replaced.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

For each of the subsections below, describe and address how Bidder will meet the following:

A. Sufficient experienced subject matter experts to manage all contracted functions for the size and complexity of this account including:

   1. Participation in quarterly account management meetings with HCA staff to be held at the HCA's headquarters.

2. Participation in activities to analyze plan performance, identify improvement opportunities, design interventions, and coordinate implementation with the HCA.
3. Participation in Healthier Washington, community-based health improvement activities and interagency coordination efforts of the five (5) Washington State health care purchasing agencies plus Washington State Board of Health, and the OIC, to develop common policies, support, and implement the work of the Prescription Drug Program, HTCC, and the Bree Collaborative as requested by the HCA, and design and implement health care reform across the Washington State health care purchasing system.
4. Approach to ensuring the account management team is responsive to the HCA's inquiries, contacts and requests, and keeps the HCA informed of new and outstanding issues.
5. Approach to reporting monthly and quarterly performance including key features of plan operations (including administrative and Clinical Management Services) covered and presentation of analyses and recommendations in response to reported performance outcomes.
6. Methods to comply with, or provide information and refund money to allow the HCA to comply with Washington and other applicable laws relating to escheatment and unclaimed property, including chapter 63.29 RCW.
7. The Bidder's account team will be obligated to inform the HCA Senior Account Sponsor(s) of state and federal law changes within fifteen (15) Days of notification.
8. Specify that the Bidder's account management team needs to be located in Washington State, and confirm where each member is located.
9. Specify the qualifications (e.g., licenses, certifications, educational levels, years of experience, etc.) for the account management team members.
10. Describe how many years each account management member has worked for the Bidder and in what capacity. Please provide a Curriculum Vitae (CV) for each account management member for the Bidder.
11. Attend meetings of the PEBB.

Required Accompanying Documents

Please provide a Curriculum Vitae (CV) for each account management member for the Bidder.

Evaluation and Scoring Insight

Preference will be given for account management teams who already know and work for the Bidder with at least 5-10 years of experience. Account Managers are not to be sales personnel.

Bidder Response

Not to exceed six (6) pages, excluding Required Accompanying Documents.

Exhibit 3.8.1 Account Management Resourcing

Overview

All FTEs identified below will be included in the PSPM rates supplied by Bidders.

The ASB will provide an account management administrative service team that is proficient in coordinating resources and services to meet all Contract requirements and Performance

Guarantees, and is responsive to the HCA's requests for support and coordination. The following resources will be dedicated to the UMP Plans and responsive to all requests from the HCA:

A. Strategic Account Manager (Solely Dedicated 1 FTE)
B. Daily Operations Manager (Solely Dedicated 1 FTE)
C. ACN Account Manager (Solely Dedicated 1 FTE)
D. Clinical Programs Manager (Solely Dedicated 2 FTE)
E. Medical Director (Solely Dedicated .5 FTE)
F. Data Analyst (Solely Dedicated 1 FTE)
G. Communications Specialist (Solely Dedicated 1 FTE)
H. Implementation Manager (Solely Dedicated 1 FTE during Implementation)
I. Accounting Contact
J. Legal Contact

Specific Instructions

Address who the Bidder proposes for each position, and how that position would function within the overall account team. The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

Describe the Bidder's proposed staff to fill all of the roles listed below. Include name, title, degrees, credentials, Curriculum Vitae (CV), and how long each person has been with the Bidder.

A. *Strategic Account Manager (Solely Dedicated 1 FTE)*

Strategic Account Manager will:

1. Be the point of contact for the HCA Senior Account Sponsor(s) and for the escalation of issues between Bidder and the HCA.
2. Coordinate and recommend strategies to the PEBB with the HCA, including lowering or maintaining cost trend, improving Utilization Management, and changing the health care market to achieve Healthier Washington goals.
3. Responds to HCA Account Team within 24 hours of initial request, and with answer or solution within three (3) Business Days of request.
4. Respond when called for urgent issues within four (4) hours.
5. Respond to proposed Work Orders within the contracted timelines.
6. Attend weekly account management meetings, and be onsite at the HCA's headquarters as requested

B. *Daily Operations Manager (Solely Dedicated 1 FTE)*

Daily Operations Manager will:

1. Be the point of contact for the HCA Senior Account Sponsor.
2. Maintain the action log and track escalated and legislative requests, reporting, Performance Guarantee reports, Work Orders, and other daily operations tasks.
3. Responds to the HCA within 24 hours of initial request, and with answer, solution, or an estimated date for such an answer or solution, within three (3) Business Days of HCA request.

C. ACN Account Manager (Solely Dedicated 1 FTE)

ACN Account Manager will:

1. Responsible for all ACNs operations, including network set up and processes, data and reporting to the HCA and Data Intermediary, and benefits programming and operations; will work full-time in support of the Contract.
2. Responds to HCA Account Team within 24 hours of initial request and with answer or solution within 3 Business Days of HCA request or ETA on the request

D. Clinical Programs Manager (Solely Dedicated Nurse (LPN or RN) 2 FTEs)

Clinical Program Manager will:

1. By January 1, 2018, Bidder will provide two (2) UMP Plan Clinical Programs Managers (CPMs) to serve as the points of contact for the HCA clinical programs manager. Each will be a licensed practical nurse or a registered nurse with current, active, and unrestricted licenses in Washington State. The CPMs will attend weekly meetings with HCA regarding clinical programs for UMP Plans, and other meetings as deemed appropriate by the HCA.
2. The CPM will participate and facilitate the bi-monthly Clinical Strategies Team and Clinical Strategies Workgroup meetings, and will attend the weekly Core Team Meetings. Provide monthly updated medical polices in operations and clinical strategies meetings.
3. The CPM will coordinate all HTCC related activities by attending weekly HTA meetings, providing feedback and input to HTA processes and programs on behalf of the Bidder, and coordinating HTA activities with Bidder's Medical Directors, Implementation Teams, and Clinical Teams
4. The CPM will provide oversight and management for all Clinical Management programs provided by the Bidder.
5. The CPM will provide leadership and oversight for the quality management and improvement for all Clinical Management programs provided by the Bidder.
6. The CPM will serve as clinical representatives when required for clinical topics when communicating and coordinating with other relevant programs, such as the ACNs and other benefit programs.
7. The CPM will attend HTCC meetings (approximately six (6) times a year).
8. The CPM will attend Bree Collaborative meeting as requested by HCA.
9. The CPM will maintain Master Grid for all HTCC determinations and implementation plans.

10. The CPM will coordinate all of the ABA program related activities, including attending all ABA program meetings; providing feedback and input to ABA processes and programs to HCA on behalf of Bidder; and coordinating ABA activities with Bidder Medical Directors, implementation, operations, and analytics teams. Additionally, the CPM will provide member advocacy services to ABA program participants, including review of denials, Appeals, and escalated issues.
11. Bidder will create a prioritization of all clinical programs requests and can be documented within the action log for the weekly core team meetings. The CPM will establish and maintain a "clinical action log" to track clinical issues that are raised as a part of the meetings and activities described above. The form and content of such log will be subject to the HCA's approval.
12. The CPM will also look up medical policies and do research as requested by the HCA to inform the HCA customized medical policies, and legislative research as needed.
13. Provide detailed quarterly and annual Clinical Management reporting, including activities, processes, and outcomes reporting.
14. Provide detailed annual Appeals and IRO reporting at Member level detail.
15. Coordinate with the Bidder and HCA communications specialists on updates to medical policies to be posted on the PEBB website monthly.
16. This team member will also support all UMP Plans including Care Transformation of the UMP Plus and other ACN programs.
17. Brief HCA on Book-of-Business Clinical Management programs and implementation thereof. Implementation plans and progress of Bree and other customized HCA medical policies. This also includes clinical requests for information from HCA Account Team or solutions/recommendations to issues with members and clinical situations and issues.
18. Provide detailed quarterly and annual Clinical Management reporting.

E. Medical Director (Solely Dedicated MD or DO, 0.5 FTE)

1. The Medical Director will be an employed physician who holds a current, active, and unrestricted license to practice medicine in Washington State who is associated with the Bidder to provide medical expertise and support HCA's Health Technology Assessment program, the Prescription Drug Program, the Bree Collaborative, and other the HCA-identified performance improvement efforts as they relate to the UMP Plans and the State's health care purchasing system. This will include the HCA customized medical policies and other requests from the HCA.
2. Approve the annually written description of Bidder's Medical Management program.

F. Data Analytic Specialist (Solely Dedicated 1 FTE)

1. Provide a UMP Plan specific database, and Book-of-Business comparisons, analytics and decision support, the Bidder will provide the HCA with enhanced access to the services of a Consulting and Analytics team. Enhanced access will provide the HCA with the collective skills of the consulting team, with priority handling and rapid turnaround time facilitated by one (1) dedicated FTE. The HCA requests will be maintained separately from other Bidder clients and may require turnaround times as short as 12-24 hours due to legislative or other HCA requirements. The Bidder will track the HCA requests via a log sheet, and will communicate prioritization to the HCA through weekly triage calls. Weekly triage calls will also be used to assess the content and intent of

prioritized requests to ensure that meaningful data is provided in a timely and reliable manner. The parties may hold additional ad hoc meetings as necessary.

2. In addition to satisfying ad hoc requests, the consulting team will provide monthly dashboard reports and in-depth analysis of cost and utilization patterns in an attempt to proactively identify cost drivers and trends, time permitting. Additionally, one (1) or two (2) members of the consulting team will be available to attend up to six (6) in-person meetings with the HCA, per year.
3. Provide monthly PDF files of any prior authorization standards, criteria or information the UMP Plans use for medical necessity decisions in compliance with chapter 41.05 RCW.
4. Priority handling and rapid turnaround of data reports and analytics; will work full-time in support of the Contract.
5. Provide analytic support and services on Claims and utilization data with the UMP Plans.
6. Points of contact for data analytics will be the Bidder Account Manager and the HCA Portfolio Management team member who submitted the request.
7. All data/report requests for the HCA will come from an HCA Portfolio Management team member. All data/report requests will be specific and include detailed requirements necessary for Bidder to prepare the report. The HCA will also work with Bidder to create a prioritization of all data/report requests.
8. Provide HCA employees twenty-four (24) hour a Day, seven (7) Days a week access to a UMP Plans Claims data base for ad hoc reporting.

G. Communications Specialist (Solely Dedicated 1 FTE)

The Communications Specialist will:

1. Be the point of contact for all Enrollee communications documents and website language, to include printed materials, Certificate of Coverage, updates to HCA websites, updates to medical policies, provider terminations communications to Members, and anything that will be viewed by Enrollees.
2. Have oversight for website and electronic communications for Members and will collaborate with HCA Communications on all Member correspondence.

H. Implementation Manager (Solely Dedicated 1 FTE during implementation)

The Implementation Manager will:

1. Coordinate and ensure performance of the implementation Services; will work full-time in support of Bidder's implementation Services.
2. Services will include CY 2018- June 2020 for initial phase and if any new plans are added, the Bidder will supply implementation manager for such projects.

I. Accounting Contact

1. Point of contact for all Contracts and Amendments and will represent Bidder on accounting and finance questions as HCA requires; available as needed.

J. Legal Contact (As Needed)

1. This person is an attorney for the Bidder who will be the point of contact for all Contracts and amendments for the Bidder and will represent the Bidder on legal questions as HCA requires. The Bidder will have no more than five (5) Business Days to turn around HCA

requested timelines and all legal documents, to include Contract amendments, BAA's, and Data Share Agreements.

Required Accompanying Documents

Provide a Curriculum Vitae (CV) for all positions listed above and length of time with the current Bidder.

Evaluation and Scoring Insight

Preference will be given for account management teams who already know and work for the Bidder with at least 5-10 years of experience. Account Managers are not to be sales personnel.

Bidder Response

Not to exceed ten (10) pages, excluding Required Accompanying Documents.

Exhibit 3.8.2 Account Management Functions

Overview

General Account Management functions will include weekly core meetings with the account team and to review items on the action log. Action log will be updated by the ASB weekly and progress will be updated. There will be a senior Account Manager who will be responsible for making sure the team is accountable for items and projects assigned. Work Orders will also be tracked via the action log each week for documentation of all details and hours.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

Describe how the Bidder will do all the following:

A. General

1. Designate a solely dedicated Washington-based account management team that is experienced, knowledgeable, and readily accessible to the HCA Senior Account Sponsor(s). The solely dedicated account management team members must have tenure and status in the organization to influence Washington innovation at the corporate executive level.
2. Designate solely dedicated, experienced account management staff and other experienced subject matter experts for each contracted administrative service in sufficient numbers for the size and complexity of the UMP Plans.
3. Be responsive to HCA inquiries, acknowledge receipt of request within 24 hours and answer the request within three (3) Business Days, unless it is urgent or a legislative request.

4. Keeps the HCA informed of new and outstanding issues related to UMP Plan administration.
5. Have a dedicated escalations process and point of contact for member inquiries that come directly to the HCA.
6. Report quarterly on performance, including key features of plan operations and presentation of analyses and recommendations in response to reported performance outcomes.
7. Specify that the Bidder's personnel that provide account management are located in Washington State.
8. Specify the qualifications (e.g., licenses, certifications, educational levels, years of experience, etc.) for the account management team members.
9. Will attend all Clinical Management meetings and follow through with clinical programs manager as needed.
10. Will attend all meetings of the PEBB.
11. Bidder will be required to collaborate and coordinate with the Attorney General's Office on any litigation against the UMP. This includes gathering of information and legal services used internally at the Bidder or in coordinating or collaborating with the AG's office. No additional fees will be paid for such services.

B. Operations Account Meetings

1. Hold monthly operations account management meetings and present the monthly operations reports with the HCA at the HCA offices. All members of the account team will participate.
2. Hold weekly core team meetings with the HCA wherein the Bidder will keep and maintain a log of all current and past issues and work orders and the team will discuss and log progress on issues each week.
3. Hold additional telephone or in-person meetings as requested by the HCA.
4. Build an operation manual and update twice a year. A sample operations manual is attached as Appendix 6, Attachment 8.

C. Strategic Account Meetings

Senior management representatives of the HCA and the Bidder will meet on a regularly scheduled basis to discuss performance and to develop strategic priorities and action plans to advance the UMP Plans value proposition. At the HCA's discretion, these meetings will be held either quarterly or twice per year. Quarterly utilization reports will be produced by the Bidder.

D. Banking

Notify the HCA via e-mail on a weekly basis of Claim payments issued.

E. Escheat

Comply with, or provide information and refund money to allow the HCA to comply with, Washington State and other applicable laws relating to escheatment and unclaimed property, including chapter 63.29 RCW.

F. Public Relations

As a state-wide public sector health plan, the UMP Plans operate within a complex public environment and the Bidder account management team needs to be sensitive and responsive to public relations issues and inquiries.

Required Accompanying Documents

The Bidder must provide up to three (3) examples of current action logs for other accounts.

Evaluation and Scoring Insight

Preference will be given for account management teams who already know and have at least 5-10 years of experience with the Bidder. Account Managers are not to be sales personnel.

Bidder Response

Not to exceed eight (8) pages, excluding Required Accompanying Documents.

Exhibit 3.8.3 Emergency Response Account Management

Overview

The HCA desires an ASB that is able to maintain critical functions during an extended closure or emergency or severe weather event.

The ASB will maintain in an uninterrupted manner those business functions and services listed in Exhibit 2 (Clinical Management in Care Transformation), Exhibit 2.1 (Utilization Management), Exhibit 2.3 (Complex Case Management), Exhibit 2.4 (Chronic Condition Management), Exhibit 3.1 (Medical Benefit Drug Management), Exhibit 3.2 (Claims Payment Services), Exhibit 3.8 (Overall Account Management Administration), and Exhibit 3.11 (Member or Customer Service), during system outages or other system failures and during severe weather and other emergency situations. Within five (5) Days of a request from HCA, and annually on July 1, the ASB will provide the current Business Interruption and Disaster Management Plan specific to UMP Plan operations.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

A. Describe the Bidder's emergency response approach to maintain uninterrupted core business operations during natural disasters or other system outages.

B. Describe the kinds of abnormal events to which the Bidder's emergency response applies.

C. Define what the Bidder classifies as core business operations and give specific information that clearly relates the emergency response approach to the UMP Plans.

D. Describe one actual emergency event that occurred and the Bidder's Response that exemplifies your ability to effectively maintain core business operations under abnormal conditions.

Required Accompanying Documents

A. Provide a detailed disaster recovery plan, including details for health care services, customer service and Claims adjudication for a current client within Washington.

B. Provide a detailed disaster recovery plan, including details for health care services, customer service and Claims adjudication for a current client with over 20,000 lives, if available and if different than Bidder's documents provided in response to A.

C. Provide a detailed disaster recovery plan for the UMP account for customer service and Claims adjudication. Include where back up office locations, account management, Claims adjudication and customer service would be provided from, and the number of back-up personnel available in emergency situations, and their location.

Evaluation and Scoring Insight

Preference will be given for a management approach that focuses on resolving problems in a way that minimizes negative impacts to Members and providers and reduces administrative delays in achieving resolution.

Bidder Response

Not to exceed four (4) pages, excluding Required Accompanying Documents.

Exhibit 3.8.4 Account Management for Public Sector or High Profile Clients

Overview

As a state-sponsored, self-insured PPO, the UMP Plans have many unique challenges to maintaining Member, provider, and public recognition of Health Plans as well-managed and fiscally responsible public sector health plans. The PEB Division serves a diverse set of public employers, and PEBB benefits are available to employees and retirees from across the legislative, executive and judicial branches of state and local governments, institutions of higher education, K-12, and tribal governments. As a result, the UMP Plans must be managed in a way that recognizes problems and issues may be highly visible to Members, state and local policy makers, and the general public. These entities may engage with the HCA, the Governor's Office, and other state or local government representatives regarding performance and operations of the UMP Plans.

Part of this management will require the ASB to assist and support the HCA throughout the legislative process. As a cabinet level agency of the State of Washington, the HCA operates under the direction of the Governor's Office, the Office of Financial Management (OFM), and the Washington State Legislature. Beginning the second Monday of each January, the Legislature meets for 90 Days in even numbered years, and for 105 Days in odd numbered years. A regular legislative session may be followed by Special Sessions ordered by the Governor if work necessary to implement a budget is not completed. Special sessions are ordered in increments of 30 Days, and more than one Special Session may be required in any year. Support will be required for the entire duration of any legislative session during the term of the Contract.

During a legislative session, the Legislature proposes and adopts new laws, modifies existing laws, and creates work groups to generate studies and reports provided to the Legislature in future years. The PEB Division may be directed to complete analyses of pertinent bills quickly. That work requires the support of the Health Plans. During the period allowed for a bill analysis and fiscal note, PEB Division account managers will ask Health Plans and TPAs for input. Each time a priority bill is amended during a legislative session, it must be reviewed, amendments assessed, may require additional TPA input. These Requests must be given priority. A response is required within 24 hours.

To help meet these ends, the ASB must:

A. Treat each bill as if it will become law.

B. Understand that not every bill will become law.

C. Assist the HCA in preparing to implement new laws. Bill analysis is the HCA's "project plan" to aid that implementation, including identifying costs, a timeline to implement, any need to hire contract or permanent staff, acquire, modify, or replace programs or systems, etc.

D. Promptly inform the HCA of any inability to implement a new mandate or process required by law. The HCA can then convey this information for consideration as part of the legislative process.

E. Understand the HCA's compliance with Washington laws is not optional.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

A. Describe Bidder's customer relations, provider relations and public relations capacities and approaches to administering public sector health plans in a highly transparent and politically active environment. Specifically address Bidder's past experience and successes in managing situations involving negative media exposure about Health Plan policy and operations, oppositional lobbying efforts by special interest groups, provider associations, etc., and direct reporting of Complaints and grievances to the Governor, senior staff, or cabinet-level agency heads regarding your entity's performance.

B. Describe how Bidder would respond to legislative requests for written information, budget analysis, and data for HCA within a 24-hour timeframe.

Required Accompanying Documents

None.

Evaluation and Scoring Insight

Preference will be given for a management approach that clearly recognizes the environment in which the PEB Division operates and the challenges this poses and describes a proactive approach to problem resolution in partnership with the HCA.

Bidder Response

Not to exceed three (3) pages, excluding Required Accompanying Documents.

Exhibit 3.9 Work Orders

Overview

The process described in this exhibit sets forth the documentation and additional payment, if any, for the performance of services not covered elsewhere in this RFP or the Contract. Other than the

compensation identified in Appendix 6, Attachment 27, and any agreed upon on fees paid under this process, there will be no other payments to the ASB. Specified additional work, or a change in existing services or procedures, state the expected completion date and criteria, including system acceptance testing procedures, and any compensation, will be set forth in a work order form attached to the Contract (Work Order). Each Work Order will be issued and approved by the HCA Contract Manager. The expected completion date will be the date by which the parties intend the work or change to be operational. The ASB will not charge or accept any compensation from any Member for any purpose.

Purpose of Work Orders:

Work Orders will be used for special tasks outside of, but related to, the scope of the contracted services. They will be used for instruction and documentation purposes to describe services that do not require an additional charge. The HCA will be entitled to up to 5,000 annual service hours at no additional charge (Pooled Hours). All Pooled Hours must be used before the HCA will pay for Work Orders, therefore the costs of these hours must be built into the proposed PSPM. Unused hours will accumulate and carry over into the following year and throughout all the term of the Contract. The ASB will keep a detailed record of all used Pooled Hours and submit with the monthly operations report. When applicable, a detailed itemized list of services completed is required on the invoice from the ASB to receive payment.

Monitoring of Work Orders

The ASB must maintain an up-to-date working log of active and closed Work Orders that will be reviewed at weekly core team meetings.

Implement Health Technology Clinical Committee (HTCC) Determinations

The HCA will send the ASB a no charge Work Order at the end of each year that details the HTCC's final determinations for that year. The ASB's response to such Work Order will include all the requirements, detailed procedure codes, and International Classification of Diseases (ICD) codes, in order for the ASB to implement the changes by the effective date provided. This Work Order will be completed by September 30 annually, for the decisions made in that same year, unless otherwise specified by HCA in the Work Order. The ASB will have specific ICD (9 or 10) version by 2019 and maintain version updates.

Charges for Work Orders

Time may be billed the HCA at the Pooled Rate after all Pooled Hours have been used. The ASB will not bill the HCA, nor will the HCA pay, for services necessary to implement annual changes in benefits or other scope of work covered in the Contract. The ASB will not deduct from the Pooled Hours for services included in the Contract.

The ASB may bill HCA for materials as agreed upon in the signed Work Order. The ASB must provide a cost estimate in the Work Order when applicable using an hourly rate less than or equal to the Pooled Rate. The ASB will not charge the HCA more than the charges agreed to in the Work Order unless the HCA agrees in writing. The ASB will bill the HCA for applicable costs via invoice once the work has been completed.

Work Orders may only identify charges for goods or materials obtained by the ASB for which the HCA has agreed to reimbursement. Any such costs for such goods may not exceed be the actual cost paid by the ASB.

Work with No Extra Charge

Work Orders may be completed to document work as part of the Contract without any additional charges. Some examples of this are implementation of HTCC determinations, HCA customized medical policies, annual benefit changes, or services performed using Pooled Hours.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

Describe how the Bidder will meet the following:

A. Submit a blended work order hourly rate where indicated in Appendix 6, Attachment 27.

B. Describe the Bidder's experience operating under an existing work order process, starting with the request, process for submission of the work request, clarification regarding the work request requirements, updating process on the work order, and final sign-off by the client or customer on the quality of the work product.

C. Describe how it will maintain and track the Pooled Hours on a monthly basis for each year.

D. Describe how it currently works with self-insured clients for work not within the contract.

Required Accompanying Documents

None.

Evaluation and Scoring Insight

Preference will be given to bidders who agree to the 5,000 work order hours and describe how hours will be tracked, assigned to projects, transparent to HCA and reported. Lower blended rates for work order hours after the 5,000 hours will also be considered.

Bidder Response

Not to exceed five (5) pages, excluding Required Accompanying Documents.

Exhibit 3.10 Reporting Requirements

Overview

The ASB will need to do the following:

A. Provide quarterly reports detailing administrative functions (e.g., customer service telephone answer time and abandonment rates) as well as Clinical Management Services.

B. Compile a quarterly executive report that includes utilization and cost reports by overall payments, PMPM payments, discount rates, and by payments by type of service (inpatient, outpatient, ambulatory surgical center, or professional) and second level Appeals summary information. This report will also include a credit balance recovery report describing the total dollars recovered that will be credited to the HCA. The ASB will deliver this report within thirty (30) Days of the end of the quarter reported.

C. Provide standard eligibility and Claims reports separately for Non-Medicare and Medicare risk groups by Plans and network, as well as combined, within five (5) Business Days of the HCA's request.

D. Provide standard key reports and ad hoc reports accurately and within mutually established dates and response times.

E. Provide HCA with its most recent SOC 1 and SOC 2 audit results upon request.

F. Provide designated HCA personnel access to the ASB's web-enabled online reporting tools at no additional cost.

G. Provide monthly and quarterly reports detailing Utilization Management reviews, including process and outcomes metrics.

H. Provide monthly and quarterly reports detailing Appeals and grievances, including process and outcomes metrics.

I. Provide monthly and quarterly reports detailing Case Management, including process and outcomes metrics.

J. Provide monthly and quarterly reports detailing Clinical Management programs, including process and outcomes metrics

K. Provide monthly and quarterly reports detailing other innovative Clinical Management programs and consumer support services, including process and outcomes metrics.

L. Provide monthly and quarterly reports detailing Quality Management and improvement activities, including process and outcomes metrics.

M. Accept and process encounter data and EHR data for the ability to monitor and report on ACNs.

N. Submit data from the UMP Plans and any fully-insured business that the Bidder has to the APCD.

O. Annually provide Healthcare Effectiveness Data and Information Set (HEDIS) data specified by the HCA to the HCA or its business associates for each UMP Plan.

P. Participate in an annual customer satisfaction survey at the HCA's request. The survey will be the current version of the NCQA Consumer Assessment of Health Plan Survey (CAHPS) or a similar survey tool identified by HCA. A third party will be used to conduct any such survey.

Q. Submit additional ad hoc reports on readily available information and data at the request of the HCA.

The table below is provided for illustrative purposes only and is presented only as an example of some, but not all, of the types of reports that the ASB will provide to the HCA. The HCA is interested in a comprehensive reporting package that addresses all of the information and data described in this section of the RFP.

Table 3.10.1: Sample Report: Reporting Inventory

	Report Name	Report Frequency	Due Date to the HCA	Content
1	Medical Management OPS Report	Monthly	30th of the following month	Case management count of open bariatric and transgender cases. Medical Policy updates and ABA Participation Spreadsheet.
2	OPS Report	Monthly	30th of the following month	PowerPoint deck to include: Claims inventory; customer service call volumes and top 5 reasons for calling; escalations report and Appeals/Complaints reports; pre-authorization reasons; ABA summary; detailed summary of annual service hours used to date
3	Paid Claims	Weekly		Email to HCA Contract Manager of Claims paid
4	Erroneous Payments	Quarterly	15 Days following end of quarter	Overpayments that have not been recovered; any money recovered will be credited to the HCA at the time of recovery.
5	Description of Clinical Management Program	Annually	May 1	Written description of Clinical Management program, which has been approved by the ASB's Medical Director
6	Changes in Medical Policy	Variable	30 Days prior to change	Notice of changes in medical policy that materially affect Plan payments
7	Clinical Management Program Statistics	By request	By request	Detailed program statistics, including disease type, Case Manager work, outcomes, and other information as determined by the HCA
8	IRO Decisions	Variable	7 Days after final decision	Copies of each IRO decision

	Report Name	Report Frequency	Due Date to the HCA	Content
9	Account Management Team Notification	Annually; and upon request	January 1	Memo identifying the Account Management Team
10	Performance Outcomes	Quarterly	April 30 July 31 October 31 January 31	Performance; key features of Plan operations; presentation of analyses and recommendations in response to reported performance outcomes
11	Executive Report	Quarterly	April 30 July 31 October 31 January 31	Utilization and cost by overall payments; PSPM payments; discount rates; payments by type of service (inpatient, outpatient, ambulatory surgical center, or professional); second-level Appeals summaries; credit balance recovery report, including total dollars recovered that will be credited to the HCA
12	Eligibility and Claims Report	By Request	By Request	Separate and combined reports for Non-Medicare and Medicare risk groups; Correct reporting of Medicare risk group Members including those who have Medicare as their primary coverage, and all other Members included in the Non-Medicare risk group
13	Standard Key and Ad Hoc Reports	By request	By request	Standard key reports and ad hoc reports; accurate and adhering to mutually-established dates and response times
14	SOC1 Type II Audit Results	By request	By request	SOC1 Type II audit results, upon request
15	Service Hours/Project Report	Monthly	30th of each month	Requested project details; number of hours remaining in the Pooled Hours for Work Orders

	Report Name	Report Frequency	Due Date to the HCA	Content
16	WHA Claims Data Report and APCD	By request	By request	Claims data to Washington Health Alliance (WHA) for UMP Plans and ASB's fully-insured business in Washington State, and to the APCD in standard formats as requested by the WHA or APCD
17	HEDIS and the Common Measure Set	By request	By request	Healthcare Effectiveness Data and Information Set (HEDIS) and Common Measure Set data specified by the HCA
18	Data & Analytics Dashboard	Monthly		Dashboard reports; in-depth analysis of cost and utilization patterns
19	Yearly Performance Guarantee Report	Yearly	March 31	Performance Guarantee results; delivered to the HCA Senior Account Sponsor(s); include any Performance Credits
20	Quarterly Performance Guarantee Report	Quarterly	45 Days following end of quarter	Performance Guarantee results; delivered to the HCA Senior Account Sponsor(s); include any Performance Credits
21	Network Discounts	Variable	Variable	Modifications to network contracted discount arrangements may result in an increase of 2% or more in monthly Claims costs
22	Overall Trend	Yearly	October 31	Overall Trend Guarantee measured annually for Claims paid through June 30 of the current; draft report of initial measurements; final settlement report
23	Subrogation Report	Quarterly	45 Days following end of quarter	Third party liability activities; delivered to the HCA Contract Manager
24	Disabled Dependent Determinations	Monthly	30 Days following the end of month	Routine monitoring/reporting; maintain accurate and timely eligibility files
25	OB Payment Reform	Monthly	30 Days following the end of month	Total number of cases reviewed and total number of facility Claims denied for early elective induction; presented at the monthly Clinical Strategy Leadership Meeting

	Report Name	Report Frequency	Due Date to the HCA	Content
26	Smart Health Data	Monthly	By the 22nd of the following month	
27	Transgender Surgery	Monthly	30 Days following the end of quarter	Number of intake cases each quarter to match the invoice
28	Appeals and IRO report overturned	Annually	30 Day following the end of the year	All cases that were overturned at any level of Appeal or IRO; include case number, Claim number, diagnosis codes and descriptions, procedure codes and descriptions, indicator of HTA decision or not, reason for overturn, case description
29	Network Access Report	Semi-Annual	March 1 and October 1	Network access maps and access statistical tables; remediation plan and timeline if any provider type or geography does not meet contractual standards
30	Paying for Value Survey	Annually	30 Days following the end of the year	All portions of survey results from ASB and all network providers
31	Business Continuity & Disaster Recovery	Annually; and upon request	January 1	Business continuity/disaster recovery plan designed to maintain uninterrupted business operations necessary to meet obligations during natural disasters or other abnormal events
32	Expedited Appeals	Quarterly		Number of expedited Appeal requests determined to be not urgent, denied or approved
33	Core Team & Clinical Action Log	Weekly		[See meeting list above]
34	Overpayments, Fraud and Erroneous payments reports	Quarterly	15 Days after the quarter ends	Processes and service descriptions of each; dollars identified as each for UMP; dollars collected for each; running annual totals
35	Primary Care Expenditures	Annually	May 31	Summary of the total expenditures for Primary Care under both the UMP Plans and the entire Book-of-Business

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

Please describe the Bidder's ability to meet each of the following items:

A. Provide quarterly reports detailing administrative functions (e.g., customer service telephone answer time and abandonment rates) as well as Clinical Management Services.
B. Compile a quarterly executive report that includes utilization and cost reports by overall payments, PMPM payments, discount rates, and by payments by type of service (inpatient, outpatient, ambulatory surgical center, or professional) and second level Appeals summary information. This report will also include a credit balance recovery report describing the total dollars recovered that will be credited to the HCA. The ASB will deliver this report within thirty (30) Days of the end of the quarter reported.
C. Provide standard eligibility and Claims reports separately for Non-Medicare and Medicare risk groups by Plans and network, as well as combined, within five (5) Business Days of the HCA's request.
D. Provide standard key reports and ad hoc reports accurately and within mutually established dates and response times.
E. Provide HCA with its most recent SOC 1 and SOC 2 audit results upon request.
F. Provide designated HCA personnel access to the ASB's web-enabled online reporting tools at no additional cost.
G. Provide monthly and quarterly reports detailing Utilization Management reviews, including process and outcomes metrics.
H. Provide monthly and quarterly reports detailing Appeals and grievances, including process and outcomes metrics.
I. Provide monthly and quarterly reports detailing Case Management, including process and outcomes metrics.
J. Provide monthly and quarterly reports detailing Clinical Management programs, including process and outcomes metrics
K. Provide monthly and quarterly reports detailing other innovative Clinical Management programs and consumer support services, including process and outcomes metrics.
L. Provide monthly and quarterly reports detailing Quality Management and improvement activities, including process and outcomes metrics.
M. Accept and process encounter data and EHR data for the ability to monitor and report on ACNs.
N. Submit data from the UMP Plans and any other fully-insured business that the Bidder has to the APCD.

O. Annually provide Healthcare Effectiveness Data and Information Set (HEDIS) data specified by the HCA to the HCA or its business associates for each UMP Plan.

P. Participate in an annual customer satisfaction survey at the HCA's request. The survey will be the current version of the NCQA Consumer Assessment of Health Plan Survey (CAHPS) or a similar survey tool identified by HCA. A third party will be used to conduct any such survey.

Q. Submit additional ad hoc reports on readily available information and data at the request of the HCA.

Required Accompanying Documents

Provide a copy of the Bidder's standard reporting package and two (2) examples of customizable reports.

Evaluation and Scoring Insight

Preference will be given to Bidders whose standard reports meets the required elements without using ad hoc reports. Preference will also be given to Bidders who communicate a willingness and ability to customize reports.

Bidder Response

Not to exceed eight (8) pages, excluding Required Accompanying Documents.

Exhibit 3.11 Member and Customer Services

Overview

The ASB's Member and customer services will provide knowledgeable, responsive, high quality service to all Enrollees, regardless of their location. The ASB's center providing such services will be structured to provide a consistently high degree of customer service and timeliness. The ASB's staff will be well trained in its systems and processes to handle complex coverage issues for Members. Customer and Member services teams must be dedicated resources to the HCA's account.

A minimum of 70% of such service team must be physically located in Washington State, and all must be within the United States. It is preferred that Claims adjudication services and staff also be located within Washington. Claims processing must be located and performed within the United States. The HCA believes staff of the ASB's service center must be well-versed in the geographic, cultural, and social aspects of Washington.

The ASB will be expected to perform the following requirements:

A. Beginning in November 1, 2019, and each year thereafter, provide at least two (2) trained staff for every Open Enrollment benefits fair (which could be held multiple times in different locations in Washington over the Open Enrollment month) who can cover topics including benefits and cost-sharing, network providers, Claim procedures, Member services, and plan informational tools and resources. These trained staff will not be the ASB's account managers or account team.

B. Provide Interactive Voice Response (IVR) for providers to access to eligibility and Claims information.

C. Provide a secure on-line portal to allow providers access to eligibility and Claims information.

D. Provide language translation services and TTY/TDD services, or other available modes of communication to accommodate visually and hearing impaired Members in accordance with state and federal law.

E. Provide for a backup customer service when local customer service is disrupted.

F. Provide customer service coordination with UMP Plan eligibility and enrollment, with the UMP PBM and other HCA vendors.

G. Collect Member feedback and respond appropriately.

H. Establish and maintain a process and system for monitoring call quality.

I. Support Members working on assignment in other countries for extended periods by providing assistance and information with evidence or verification of benefits for Foreign governments and with filing and tracking status of Claims.

J. Provide a clinical case manager or reviewer as the first point of contact for clinical programs.

K. Provide one trained staff member to manage the disabled Dependent certification process.

L. Provide a customer service escalation team for Members and the HCA Account team for Complaints. This team should be able to resolve Complaints within two (2) Business Days and investigate the reasons and outcomes for Claims, payment and medical policy issues.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

A. Describe the Bidder's service center and staff. Include the proposed UMP customer service center location, size of UMP support staff, experience of staff who will be dedicated to UMP, and whether customer service staff would perform other roles, such as processing Claims. Also include the number of member lives the Bidder's customer service center currently supports, and how/when additional staff may be added if the Bidder is selected as the ASB.

B. Describe the Bidder's current customer service staffing ratio (staff to customers/members) and its annual customer service staff turnover rate.

C. Describe the Bidder's ability to participate in-person in annual Open Enrollment benefit fairs, covering topics such as benefits and cost-sharing, network providers, Claim procedures, member services, and informational tools and resources.

D. Describe the Bidder's use of innovations, including IVR and/or other technology strategies that address specific customer- or client-related issues (such as eligibility and/or benefits questions). Describe how the Bidder has improved customer service in the last two (2) years.

E. Describe how the Bidder customer service staff deals with any current clients who have customized medical policies and benefit provisions that are different from the Bidder's Book-of-Business, while maintaining the correct policies and benefits to respond to each client.

F. Describe how the escalation team currently works within the Bidder's Book-of –Business. If the Bidder does not currently have one, describe how such a team would be established. Include staffing ratios to customer population and how many other clients the customer service escalation team does or would service.

G. Describe how the Bidder prioritizes client IT projects.

H. Describe the Bidder's available language translation services.

I. Describe accommodations for clients who are blind, or hearing and/or speech impaired, in accordance with the ADA.

J. Explain how the Bidder would provide seamless customer service coordination with PEBB benefits services, the UMP PBM, and other HCA vendors.

K. Describe the Bidder's setup for serving customers located in other countries for extended periods of time. This must include offering assistance and information to help them provide evidence of insurance, Dependent verification, and/or other required benefits documentation. Include information about how members can initiate Appeals via telephone, and the process thereafter.

L. Outline the Bidder's member feedback processing services, including processing of Complaints.

M. Note which processes, tools and systems the Bidder uses for monitoring call quality.

N. Describe the Bidder's Customer Service training program, Quality Control monitoring, and auditing processes. Describe the customer service representative account onboarding process, particularly concerning proposed UMP Plan training. Include additional proposed annual customer service training on Open Enrollment.

O. Explain the process by which the Bidder would provide the PEB Division with regular feedback from Members.

P. Explain performance measures that staff, supervisors, managers, and directors are expected to adhere to and how they have been met them over the last two (2) years.

Q. Describe any mobile application(s), including secure instant messaging and chat functions, the Bidder offers that members can use.

Required Accompanying Documents

A. Provide customer service response time and call center-member satisfaction data.

B. Include a customer service organizational chart.

C. Include CAHPS member experience scores for the last two (2) years.

D. Provide an example of the documentation collected or generated during a customer service call.

E. Provide an outline of the Bidder's new customer service employee training program or plan.

F. Include policies for ongoing monitoring of customer service quality and timeliness.

G. Provide written policies and/or processes for handling Complaints.

H. Provide the Bidder's plan to continuously improve customer service.

Evaluation and Scoring Insight

Preference will be given to Bidders who:

A. Maintain flexible systems that can accommodate the HCA's specific needs, particularly the ability to work with other vendors and systems without disruption to Members.

B. Have a customer service center and staff that are either located within Washington State.

C. Have a proven high level of customer satisfaction on CAHPS surveys within their Washington State Book-of-Business.

Bidder Response

Not to exceed eight (8) pages, excluding Required Accompanying Documents.

Exhibit 3.12 Enrollee Communications

Overview

The HCA desires a communications team (including writers, web team and graphic designers) that works directly with the HCA communications staff. The ASB must provide effective and efficient communications to Members and potential Members to enable them to make informed decisions in selecting a Health Plan, appropriately utilize available benefits, and actively engage in managing their health. All communications will be readable and clear. The ASB will comply with the document control policies and procedures that are established by the HCA. At the beginning of each year, the ASB will provide the HCA a single point of contact regarding these services.

The ASB will be expected to perform the following:

A. Assume responsibility to write, design, print, and distribute the Certificates of Coverage for the UMP Plans annually, ensuring their compatibility with the ASB's administration of the plan and the HCA's responsibility for defining eligibility and benefits. The ASB will develop the review schedule and get the HCA's approval. The HCA has final approval of COC benefits, content, and design which must be finalized in PDF format at least one (1) Business Day before November 1 of each year.

B. Write, design, print, and distribute agreed upon Open Enrollment materials, such as benefits fairs handouts, web content, FAQs, and other collateral to promote the UMP Plans.

C. Design identification cards that display an HCA-approved logo, the UMP PBM logo, RxBin number, RxPCN, Group number, ACN logo and information and other information as requested by HCA.

D. Submit Member identification card design to the HCA for approval, in advance of printing or distribution of the cards.

E. Issue replacements for lost cards at no charge to the Member or the HCA.

F. Reissue identification cards to all Members when directed by HCA.

G. Distribute welcome packets to all Members no later than December 20 of each year, unless otherwise agreed upon by the HCA.

H. Ensure appropriate communications to be sent to Subscribers, Members, or Enrollees (1) receive advanced written approval from the HCA Portfolio Management or the HCA Communications staff per WAC 182-08-220, and (2) that such communications are in compliance with the ADA.

I. Ensure that all communications relate directly to only the UMP Plans. The ASB will not send, help, or allow any other person or entity to send, communications to Subscribers, Members, or Enrollees except those relating directly to the UMP Plans, unless authorized in writing in advance by the HCA.

J. Dual brand, between the HCA and the ASB, all communications as UMP Plans, with the UMP Plans or the HCA logo and name, unless the HCA requests single branding. No communications will be branded as being solely from the ASB except with advance approval of the HCA.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

Please address each of the following in the Proposal:

A. Describe the Bidder's ability and resources to write, design, print, and provide an internet-ready and ADA-compliant electronic documents for each UMP Plan and ACN, and distribute hard copies of the annual COC to Members, the HCA staff, and Enrollees upon request.

B. Describe the Bidder's ability to write the COCs for the UMP Plans annually, in collaboration with HCA, so that they are compatible with the Bidder's administration of the plan and HCA's responsibility for defining eligibility and benefits.

C. Describe its ability and resources to write, design, print, and distribute the following materials for each UMP Plan and ACN at Open Enrollment benefit fairs:

    1. Summaries of benefits and coverage documents that are readable and comprehensible.
    2. Benefit summary comparison documents.
    3. CDHP materials.
    4. Print copies of provider directories.
    5. Informational materials, including the "What's Changing for UMP" document.
    6. Web services promotional page.
    7. Postcard for Members to submit in order to request a hard copy of the COC.
    8. Disclosure items required by the applicable part of the Washington State Health Care Patient Bill of Rights described in RCW 41.05.017.

D. Describe its ability to distribute HCA-requested materials at Open Enrollment benefit fairs. The materials may include, but not be limited to:

    1. Other HCA vendor materials.
    2. PEBB Wellness Program materials.
    3. Promotional materials from other vendors such as the UMP PBM and ACNs networks

E. Describe its ability and resources to write, design, print, and distribute a hard copy welcome packet for rejoining Members (no later than December 20 of each year) and new Members (within thirty (30) Days of joining). These materials may include:

    1. Cover letter.
    2. Wellness promotional piece (one page).
    3. Notice of Privacy Practices (print and distribute only).
    4. Web services promotional piece.
    5. Postcard to request a hard copy of the COC.
    6. Pharmacy Benefits Manager quick tips.
    7. Other materials, including other vendor materials, as requested by the HCA.
    8. PEBB Wellness Program materials.

F. Describe its ability and resources to design, print and distribute identification cards or replacement cards at no charge to all Members. Identification cards shall display an HCA-approved logo, the UMP PBM logo, RxBin number, RxPCN, Group number, ACN logo and information (if any), and other information as requested by the HCA.

G. Describe its ability and resources to provide both written and online EOBs in one online portal for each of the UMP Plans and ACNs.

H. Describe its ability and resources to update and provide an internet-ready and ADA-complaint PDF and distribute the federal Summary of Benefits and Coverage to all Members in all UMP Plans. Show how the Bidder will include Medicare retirees, follow federal formatting standards and guidelines, and provide all documents in alternate formats and required languages.

I. Describe its ability to reissue identification cards to all Members when significant information changes are requested by the HCA.

J. Dual brand all communications with the UMP Plans and the appropriate plan or network logo and name, unless the HCA requests single branding.

K. Describe any of the Bidder's other clients or customers who have discontinued or significantly decreased the amount of printing and mailing of materials to their members. Include how this was achieved, and the associated cost savings to the client or customer.

L. Describe its current methods of communicating with members electronically, including but not limited to email, mobile applications, and other methods.

M. Describe the information shared with members upon enrollment and annually. Include examples of the unique information the Bidder shares to encourage preventive and appropriate use of care.

N. Provide two (2) examples of how the Bidder shares information with members over a calendar year to educate them about health care services and promote wellness behavior.

O. Describe the business processes, policies and procedures used by the Bidder to ensure safeguards are in place for PHI.

P. Note its intent to obtain advanced written approval from the HCA Portfolio Management or the HCA Communications staff, per WAC 182-08-220, for any and all ADA-compliant communication sent to Enrollees.

Q. Ensure that all communications sent will relate directly to UMP Plans. The Bidder may not send, help or allow any other person or entity to send any communications to Subscribers, Members, or Enrollees except those relating directly to the UMP Plans, unless authorized in writing in advance by the HCA.

R. Note its intent to provide HCA Communications with a PDF file each month with UMP Plan coverage criteria that meets the requirements of RCW 41.05.074(3).

Required Accompanying Documents

A. Provide an example of an EOB form. Identify which areas of the form are customizable, and if there are additional fees for customization.

B. Provide an example of a member identification card. Identify which areas of the card are customizable, and if there are additional fees for customization.

C. Provide examples of in-house designed COCs, welcome packets, and other informational materials.

Evaluation and Scoring Insight

Preference will be given to Bidders who agree to perform all of the functions mentioned in this Exhibit without exception, and can offer flexibility regarding customization of documents at no additional cost.

Bidder Response

Not to exceed twelve (12) pages, excluding Required Accompanying Documents.

Exhibit 3.13 Online Services

Overview

The HCA desires a web team that provides Members and UMP Plan shoppers with access to a robust, accurate, and up-to-date array of web-based tools and information.

The ASB's online services must at all times meet or exceed the following Washington State Information Technology Standards, or their replacements or successors:

A. Security

B. Accessibility Guidelines

C. Public Records Privacy Protection Policy

The HCA intends to support the current and next most recent versions of each of the four major browsers: Internet Explorer, Safari, Firefox, and Chrome.

The ASB will be expected to perform each of the following:

A. Provide ongoing maintenance of the UMP Plan websites as part of the Administrative Fee. Website maintenance will include updates to content both (i) as benefits and plans are updated and (ii) upon HCA request.

B. Provide Member access to the UMP Plan websites twenty-four (24) hours a Day, seven (7) Days a week, except for scheduled downtime.

C. Ensure that information on the website is up-to-date, accurate, and complies with the ADA and associated regulations, such as HIPAA.

D. Respond to all Member emails by the end of the next Business Day.

E. Capture and maintain all Member communications within a searchable data warehouse.

Specific Instructions

The Response should demonstrate strong technical knowledge of the contents of these policies and standards and affirm Bidder's ability to meet or exceed the standards. Additionally, the Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

A. Provide examples of member portal and online user name and password for evaluators for demonstration.

B. Demonstrate how patient communications, including Appeals and preauthorization letters, are captured within the member portal.

C. Demonstrate how the Bidder complies with ADA requirements for online services and give two (2) examples.

D. Provide and maintain an HCA-approved, up-to-date, accurate, ADA-compliant UMP Plan-specific website that is available 24 hours a Day, seven (7) Days a week (except for scheduled maintenance) that includes both non-secure and secure access and sites as described below.

E. Non-Secure Access: On a website specific for the UMP Plans that is available to the public but does not require a specific sign in, the Bidder will provide the following:

   i. Identification of UMP as an HCA self-funded PPO, identification of the UMP Plans, and a statement of the relationship of HCA and Bidder.

   ii. Searchable, accurate, up-to-date provider directories for each of the UMP Plans and networks by provider location (city, ZIP Code), type (specialty), and UMP Plan/network participation. Searches must indicate if a provider is an ACN Partner Provider or ACN Ancillary Provider within each ACN network.

   iii. Certificates of Coverage, Summaries of Benefits and Coverage, and general benefit information.

   iv. Links to Washington State or other HCA vendor websites relevant to the subject matter of the UMP Plans.

   v. Downloadable forms in PDF or Word format.

   vi. Current Professional Fee Schedule.

   vii. Tools that empower Members, such as:

      a. Provider cost transparency and comparison tools.

      b. A provider quality tool.

      c. Informed decision-making tools and education.

      d. Personal health records and tools.

e. HCA-certified Shared Decision Making tools.

f. A list of services (not as a hyperlink to an external website) requiring preauthorization and related standards, coverage criteria, or other information, to be updated monthly in accordance with RCW 41.05.074.

g. An online portal that allows Members to track their communications.

F. Secure Access (requires secure sign-on and protects Member PHI): On a site that requires secure sign-in and provides PHI, such as services a Member has received, Bidder will provide the following:

i. Sign-in security approach that achieves the OCIO security standards (see, Appendix 5) and in coordination with other vendors that provide Member online services to ensure a single sign-on across sites.

ii. Ability for Members to login from the Bidder's UMP-specific website.

iii. Personal and family Claims history that complies with HIPAA privacy requirements (e.g., some family members may need to be masked on diagnosis or age related Claims), accumulator status, deductible status, and out-of-pocket maximum status.

iv. Secure email to and from customer services with next Business Day response.

v. Ability to administer incentives via online accounts.

G. Confirm the Bidder can meet all requirements listed above, and list any requirement that cannot be met.

Required Accompanying Documents

A. Provide links to both Bidder's non-secure and secure site, and identify what level of customization is available for both.

B. Provide links to an online provider directory and show what is available for customization beyond what is described above (and indicate if there are additional fees for customization).

C. Provide links to medical policies for Bidder's Book-of-Business.

D. Provide the Bidder's Americans with Disabilities Act (ADA) policy regarding the provision of online services.

Evaluation and Scoring Insight

Preference will be given to Bidders whose web-based products meet Washington State security requirements and promote Member engagement and empowerment using transparency, price tools, patient decision aids, etc.

Bidder Response

Not to exceed eight (8) pages, excluding Required Accompanying Documents.

Exhibit 3.14 Conversion Offering

Overview

For Members terminating PEBB coverage that are not entitled to Medicare or other group coverage, the HCA requires the offering of a standard Conversion policy that provides benefits for hospital or

medical care (Conversion Plan) if the Subscriber resides in a state that mandates a Conversion Plan offering.

If the terminating Member does not reside in a state with a mandated Conversion Plan offering, an individual health policy must be offered without any waiting period or proof of insurability.

The Bidder should include in Appendix 6, Attachment 27, any one-time conversion fees or costs to transition terminating Members. All other costs and premiums to continue individual coverage will be billed to the Member. The HCA has no further responsibility for these individuals. In addition to the Conversion Plan offering, the ASB may also offer the Washington State Health Benefit Exchange (HBE) as a possible alternative to Members.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

Provide a brief narrative which addresses:

A. The one-time fee for each member moving to a Conversion Plan, if any.

B. The Bidder's existing standard Conversion or individual Plan which would be offered to Washington residents.

C. Existing standard Conversion Plans or other individual policies which would be available to subscribers residing in other states, where required.

Required Accompanying Documents

A. Summary of Benefits and Coverage (SBC) that is similar to current UMP offerings, with indication of network difference between Conversion plans and UMP Plans.

B. Sample Conversion Plan and member communications.

Evaluation and Scoring Insight

Preference will be given to Bidders who address all Key Elements and offers the lowest administrative fee for transition to a Conversion Plan.

Bidder Response

Not to exceed two (2) pages, excluding Required Accompanying Documents.

Exhibit 3.15 Implementation Plan

Overview

The HCA desires a timely and accurate transition from the incumbent TPA to the ASB. A successful transition requires a comprehensive and detailed implementation plan that addresses each contract area and all related issues to ensure the ASB is fully operational prior to January 1, 2020. In

addition, the HCA desires an ASB who has experience effectively managing a change of this magnitude. Specifically, the HCA is seeking an ASB who will work with the UMP network providers; other providers, including the ASB's network; and the Members to ensure a positive outcome.

As part of implementation, the HCA will conduct a readiness assessment of the ASB's operations, the timeframe to be agreed upon between the HCA and the ASB.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

The HCA desires a comprehensive implementation plan for the time period from January 1, 2018 through December 31, 2019. Below is a description of the work that must be included in the Bidder's implementation plan as well as expected milestone deadlines for completion of the different phases. Please provide a detailed implementation plan that addresses all key operational areas (see, Appendix 3).

A. Describe the structure of Bidder's implementation team:
    1. Roles, responsibilities, and experience level of team members.
    2. Staffing plan for implementation team and key account team members listed in Exhibit 3.8.1. All must be active on the account during the RFP evaluation phase, including oral presentations.

B. Provide a detailed project management implementation plan, including assigned staff and other resources, project management support, work breakdown structures, contingencies, strategies, and tactics.

C. Provide an implementation plan that addresses the following key areas and meets the key milestone due dates listed below.
    1. On January 1, 2018, start OCIO Design Review process for the Bidder's technical implementation (For more information, see Appendix 5, Attachment 7).
    2. By April 1, 2019, ensure that the following will be fully tested, accepted, and operational:
        i. Eligibility systems, including the ability to accurately accept and load the HCA's eligibility file.
        ii. All required data transfers and/or integrations with other HCA vendors including but not limited to the UMP PBM.
        iii. Transition of care processes for Members receiving treatment for life-threatening or certain other conditions, such as pregnancy.
        iv. A formal written fraud and abuse plan for all UMP Plans that outlines related procedures, activities, reporting and staffing.

v. Complete a successful recruitment of key professional providers who will be identified as needed providers based on the match between the current provider network and the Bidder's provider network as indicated by Bidder's response to Exhibit 4.4 regarding disruption analysis.

3. By June 1, 2019, build and successfully transfer a test data file to the HCA's data warehouse vendor.
4. By July 1, 2019, ensure the Claims adjudication (benefits and plan provisions) system is fully operational.
5. By July 15, 2019 finalize:
    i. Programming of PEBB benefits and Plan provisions.
    ii. All UMP Plus ACNs are operational and technical Key Elements from Exhibit 3.6 are operational.
    iii. All Key Elements necessary to implement SmartHealth are operational.
    iv. Completed HCA clinical audit. Clinical Management programs are essential to ensure that the HCA is receiving the expected value and outcomes from the ASB. The Clinical Management audit may be completed by an HCA appointed third party.
6. By August 1, 2019, submit:
    i. Identification of key knowledgeable staff to support and attend benefit fairs.
    ii. Detailed project disaster plans for customer service and Claims adjudication.
    iii. A change management plan that addresses the impact of network changes on both the provider and Member community.
    iv. A completed Claims Payment Audit that adheres to the following:
        a. A professional audit of sample Claims after the ASB completes its system programming for 2020 benefits and Claim processing, and before live Claim processing commences January 1, 2020.
        b. The ASB will perform a series of sample Claim adjudications of various types of Claims (hospital, professional, ancillary, Medicare and non-Medicare COB, etc.) so auditors may confirm the ASB's Claim system is ready to accurately process UMP Plan Claims, all necessary plan features are correctly programmed, and accumulators are working.
        c. Cooperation with auditors and expedition of the audit as needed. This audit will be performed by independent, professional auditors contracted at the expense of the ASB and completed (including corrective actions) by this date.
        d. Additional processes, such as Appeals and Complaints, may be added to this implementation audit at the HCA's sole discretion.
7. By September 1, 2019, finalize:
    i. A fully operational customer service center and system that meets the required customer service standards available for current Members, or for

Enrollees that have questions regarding the UMP Plans, or who may be considering joining the UMP Plans.

ii. Programming of PEBB benefits and UMP Plan provisions for final plan year changes.

iii. Open Enrollment items including communication materials.

8. By September 30, 2019, ensure that:

i. No more than 0.5% of the eligibility files fail to reconcile.

ii. Customized Member websites for UMP Plans are fully developed, tested, and launched.

iii. All Claims and provider networks are included in one resource for Members to receive EOBs and claims information (electronically and paper based) and search for providers.

iv. Customized Member websites for UMP Plans.

9. By December 1, 2019:

i. Load hearing aid and vision hardware accumulators from the prior administrative services contract.

Required Accompanying Documents

A. Provide one (1) example of the Bidder's standard implementation plan for transitioning from another TPA.

B. Provide two (2) examples of other large, complex implementations that were successful, including lessons learned from such past implementations.

C. Provide an implementation plan Specific to UMP Plans.

Evaluation and Scoring Insight

Preference will be given to Bidders who provide a comprehensive implementation plan that demonstrates an understanding of the UMP Plans and HCA complexities like data transfers between a variety of vendors and integration of ACNs. Preference will also be given to Bidders with proven experience successfully implementing other large, complex programs. Finally, preference will be given to Responses with a change management plan that addresses issues pertinent to providers and Members.

Bidder Response

Not to exceed ten (10) pages, excluding Required Accompanying Documents.

Exhibit 3.16 Administrative Performance Guarantees

Overview

It is critical to the success of the Health Plans that ASB performs services in a timely and reliable manner. Therefore, there will be a "fee at risk" amount for credit toward future Administrative Fees in the event of a failure to perform to certain standards. Annual (ongoing) Performance Credits will be worth 40% of the Administrative Fees. An additional 10% of the Administrative Fees payable during 2020 will be at risk for implementation deliverables.

The HCA desires an ASB that is dedicated to the sustainability of PEBB benefits and the UMP Plans. The HCA believes this sustainability lies in its ability to achieve affordability through

controlling its cost trends. The HCA believes there are two key areas in which an ASB can make a positive impact: (1) Medical Management and (2) provider Claim trends.

An outcome-based Medical Management Performance Guarantee is a required part of this section and will be included in scoring. In addition, the Bidder must agree to the performance standards and associated Administrative Fees at risk for the administrative services listed in Exhibits 3.1 through 3.15. In addition, HCA will reserve the right to audit the performance of the Bidder on any of the measures listed below.

Specific Instructions

Below are descriptions (Exhibits 3.16.1 – 3.16.8) and definitions (after Exhibit 3.16.8) for each of the required Performance Guarantee targets. Each of the following tables lists the guarantees the HCA is seeking, grouped by the area of service. Each table lists a name for the measure group, the number of points available for each group, the title for each measure, and the HCA's target metric. Following the group name, in parentheses, is the percentage of the Administrative Fee that will be awarded to the HCA as a service credit for failure to meet all the measurements in such group, as measured on a quarterly basis.

Key Elements to Be Addressed

The required percentage of Administrative Fees at risk for each of the Performance Guarantees is listed in each Exhibits 3.16.1 – 3.16.8, for an overall 40% of Administrative Fees at risk for the Contract. If the Bidder has concerns about the measurements, please note them in the Response.

Required Accompanying Documents

None.

Evaluation and Scoring Insight

Highest preference will be given to Bidders who can meet and will agree to the measures stated in Exhibits 3.16.1 through 3.16.8, below.

Bidder Response

Not to exceed three (3) pages, excluding Required Accompanying Documents.

Exhibit 3.16.1 Implementation Services Performance Guarantees (One Time)

The HCA will be entitled to a Performance Credit in the amount of 10% of the total Administrative Fee for all UMP Plans paid in 2020 unless the ASB meets every Performance Guarantee listed in Table 3.16.1. The Performance Credit will be in addition to, and not in place of, any other right or remedy available to the HCA. Each of the items listed in Table 3.16.1 will be a key milestone in the ASB's implementation services that must be completed by the ASB and certified by the HCA by the date indicated in order for the Performance Guarantee to be met.

Table 3.16.1

Performance Guarantee	Milestone	Due Date
Benefits & Plan	The benefits and plans provisions are finalized.	September 1, 2019
Open Enrollment	All Services and Deliverables to be used during Open Enrollment have	September 1, 2019

	been completed. This includes COCs and Member communications.	
Customer Service System	Bidder's customer service system is fully operational.	September 1, 2019
Support Staff	Key staff to support and attend all benefit fairs is identified.	August 1, 2019
Fraud and Abuse Prevention Programs	Formal written plan outlining related procedures, activities, reporting and staffing is submitted for UMP.	April 1, 2019
Eligibility Files and Systems	No more than 0.5% of eligibility files fail to reconcile	September 30, 2019
Claims Audit and Systems	Pass audit of Claims systems and processing	August 1, 2019

Exhibit 3.16.2 Ongoing Core Measure Performance Guarantees

The HCA will be entitled to a Performance Credit in the amount of 5% of the quarterly Administrative Fee for that quarter's performance, unless the Bidder meets every Performance Guarantee listed in Table 3.16.2. The Performance Credit will be in addition to, and not in place of, any other right or remedy available to the HCA.

Table 3.16.2

Performance Guarantee	Performance Metric	Measurement Period
Customer Service – Answering	Average Answer Time for all calls into the ASB's UMP Plan customer service line is 30 seconds or less.	Quarterly
Customer Service – Abandoned Calls	Abandoned Call Rate for all calls into the ASB's UMP Plan customer service line will be no more than 3%.	Quarterly
Claims Processing	The ASB will process 97% of Clean Claims within 15 Business Days of receipt, and 99.5% of all Claims within 30 Days.	Quarterly
Financial Claims Payment Accuracy	99% of Claims dollars are paid accurately in accordance with the provisions of the medical benefit coverage administered by the Claim Administrator, calculated as the total paid dollars minus the absolute value of over and under payments, divided by total paid Claims dollars.	Quarterly
Procedural Coding Accuracy	99% of Claims processed with no procedural (non-payment) errors.	Quarterly

Claims Adjudication Accuracy	ASB-adjudicated Claims has an Adjudication Accuracy of 98% or greater.	Quarterly
HSA Trustee Customer Service	The ASB will require the HSA Trustee to do the following: 1. Send 95% of debit cards/welcome kits within five (5) Business Days of account activation, and 100% sent within seven (7) Business Days. 2. Send 95% of replacement cards within five (5) Business Days of request, and 100% sent within seven (7) Business Days. 3. Provide customizable welcome packet materials to be reviewed and approved by the HCA. 4. Provide Twenty-four (24) hours per Day, seven (7) Days per week, 365 Days per year, live customer support. 5. Resolve 98% of calls within two (2) Business Days. 6. Answer 80% of calls within thirty (30) seconds or less. 7. Have an average call abandonment rate of less than 5%. 8. Initiate a reimbursement process for paper/electronic submissions in three (3) Business Days or less. The ASB will provide quarterly reporting on all metrics above, to be completed within 45 Days of each quarter end.	

Exhibit 3.16.3 Appeals & Complaints Performance Guarantees

The HCA will be entitled to a Performance Credit in the amount of 3% of the total quarterly Administrative Fee, for each quarter in the plan year, unless the ASB meets every Performance Guarantee listed in Table 3.16.3. The Performance Credit will be in addition to, and not in place of, any other right or remedy available to the HCA.

Table 3.16.3

Performance Guarantee	Description	Measurement Period

Appeals & Complaints Processing	If no extension of time granted or permitted, the ASB will complete 98% of (i) Non-Expedited Appeals within 30 Days, includes, first and second level Appeals and IROs, (ii) expedited Appeals within 72 hours, and (iii) Independent Review Requests within 3 Days. For all Appeals, time is calculated from the date the ASB received notice of Appeal and the date final resolution notice is received by the Member. For Independent Review Requests, time is calculated from the date the request is received by the ASB to the date it is sent to the IRO.	Quarterly

Exhibit 3.16.4 Reporting Performance Guarantees

The HCA will be entitled to a Performance Credit in the amount of 3% of the total quarterly Administrative Fee at the end of each quarter of a plan year unless the ASB meets every Performance Guarantee listed in Table 3.16.4. The Performance Credit will be in addition to, and not in place of, any other right or remedy available to the HCA.

Table 3.16.4

Performance Guarantee	**Description**	Measurement Period
PEBB Plan Data	PEBB Plan data is submitted to the Washington Health Alliance and the All-Payer Claims Database.	Quarterly
HIPAA Report	HIPAA 834 report is provided to certain contractors identified by the HCA.	Quarterly
Eligibility Audit	Eligibility audit is provided that matches on all HCA-specified fields and is reconciled, both internally and externally, with other HCA vendors who receive the ASB's eligibility data.	Quarterly
Fraud/Abuse and Improper Payment Data	Reports of program and payment integrity performance: allegation management, investigations, referrals, Overpayments, fraud, erroneous payments, and recoveries. Annually update a formal written plan outlining related procedures, activities, reporting and staffing is submitted.	Quarterly

All Reports in Table 3.10.1	All reports are delivered on time and complete	As set forth in Table 3.10.1

Exhibit 3.16.5 Overall Trend Performance Guarantees

The HCA will be entitled to a Performance Credit in the amount of 15% of the total annual Administrative Fee each plan year unless the ASB meets all Performance Guarantees listed in Table 3.16.5. The Performance Credit will be in addition to, and not in place of, any other right or remedy available to the HCA. Please note that Bidders will be required to propose a Unit Cost Guarantee and Utilization Trend Rate in response to Exhibit 5.3.

Table 3.16.5

Performance Guarantee	Performance Metric	Measurement Technique	Measurement Period
Medicare Lite Unit Cost Trend Rate	The base unit cost increase from the prior to performance year as calculated by a third-party actuary.	Medicare Lite	Annually
Unit Cost Guarantee Margin	Meets its proposed annual rate of guarantee margin for unit cost increases above the Medicare Lite Unit Cost Trend Rate for contribution to the overall rate of trend.	This component is not measured separately.	Annually
Utilization Trend Rate	The proposed annual rate of Utilization Trend for contribution to the overall rate of trend.	This component is not measured separately.	Annually

Exhibit 3.16.6 Account Management Satisfaction Performance Guarantees

The HCA will be entitled to a Performance Credit in the amount of 3% of the total annual Administrative Fee for each plan year unless the ASB meets every Performance Guarantee listed in Table 3.16.6. The Performance Credit will be in addition to, and not in place of, any other right or remedy available to the HCA.

Table 3.16.6

Performance Guarantee	Description	Measurement Period
Account Management Satisfaction	Responds within 24 hours for acknowledgement of receipt and	Annually

	providing resolution within three (3) Business Days. Responds within 4 hours when called for urgent issues. Responding to work orders within the contracted timelines and detailed invoices. Inform HCA of state and federal law changes that affect the Book-of-Business and what action will be taken to comply. The HCA will make the final determination as to whether the change will affect the UMP. Responds and implements RFR projects and tasks within specified timelines. Partners with the HCA on Value Based Payments, networks and benefit designs, and implementing as HCA requires. Meets all due dates within the timeline to enroll disabled Dependent for all applicants each calendar year. Meets with the HSA Trustee each year to: 1. Accepts enrollment files via FTP and/or online submission process, sets up new Member accounts within two (2) Business Days of receipt. 2. Accepts employer contribution from HCA via secure protocols. Deposits will be available to Members within one (1) Business Day. 3. Accept Member discretionary contributions via payroll deduction in the form of data files from employing agencies using accepted secure protocols. Member contributions must be accessible within one (1) Business Day. 4. Accept Member contributions via Member's online accounts or paper check. Funds must be available to Member within one (1) business Day of transaction.	

	5. Notifies Member if annual contributions are anticipated to exceed IRS maximum contribution amounts, based on combination of employer contribution, SmartHealth Financial wellness incentive, and Members voluntary contributions.	

Exhibit 3.16.7 Value-Based Performance Guarantee

The HCA will be entitled to a Performance Credit in the amount of 4% of the total annual Administrative Fee for each plan year unless the ASB meets all Performance Guarantees listed in Table 3.16.7. The Bidder will be required to attest to their status or performance on each strategy and submit evidence to validate their performance annually using the Paying for Value Survey (Appendix 6, Attachment 24). The Performance Credit will be in addition to, and not in place of, any other right or remedy available to the HCA. The HCA will have the right to audit the self-reported survey responses from the ASB no more than once per year. HCA may use a third-party assessment organization to review and validate the ASB's results. The ASB must pay for the audit performed by the third-party assessment organization, if requested by the HCA.

Value Based Payment Strategies Tied to PGs	2020	2021	2022	2023
% of total annual payments to providers in CMS LAN APM Categories 2c-4b in Bidder's Washington State Book-of-Business, as self-reported by Bidder. Metrics tied to payment must be from the Common Measure Set.	70%	75%	80%	85%

Exhibit 3.16.8 Clinical and Patient Experience Performance Guarantee

Overview

The HCA desires an ASB that will provide a plan to measure and improve both clinical quality of care (including process and outcomes measures) and Member experience using validated measurement tools and methods. Outcomes measures may be based on clinical information as well as from Patient Reported Outcomes. These measures will be produced from several different data sources (e.g., Claims, electronic health records, surveys, etc.) and will be subject to independent audit.

The ASB will be required to produce clinical performance measures including a subset of published measures from the Common Measure Set. Member experience shall be evaluated using the Consumer Assessment of Health Plans (CAHPS), Clinician and Group (CG) CAHPS survey, or another survey tool specified by the HCA.

Required clinical performance measures are displayed in Table 3.16.8-2 and contain the current clinical performance measures for the combined UMP Classic, Non-Medicare and UMP CDHP Member population of which fifteen (15) measures have been identified as Performance Guarantees. Exhibit 3.16.7 contains clinical performance measures for the HCA-developed ACNs for UMP Plus. All of the measures within Exhibit 3.16.7 are also currently tied to the reimbursement methodology of the ACN.

The ASB will not be responsible for calculating or reporting clinical or Member experience data for the HCA-developed ACNs. If an ACO is incorporated, then the ASB must incorporate the measures from Exhibit 3.16.7 into this Performance Guarantee.

All clinical performance measures for evaluating the quality of care for the various UMP Plans are subject to change at the discretion of the HCA Chief Medical Officer. Changes over the life of the Contract could include, but are not limited to, the clinical measures selected for evaluation, change in clinical measures, measure specifications, measure methods, versions, surveys, and survey instruments, including measures selected for Performance Guarantees.

Specific Instructions

A total of 7% of the total Administrative Fee each year shall be designated at risk based on 5% at risk for performance on clinical measures, and 2% at risk on Member experience measures. In the evaluation of performance, each measure will be equally weighted within the overall context of performance for the combined results of UMP Classic Non-Medicare and UMP CDHP.

Once each measure is reported, the HCA will review the Bidder's overall Clinical Performance, comparing Bidder's performance on each measure to a Quality Compass benchmark identified in Table 3.16.8-2, below. An aggregate for each performance year will be calculated for all selected measures.

Each measure will receive one point for performance above the median (50th percentile), and one additional point for each percentile of performance above the 51st percentile. Two additional points will be awarded for each percentile of performance at the 70th percentile and above, and two more additional points will be awarded for each percentile of performance at the 80th percentile and above. No additional points are awarded for performance above the 89th percentile and the score is capped at 100 for the measure. The HCA will use linear interpolation for points between the benchmark source's reported results to determine the score.

The following table details performance scores at the various percentiles:

Table 3.16.8-1

Measure Score for Percentile Performance							
Percentile	*Score*	Percentile	*Score*	Percentile	*Score*	Percentile	*Score*
50	*1*	60	*11*	70	*23*	80	*55*
51	*2*	61	*12*	71	*26*	81	*60*
52	*3*	62	*13*	72	*29*	82	*65*
53	*4*	63	*14*	73	*32*	83	*70*
54	*5*	64	*15*	74	*35*	84	*75*
55	*6*	65	*16*	75	*38*	85	*80*
56	*7*	66	*17*	76	*41*	86	*85*

57	*8*	67	*18*	77	*44*	87	*90*
58	*9*	68	*19*	78	*47*	88	*95*
59	*10*	69	*20*	79	*50*	89	*100*

The total score across all measures will be calculated for each performance year. Tables 3.16.8-2 and 3.16.8-3, below, describe the subset of clinical and Member experience performance measure targets that the HCA will use.

Table 3.16.8-2

Performance Measure	Benchmark Source	Benchmark Target
Clinical Performance Measures (for UMP Classic, Non-Medicare/UMP CDHP population)		
1. Adult Body Mass Index Assessment	Quality Compass (PPO)	90th percentile
2. Antidepressant Medication Management – Effective Acute Phase Treatment*	Quality Compass (PPO)	90th percentile
3. Antidepressant Medication Management – Effective Continuation Phase Treatment*	Quality Compass (PPO)	90th percentile
4. Breast Cancer Screening*	Quality Compass (PPO)	90th percentile
5. Cervical Cancer Screening*	Quality Compass (PPO)	90th percentile
6. Childhood Immunization Status (Combo 10)	Quality Compass (PPO)	90th percentile
7. Chlamydia Screening in Women	Quality Compass (PPO)	90th percentile
8. Comprehensive Diabetes Care: Blood Pressure Control	Quality Compass (PPO)	90th percentile
9. Comprehensive Diabetes Care: Eye Exam	Quality Compass (PPO)	90th percentile
10. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Quality Compass (PPO)	90th percentile
11. Controlling High Blood Pressure	Quality Compass (PPO)	90th percentile
12. Medication Management for People with Asthma (Asthma Medication Ratio)	Quality Compass (PPO)	90th percentile
13. Statin Therapy for Patients with Cardiovascular Disease (Received Statin Therapy)	Quality Compass (PPO)	90th percentile
14. CAD Statin Adherence Measure	Washington Health Alliance	90th percentile
15. Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	Quality Compass (PPO)	90th percentile

Table 3.16.8-3

Performance Measure	Benchmark Source	Benchmark Target
Member Experience – CAHPS Adult Health Plan Survey Composites		

(for UMP Classic, Non-Medicare/UMP CDHP population)		
Health Plan Information and Customer Service	National CAHPS Benchmarking Database NCBD	90th percentile, Top Box Scores

*These 4 measures will be implemented over a 4 year period to account for look-back periods defined in the measure specifications. See current *HEDIS® Technical Specifications for Health Plans* publications for further information.

Clinical and Member experience performance measures will be calculated annually and reported in the following June of each year. The Performance Guarantee is applied to the Administrative Fees for December in the year following the reporting year. For each performance year, the number of total points scored will be totaled for the selected clinical measures. The Performance Credit will be proportional to the threshold quality score for the year listed below in Table 3.16.8-4. The threshold quality score for each year will be based on achieving the benchmark target in a certain number of the clinical measures with those additional measures selected still contributing to the overall score. The table below summarizes the clinical measure threshold score for each year:

Table 3.16.8-4

Year	Threshold	Year	Threshold	Year	Threshold
2020	200	2024	400	2027	500
2021	200	2025	400	2028	500
2022	200	2026	400	2029	TBD
2023	200				

For example, in reporting year 2021 if a total clinical measure score of 150 is achieved then the penalty for clinical measures would be 75% (150/200 of the 4% at risk for a December 2021 settlement or 3% on the annual 2020 Administrative Fees) relating to UMP Classic, Non Medicare and UMP CDHP Plans.

For the Member experience measures, as there is only one Member experience measure, the threshold is 38 for each year. For example in reporting year 2020 if the Member experience score is 19 for performance at the 68th percentile then the penalty for the Member experience measure would be 50% (19/38) of the 3% at risk for a December 2021 settlement of 1.5% on the annual 2020 Administrative Fees relating to UMP Classic, Non Medicare and UMP CDHP Plans. In combination with the clinical measure penalty the total reduction to annual 2020 Administrative Fees is 4.5% for UMP Classic, Non Medicare and UMP CDHP Plans.

The Bidder will be notified of any changes to the performance measures in advance of the measure taking effect so that the measure can be reported. There will be no Clinical and Patient Experience Performance Guarantee penalty for the first year of fees. The implementation schedule for measurement, reporting and Performance Guarantees are described in the following table.

Plan Year	Measurement and Reporting	Performance Guarantee Implementation Schedule
2020	Baseline clinical and patient experience data collection year	N/A
2021	Calculate clinical and patient experience data 2020 Reporting year clinical and patient experience data	Performance Adjustment December based on 2020 reporting year

Plan Year	Measurement and Reporting	Performance Guarantee Implementation Schedule
2022	Calculate clinical and patient experience data 2021 Reporting year clinical and patient experience data	Performance adjustment December based on 2021 reporting year
2023 through 2029	Approach as described above.	Approach as described above.

Key Elements to Be Addressed

A. Describe the actions the Bidder will take to ensure improvement in both clinical and patient experience measures during the life of the Contract.

B. Describe how Bidder will engage Members in the importance of preventive care and management of chronic conditions in order to support improved clinical performance and patient experience.

C. Describe how the Bidder will engage primary care and specialty clinics in the processes for improvement to support improved clinical performance and patient experience, and what outcomes Bidder has achieved.

D. Describe the Bidder's approach to rewarding clinics on clinical performance measures and patient experience.

E. Describe how clinical quality and patient experience metrics and performance requirements have been incorporated into the Bidder's current ACO agreements with provider clinics.

F. Describe how the Bidder has worked with Primary Care and specialty care clinics to transmit and provide data from electronic health records that is required to calculate clinical quality and patient experience measures.

G. Describe the Bidder's approach to data collection, management, and reporting, including different types of data (e.g., Claims, clinical, survey, and others), data feeds, data storage, and reporting capabilities.

Required Accompanying Documents

A. Provide two (2) sample contracts with ACOs.

B. Submit a table listing Bidder's performance on clinical performance measures in Washington or a comparable market.

C. Submit a table listing Bidder's performance on patient experience measures in Washington or a comparable market.

Evaluation and Scoring Insight

Preference will be given to Bidders who:

A. Communicate successful experience implementing Value Based Payment methods that financially reward performance on clinical and patient experience measures.

B. Show ongoing, successful engagement of both small and large health systems, gaining their commitment to improved quality of care and services. The Bidder will describe its approach to data collection, management, and reporting on clinical quality and patient experience.

C. Agree to the required performance standards as written in this RFP.

Bidder Response

Response shall not to exceed ten (10) pages, excluding Required Accompanying Documents.

Performance Guarantee Definitions

"**Abandoned Call**" means the caller hangs up before being connected to a live agent working for or on behalf of the ASB.

"**Abandoned Call Rate**" means the number of Abandoned Calls divided by the total number of calls. Any call that is abandoned within ten (10) seconds of being placed in queue or is resolved by automated response will not be used in calculating the Abandoned Call Rate.

"**Adjudication Accuracy**" means the total number of Claims filed less the number of Claims processed with one or more Errors, then divided by the total number of Claims filed.

"**Answer Time**" means the time between the connection of a call to the ASB's call center and the time when an ASB employee, agent, Subcontractor, or representative answers the call.

"**Appeals**" includes both Expedited Appeals and Non-Expedited Appeals.

"**Average Answer Time**" means the mean Answer Time of all calls received by the ASB during the measurement period.

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

"**Error**" means any inaccuracy in entering or processing a Claim, regardless of cause or whether the error has a financial impact.

"**Expedited Appeals**" shall have the meaning ascribed to it in the COC.

"**Independent Review Request**" shall have the meaning ascribed to it in the COC.

"**IRO**" means an Independent Review Organization certified by the Washington Office of Insurance Commissioner pursuant to RCW 43.70.235 and Chapter 246-305 WAC.

"**Non-Expedited Appeals**" shall have the meaning ascribed to it in the COC.

"**Overpayments**" means any payment, in any amount, that, for any reason, should not have been paid under the Contract.

"**Payment Accuracy**" means Total Payments minus the absolute value of the sum of Overpayments and Underpayments, divided by Total Payments.

"**Underpayments**" means any payment made by the ASB under the Contract that, for any reason, (i) should have been paid but was not, or (ii) was less than what was required under the Contract.

"**Total Payments**" means all Claims payments made by the ASB pursuant to the Contract.

Exhibit 3.17 Request for Renewal

Overview

On an annual basis, the HCA conducts a Request for Renewal (RFR) process for both fully insured and self-insured Health Plans. This process creates consistency in how the HCA communicates and validates its expectations for the coming Open Enrollment and plan year.

The annual RFR process enables the PEBB to adjust employee benefits in response to new requirements under the ACA, changes requested by HCA's Chief Medical Officer or other internal

policy drivers, benefit design strategies promulgated by the PEB Division, and legislative mandates and other changes.

In the first quarter of each year, the Procurement Manager will gather a list of approved changes for the following year's benefits and begins the process of proposing those requested changes in an RFR document. All Health Plans will then respond with detailed proposals regarding how each intends to implement the changes, and inform the HCA of possible changes to the administrative costs or timelines and resources as a result. The ASB will be required to respond each year on behalf of all of the UMP Plans with implementation and project planning for the new requests. If the annual RFR requests are mandates, or are in the course of normal operations, or are included in this RFP or the Contract, no new funding will be given by HCA for this effort.

The HCA intends to be the driver of change and the testing ground for innovation and Value Based Payments within Washington state health care. Most intended UMP Plan changes will be discussed with the ASB in advance, but the annual RFR provides formal documentation for requested UMP Plan and cost changes.

The ASB will prepare a thorough analysis and response to the RFR during each April and May and provide accurate planning evaluation and implementation planning for requested benefit changes. Though Health Plans are not re-procured each year, the RFR process may have many similarities to an annual re-procurement. The ASB will be expected to:

A. Carefully read and analyze the RFR,

B. Provide a clear and comprehensive evaluation and implementation plan for each benefit change in the time period allotted for proposals, and

C. Respond to no charge Work Order request for detailed work.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

A. Describe Bidder's experience partnering with other large employers on annual strategic initiatives.

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

C. Explain how the Bidder will absorb costs of these implementations each year within the Administrative Fees.

Required Accompanying Documents

None.

Evaluation and Scoring Insight

Preference will be given to Bidders who address the required elements in a comprehensive and cost neutral manner.

Bidder Response
Not to exceed four (4) pages, excluding Required Accompanying Documents.

EXHIBIT 4 – PROVIDER NETWORK

Exhibit 4.1 Provider Network

Overview

The HCA seeks an ASB that can communicate a track record of successful and proactive engagement with its provider network and offers a provider network that is cost effective, delivers high quality services to Members, and meets the same standards applied to regulated health carriers under WAC 284-170-200. The network must have sufficient breadth and capacity to provide access to the types and numbers of in-network providers necessary to deliver care for all covered benefits. At a minimum, the ASB must comply with HCA access and adequacy requirements. Bidder Responses should demonstrate how it cost effectively contracts with providers.

The HCA will require the ASB to:

A. Provide a network contracting and credentialing program consistent with NCQA or URAC accreditation standards that applies to all providers in all networks available to Members, including ACNs, and submit such written confirmation annually to the HCA.

B. Maintain a contracted provider network that meets or exceeds nationally accepted access standards for all applicable HCA-approved provider categories, adjusted for geographical factors. In the case where national standards are not available, the standards in Table 4.4, Washington Provider Network Coverage Access Standards, will apply for the State.

C. Notify the HCA when modifications to network discount arrangements may result in an increase of 2% or more in monthly Claims costs.

D. Notify the HCA when any provider group or facility is going to become out-of-network.

E. Perform the network analysis set forth in Table 4.4.1 of this RFP on an annual basis, and provide results to the HCA by January 31 of each year.

F. Respond to network adequacy issues, taking all action to ensure Members have access to a preferred provider for all covered services. This includes recruiting new providers into the professional provider network and following HCA-led recruitment priorities.

G. Provide a network that meets OIC network adequacy standards and HCA standards for every county in Washington State for UMP Classic and UMP CDHP.

Specific Instructions

Develop a separate technical Proposal for each of Exhibit 4.1 through Exhibit 4.4. Demonstrate the Bidder's agreement to adhere to each of the required elements as stated, and describe the proposed scope and nature of service that will be provided under the PSPM fee proposed in Exhibit 5.2.

Each Response must stand on its own merits in terms of addressing the scope of the topic and will be scored independent of other Responses. Do not refer to other information provided in other Proposal sections as supporting information. The evaluation team will be under no obligation to consider information that is not contained in the specific Response being evaluated.

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of

any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

A. Communicate the Bidder's capabilities and capacity relative to the size and complexity of the UMP Plans and their status as a public sector self-insured PPO.

B. Describe how the Bidder's provider network discounts are made affordable for all network elements including inpatient, outpatient, professional, ancillary and others.

C. Describe the Bidder's current actions for controlling facility fees through network contracts, and describe how it will maintain current provider network discounts during the term of the Contract.

D. Demonstrate that the Bidder's network contains an adequate number of Behavioral Health providers to diagnose and treat Members for all covered services for conditions used in the current version of the ICD-10-CM and DSM 5 Diagnostic Guides. Bidder must promote the use of evidence-based, research-based or promising Behavioral Health practices recognized by the Washington State Institute for Public Policy (See http://wsipp.wa.gov/Reports) or the Substance Abuse and Mental Health Services Administration (SAMSHA).

E. Demonstrate that the Bidder's network contains or will contain an adequate number of Applied Behavioral Analysis (ABA) providers within their local and national network.

F. Demonstrate that the Bidder's network contains or will contain an adequate number of providers for the UMP Plans transgender and gender dysphoria benefit within their local and national network.

G. Describe how the Bidder will expand the network as needed if eligible membership increases significantly in future years (more than 10%) due to legislative mandate.

H. Confirm the Bidder will contract with providers who are currently with ACNs under the current TPA, as well as new providers who enter into ACNs during the Contract.

I. Describe how the Bidder will adhere to the new policies and contract with new provider types as required for the UMP when the HCA creates new clinical policies.

J. Describe the Bidder's policy that places provider reimbursement at risk upon the occurrence of a Never Event. This policy must also be reflected in the terms and conditions of the ASB's contracts with its network providers.

Required Accompanying Documents

None.

Evaluation and Scoring Insight

Each Response will be evaluated on how well the Bidder is able to meet the HCA's stated goals and outcomes and ensure access to quality providers in sufficient numbers to meet the demands of a health plan of this size.

Bidder Response

Not to exceed seven (7) pages, excluding Required Accompanying Documents.

Exhibit 4.2 Washington Network

Overview

The ASB must provide a Washington State network as a contracted service beginning January 1, 2020.

The HCA desires broad access to a full scope of providers in Washington State to provide the benefits and services noted in the Certificate of Coverage. It desires a high quality provider network of sufficient size and distribution to serve Members in Washington State. The ASB must provide Members access to this network (including hospitals, ambulatory surgery centers, professional provider, ancillary providers, etc.) on January 1, 2020. Payment for all services in Washington State will be based on the terms of the ASB's contracts with providers. Provider network adequacy is required in all 39 counties in Washington for all provider types.

The HCA requires the ASB to set up custom networks for the ACN products in specific Washington counties and provide an ancillary wrap around network based on NPI, provider type, county, TIN, and other specific requirements. The ASB must have access to all of its provider contracts within Washington State for use with custom network builds, network benefit administration, data reporting, provider search tools, provider and Member communications, and other uses.

Specific Instructions

The Bidder must provide a detailed description of the Washington State provider network that is currently in place, and submit documentation showing that the Washington State network is in place as of the date of Proposal.

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

The Bidder must:

A. Describe how it meets all OIC standards for Washington State related to provider network adequacy for UMP Classic and CDHP Plans as set forth in Table 4.4.

B. Confirm that it will provide documentation that the Washington State provider network is in place annually or as requested by the HCA, including detailed information about whether there are recognized provider types consistent with RCW 48.43.045(1) and at least 10,000 physicians (M.D. or D.O.) in the network.

C. Provide an explanation regarding any Washington hospitals or large provider groups not in the network.

D. Explain how provider network access and adequacy are measured, and ensure compliance with WAC 284-170-200. Describe the standards used to monitor the provider network, the data used to inform its development, and actions taken to address deficiencies in network access or adequacy (provide examples). Explain the process for expanding the network when Member growth or other market conditions make it necessary to do so.

E. Describe actions taken to ensure accurate network information is provided for Members. Include information about online provider information, paper directories, and information provided verbally to Members.

F. Describe its ability to customize provider contracts, and note if it owns all Washington State contracts. If it does not, identify the Subcontractors.

G. Describe how it will create and implement a customized network for the UMP Plus ACNs.

H. Explain how the Bidder's network meets the HCA's requirements for inclusion of specific provider types (e.g., Behavioral Health, gender dysphoria, etc.).

I. Describe any transition of care standards, guidelines and processes that are in place and how they will be used for Members.

J. Describe how it will contract with new provider types as required for the UMP Plans.

Required Accompanying Documents

Provide the most recent annual Access Plan Report filed with the OIC as required by WAC 284-170-280. Include any corrective action plan(s) and the current status of remediation activities related to those plan(s).

Evaluation and Scoring Insight

Preference will be given to Bidders who meet or exceed all of the HCA's standards for network access, adequacy and costs.

Bidder Response

Not to exceed four (4) pages, excluding Required Accompanying Documents.

Exhibit 4.3 Out-of-State Provider Network

Overview

The ASB must provide an out-of-state provider network as a contracted service from January 1, 2020 through the term of the Contract. The out-of-state provider network must provide coverage to meet comparable standards to the Washington State provider network and provide all covered UMP Plan services.

The HCA desires Members living outside of Washington State to have access to a comprehensive national PPO network with providers in all states, the District of Columbia, and U.S. territories. The HCA requires a seamless process for Members accessing providers outside of Washington. Payment for all out-of-state covered services will be based on the terms of the Bidder's contracts with the providers. Payment of worldwide Claims is also required at in-network rates.

Specific Instructions

A. Provide a detailed description of the out-of-state provider network that is currently in place. The description must include detail demonstrating that the out-of-state network will provide coverage to meet comparable standards to the Washington provider network.

B. Include accompanying documentation that the out-of-state provider network covering the other 49 States, District of Columbia and the U.S. territories is in place as of the date of Proposal.

C. Describe how current Claims are processed for worldwide Claims and how the Claims would be processed as in-network for Member Claims and how translation services would be provided.

D. The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues

and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

A. Confirm whether Bidder is currently registered through OneHealthPort with ProviderSource/Medversant for credentialing in Washington State.

B. Describe whether the national network is owned and managed by the Bidder, subcontracted, or provided under another arrangement. If subcontracted or provided under another arrangement, identify

   1. The responsible party and the relationship between the Bidder and the responsible party,
   2. How long the contract has been in place,
   3. Any corrective action plans related to network adequacy in a specific geographic area, and
   4. Any other network management issues in the past ten (10) years.

C. Describe how network adequacy is determined in the out-of-state network, what recruitment efforts are underway, and how quality is currently reported. Describe how the out-of-state network will provide coverage to meet comparable adequacy standards to the Washington State provider network.

D. Describe how out-of-network waivers are granted and processed.

E. Describe how worldwide Claims are processed and include how and by whom Claims and/or documents are translated.

Required Accompanying Documents

A. Provide documentation that the Bidder's out-of-state provider network covering the other 49 states, the District of Columbia and U.S. territories is in place as of the date of Proposal.

B. Provide a list with the total count of physicians (M.D. or D.O.), ancillary provider types, and the number of hospitals under contract in each state, the District of Columbia and U.S. territories.

Evaluation and Scoring Insight

Preference will be given to Bidders with the broadest seamless national PPO network that offers Members robust access outside of Washington State.

Bidder Response

Not to exceed five (5) pages, excluding Required Accompanying Documents.

Exhibit 4.4 Washington Provider Network Analysis

Overview

The network analyses described below provide information regarding general provider disruption, disruption in highly utilized providers, network adequacy, and geographical access to providers and access to providers of various types. The HCA is interested in understanding the Bidder's internal standards for provider network access and adequacy and how its entire Book-of-Business conforms to the standards. The Bidder must demonstrate how it meets the HCA's network standards, which will be confirmed by the Bidder submitting reports and files to Milliman.

Specific Instructions

The Bidder must download the files and instructions listed under "Key Elements to Be Addressed" from the Milliman FTP site. After reviewing those files and instructions, Bidder must upload the matched file results to the Milliman FTP site by the deadline listed in the Procurement Schedule. The submission will be time stamped upon file upload and that time will be used to determine the timeliness of the Bidder's Response. If the Bidder does not currently meet any of the Key Elements, please describe in the response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Element questions must be included together in all responses and documentation.

In addition to data submitted to the Milliman FTP website, submit a supporting narrative that demonstrates how network adequacy is ensured through internal standards and monitoring processes in order to quickly resolve identified deficiencies. This description should not be uploaded to the Milliman FTP website, but instead submitted to the Procurement Coordinator as part of Bidder's Proposal.

In order to complete the data submissions, the Bidder must first sign and submit the Letter of Intent and Data Share Agreement (DSA) (see, Appendix 7, Form A) to the Procurement Officer, contracts@hca.wa.gov. The Bidder will then be provided with instructions for connecting to the Milliman FTP website. Files can be downloaded from the Milliman FTP website along with additional instructions for completing the Response.

Actuarial Certification

In order to ensure data quality, the HCA requires that the Bidder provide an actuarial certification along with all uploaded files. An actuary review must be conducted and include a certification that the data and information is: (a) consistent with the RFP specifications, (b) complete and accurate to the best of his/her professional judgment, and (c) consistent with the appropriate actuarial standards of practice.

Contact

The Milliman point of contact for the provider network analysis is:

Ben Diederich, FSA, MAAA
Consulting Actuary
1301 Fifth Avenue
Seattle WA 98101
Email: **ben.diederich@milliman.com**
Phone: 206-504-5561

Mr. Diederich may only be contacted regarding the Claim pricing submission (see Exhibit 5.1) or network adequacy provider files by a Bidder who has submitted a Letter of Intent and a signed

DSA. Any questions addressed to Mr. Diederich must also be copied to the HCA Procurement Coordinator. All data transfers will be securely exchanged through the FTP site.

Key Elements to Be Addressed

A. Network Disruption Analyses

Match the Bidder's current provider network with the csv file named "Provider File." Each provider will be matched by using the combination of TIN and ZIP Code. After indicating which providers are currently contracted in the Bidder's existing network to be used for the UMP Plans, populate the "Network Disruption Summary" worksheet in Appendix 6, Attachment 29, "WA Provider Network Analysis.xlsx." The workbook summarizes network disruption by county by counting the number of rows in the "Provider File" indicated as in-network providers.

B. High Utilization Analyses

Indicate which of the providers listed on the "High Utilization" worksheet in the "WA Provider Network Analysis.xlsx" Excel workbook (Appendix 6, Attachment 29) are in the Bidder's current provider network. Each provider will be matched using the combination of TIN and ZIP Code.

C. Geographical Analyses

Populate the "Network Adequacy Summary" worksheet in the Excel workbook attached as Appendix 6, Attachment 29 with the percentage of UMP members for a given county and provider type cell that satisfy the network adequacy standards. The location of members is provided in the "Member File.csv". The worksheet uses the standards in Table 4.4.1. .

The HCA has identified minimum standards for provider network access in Table 4.4.1. The HCA stipulates the minimum percentage of Members who must have access to one provider of each provider type within both Urban and Rural mileage standards. For the purposes of this RFP, the HCA defines Urban and Rural service areas as follows:

1. Urban – a county with a density of 90 persons per square mile.
2. Rural – a county with a density of 89 or fewer persons per square mile.

At a minimum, define standards for the provider and facility types included in Table 4.4.1. Also define which specific provider types are included where indicated (e.g., Primary Care, Pediatric Subspecialties, etc.).

The data must be submitted by county or ZIP Code on an annual basis, or as requested by HCA.

Table 4.4
Washington Provider Network Coverage Access Standards

Provider Type	Urban Standard (Miles)	Rural Standard (Miles)	Percent of Members Within Standard
Primary Care			
All Primary Care	1:30	1:60	80%
Pediatrics	1:30	1:60	80%
Women's Health OB/GYN	1:30	1:60	80%

Provider Type	Urban Standard (Miles)	Rural Standard (Miles)	Percent of Members Within Standard
Pediatric Subspecialties			
All Pediatric Subspecialties	1:60	1:90	80%
Pediatric Cardiology	1:60	1:90	80%
Pediatric Neurology	1:60	1:90	80%
Pediatric Psychiatry	1:60	1:90	80%
Medical Specialties			
All Medical Specialties	1:30	1:60	80%
Allergy/Immunology	1:30	1:60	80%
Cardiology	1:30	1:60	80%
Dermatology	1:30	1:60	80%
Endocrinology	1:30	1:60	80%
Gastroenterology	1:30	1:60	80%
Hematology/Oncology	1:30	1:60	80%
Infectious Disease	1:30	1:60	80%
Nephrology	1:30	1:60	80%
Neurology	1:30	1:60	80%
Pulmonology	1:30	1:60	80%
Rheumatology	1:30	1:60	80%
Surgical Specialties			
All Surgical Specialties	1:30	1:60	80%
General Surgery	1:30	1:60	80%
Neurosurgery	1:30	1:60	80%
OB/GYN	1:30	1:60	80%
Ophthalmology	1:30	1:60	80%
Orthopedic Surgery	1:30	1:60	80%
Urology	1:30	1:60	80%
Behavioral Health			
Psychiatry	1:30	1:60	80%
Behavioral Health: Non-Physician PhD and Master's-Level Providers	1:30	1:60	80%
Behavioral Health: Non-Physician with All Other Credentials	1:30	1:60	80%

Provider Type	Urban Standard (Miles)	Rural Standard (Miles)	Percent of Members Within Standard
Applied Behavioral Analysis	1:30	1:60	80%
Inpatient and Outpatient Behavioral Health Facility/Treatment Center	1:30	1:60	80%
Inpatient and Outpatient Chemical Dependency Facility/Treatment Center	1:30	1:60	80%
Facility			
Hospital	1:30	1:60	100%
Urgent/Emergent Care	1:30	1:60	100%
Ancillary			
Home Health	1:30	1:60	80%
Durable Medical Equipment	1:30	1:60	80%
Therapies: Chiropractic	1:30	1:60	80%
Therapies: OT/PT	1:30	1:60	80%
Therapies: Acupuncture	1:30	1:60	80%
Therapies: Massage	1:30	1:60	80%
Hospice	1:30	1:60	80%

D. Generate geographic network reports using HCA standards and PEBB membership data (to be supplied by the HCA). Include clearly labeled access statistic tables at a county level for each of the provider types in Table 4.4.1, and for any additional provider types that are included in the Bidder's internal standards for network adequacy and geographical access.

E. Provide the Bidder's definition of provider types included in each of the provider categories in Table 4.4.1. Detailed definitions must include descriptions of how mid-level practitioners, e.g. Advanced Registered Nurse Practitioners (ARNPs), are categorized.

F. Analyses Results to Report

1. Provide the member-weighted total provider disruption percentage, which is calculated on the "Network Disruption Summary" worksheet in the "WA Provider Network Analysis.xlsx" Excel workbook attached as Appendix 6, Attachment 29. If the Network Disruption Analyses matches are below 80%, describe how the match rate will be improved. Include regular monitoring and action taken to retain and recruit providers to avoid disruption.
2. Provide the percentage of high utilization providers that are in the Bidder's network, which is calculated on the "High Utilization" worksheet in the "WA Provider Network Analysis.xlsx" Excel workbook attached as Appendix 6, Attachment 29.
3. Provide copies of internal network adequacy standards that are used for the Bidder's commercial Book-of-Business or other large public sector clients, including adequacy measures by provider type, as well as internal definitions and policies around provider adequacy.

4. Provide a summary of analysis results for the Bidder's Washington State Book-of-Business. Provide a separate summary for the Members when matched against network adequacy standards for Washington State. Provide the percent of the Washington State ZIP Codes and counties that met the Bidder's internal standards. Describe how the network will be regularly monitored, and describe what action will be taken to retain and recruit providers to avoid reduction in access. If the Bidder does not meet the geographical access standards in 95% of counties, explain how this standard will be met before January 1, 2020.
5. Document whether the proposed provider network contains all network provider types necessary to cover all benefits set forth in the UMP 2017 COCs (Appendix 6, Attachments 4 – 7).

G. Files To Upload To Milliman FTP

1. Upload the "WA Provider Network Analysis.xlsx" Excel workbook attached as Appendix 6, Attachment 29 to the Milliman FTP. The "Network Disruption Summary", "High Utilization", and "Network Adequacy Summary" worksheets should have the gray cells populated with the Bidder's information.
2. Upload the "Provider file". Add an indicator to each record showing whether the provider is in the Bidder's network. '1' means the provider TIN and ZIP Codes are 'IN Network' and '0' means they are 'OUT of Network'. Milliman will supply this file to the HCA.
3. Upload the files and documentation supporting how the "Network Adequacy Summary" worksheet was populated.
4. Upload the geographic network reports using the HCA's standards. Include clearly labeled access maps and statistic tables for PEBB membership.
5. Provide copies of internal network access and adequacy standards used for the Bidder's Book-of-Business or other large public-sector clients. Show that the internal standard policy was written and in place before the RFP release date.

Required Accompanying Documents

None.

Evaluation and Scoring Insight

A. Bidders must match 80% on High Utilization Analyses to receive any points in this section.
B. Preference will be given to Bidders who meet or exceed an overall match of 80% on their Network Disruption Analyses. Additional preference will be given to Bidders who have established internal network adequacy standards and meet both their own and the HCA's standards.
C. Preference will be given to Bidders who can meet or exceed all of the HCA's standards for network access and adequacy.

Bidder Response

Page limit not applicable.

EXHIBIT 5 – CONTRACT COSTS AND TREND GUARANTEE

Exhibit 5.1 Claims Repricing

Overview

Bidders must complete a data submission relating to calculation of the Bidder's provider network unit cost levels based on a historical sample of UMP Classic Non-Medicare Claims, a portion of which will be used in the evaluation and scoring of this Exhibit 5.1.

In order to complete the data submission, the Bidder must first sign and submit the Letter of Intent and Data Share Agreement (DSA) (see, Appendix 7, Form A) to the Procurement Officer at contracts@hca.wa.gov. The Bidder will then be given a personalized login and password and provided with instructions on how to connect to Milliman's secure FTP website. Files can be downloaded from the Milliman FTP website along with additional instructions for completing the Response.

Specific Instructions

Download the "Sample Claims File.csv" file and the "Pricing Summary.xlsx" Excel template from the Milliman FTP site. The claims file has comma-separated values files with headers in the first row. It represents a six (6) month sample of UMP Plans Non-Medicare incurred Claims experience with six (6) months of additional run-out. No completion factor was applied, nor does a completion factor need to be applied by the Bidder. The type of service ("Type_Of_Service") field identifies the claims with the following five values and will be used to summarize Claims:

A. Facility Inpatient
B. Facility Outpatient
C. Ambulatory Surgery Center
D. Professional (including M.D., D.O, and ARNP Claims)
E. Ancillary Providers

Adjudicate the "Sample Claims File.csv" to determine Allowed Amounts and which Claims are in-network versus out-of-network. After processing the Claims, populate the Appendix 6, Attachment 30, "Repricing of Claims Summary.xlsx" template with the summarized results. Then upload the "Repricing of Claims Summary.xlsx" template and the processed Claims file to the Milliman FTP site.

The file "Pricing Summary.xlsx" calculates the total reported unit cost for the five places of service based on the Bidder's populated values. Not all unit cost levels will be used in the evaluation and scoring of the Response. Report unit cost levels based upon the date-of-service reported on the Claim, specific to the type of provider and geographic location of the Claim. Address any possible improvements to the reported unit cost levels in future years or the level of disruption within the Claim sample and the current networks.

Milliman will use the re-adjudicated claims file to validate the values populated by each Bidder in the pricing summary and potentially perform a more detailed analysis of the files. The more detailed analysis may include understanding the likelihood of alternative provider utilization, or a comparison to current hospital discount performance. By responding to this request, the Bidder authorizes Milliman to use the data in such further analysis. **The HCA will *not* receive a copy of the detailed pricing files**. Any discrepancies discovered during validation will supersede the Bidder's populated pricing summary.

Database Fields included in the "Sample Claims File.csv":

A. Masked Member ID (“Masked_ID”)
B. Member’s 5-digit ZIP Code (“Zip”)
C. Member’s County (“County”)
D. Member’s State Abbreviation (“State”)
E. Provider Tax ID Number (“TaxID”)
F. Provider Tax ID Name (“TaxID_name”)
G. Provider TIN ZIP Code (“TaxID_ZIP”)
H. National Provider ID for Provider of Service (“NPI”)
I. NPI Name (“NPI_Name”)
J. NPI ZIP Code (“ProviderZIP”)
K. Claim Number (“ClaimID”)
L. Claim Line Number (“LineNum”)
M. Begin Service Date (“FromDate”)
N. End Service Date (“ToDate”)
O. Primary Diagnosis Code (“ICDDiag1”)
P. Primary Diagnosis Code Version (“ICDVersion”)
Q. Procedure Code (HCFA revenue for facility, CPT or HCPCS for practitioner) (“HCPCS”)
R. Procedure Code Modifier (“Modifier”)
S. Place of Service Code (“POS”)
T. DRG (for inpatient hospital Claims) (“MS_DRG”)
U. Milliman MR Units (“MR_Units_Days”)
V. Provider/Specialty Type Code (“Specialty”)
W. Type of Service Code (“Type_Of_Service”)
X. Billed Claim Amount (“Billed”)
Y. Medicare Lite Claim Amount (“MedicareLite”)

While the website address is generic, the Bidder will have access only to materials specific to its Response. A text file describing the contents of each download and upload file will be available in the Bidder’s FTP folder. Specifications for all data files transferred via the FTP will include appropriate proprietary and/or confidential labels to ensure appropriate treatment of information. The HCA and Milliman understand that the data requested is proprietary and confidential. Milliman will treat all network provider information, Claim pricing files received from the Bidder, and populated summary files as confidential.

All files must be completely posted to the Milliman FTP site by the date and time listed in the Procurement Schedule under “Repricing Files Due.” The time stamp applied by the system to all uploaded files will be used by the HCA to determine compliance.

Actuarial Certification

In order to ensure data quality, the HCA requests an actuarial certification along with all uploaded files. The actuary review must include a certification that the data and information is (a) consistent with RFP specifications, (b) complete and accurate to the best of his/her professional judgment, and (c) consistent with the appropriate actuarial standards of practice.

Contact

The Milliman point of contact for Claim pricing is:

Ben Diederich, FSA, MAAA
Consulting Actuary
1301 Fifth Avenue
Seattle, WA 98101
Email: ben.diederich@milliman.com
Phone: (206) 504-5561

Mr. Diederich may only be contacted regarding the Claim pricing submission or network adequacy (see, Exhibit 4.4) by a Bidder who has submitted a Letter of Intent and a signed NDA. Any questions addressed to Mr. Diederich must also be copied to the Procurement Coordinator. All data transfers will be securely exchanged through the FTP site.

Key Elements to Be Addressed

A. To submit pricing, populate the following fields in the Claims file, per the instructions below:
    1. In-Proposed Network Claim Indicator (as described below) (“InNetwork”)
    2. Allowed Charge 1 – after applying Network Unit Cost Levels (Method #1 as described below) (“Allowed_1”)
    3. Alternative Provider Tax ID 2 (Method #2 as described below) (“TaxID_2”)
    4. Alternative NPI for Provider of Service 2 (Method #2 as described below) (“NPI_2”)
    5. Alternative Provider Name 2 (Method #2 as described below) (“TaxID_name_2”)
    6. Alternative Provider 5-Digit ZIP Code (Method #2 as described below) (“TaxID_2”)
    7. Allowed Charge 2 (Method #2 as described below) (“Allowed_2”)
    8. Allowed Portion with FFS Contract – the percentage of allowed charge after discount that is under a Fee-for-Service (FFS) Contract. (“Allowed_FFS_Pcnt”)

B. Pricing should be based on Contract provisions at the time of service, not based on current or future Contract negotiations. If the Bidder is unable to populate discount pricing based on Contracts in place for the service period of the sample, indicate the historical time period in which the pricing is based. The application of Network Unit Cost levels should be based upon existing provider Contracts. The pricing should be done on a line-by-line basis and be consistent with actuarial standards of practice. If this basis cannot be followed, explain how the basis used compares to the estimation of line-by-line pricing.

C. First, the Bidder must determine if the servicing provider on the Claim is in the Bidder’s network. This designation will be noted by populating the “InNetwork” indicator with “Yes” for those providers considered participating as of January 31, 2017. For in-network Claims, the field “Allowed_1” should reflect the level of unit cost for the servicing provider’s Contract. All attempts should be made to populate this amount field with a value as close as possible to what the actual allowed charges would be in the adjudication of the Claim for the date-of-service noted on the Claim.

D. For Claims with out-of-network providers, populate the "InNetwork" indicator with "No". In this case, pricing should reflect two (2) methods:

   1. For Method #1, assume Members do not change providers. Price these Claims using the provider's billed charges. Populate "Allowed_1" after discount to be equal to submitted charges, reflecting no savings.

   2. For Method #2, assume Members change to the closest in-network substitute provider who is accepting new patients and is appropriate for the applicable service or treatment. Populate "Allowed_ 2" with the network unit cost levels to be the contracted cost. For such substitute provider, include Provider Tax ID Number, Provider Tax Name, 5-digit ZIP Code, and Provider NPI, when available.

E. Populate the Carrier Summary to total the Allowed Charge 1 for in-network Claims and Allowed Charge 2 for Claims where the servicing provider is out of network and an alternative provider is used. Once copied to the Pricing Summary workbook, assume the discount and percentage of charges will go through such alternative providers.

F. For both in-network and out-of-network providers, populate the field "Allowed Portion with FFS Contract," with the percentage of the actual allowed charges that are under a FFS contract.

Evaluation and Scoring Insight

Bidder's score will be based on a Claims target pricing amount of $430 million ("Claims Target") for all Claims in the files provided by Milliman. While the actual allowed cost was not included within the Claim files, the HCA's historical results were used to inform the Claims Target. Bidders submitting a Claim pricing file ("Bidder Pricing") for less than the Claims Target amount will receive the full points available for this exhibit as listed in Section 3.2.A.1.

Bidder Pricing in excess of the Claims Target will be awarded points based on the following formula:

$$1{,}250 - \left\{\left(\frac{Bidder\ Pricing}{Claims\ Target} - 1\right) \times 125{,}000\right\} = Bidder's\ Points$$

The Bidder's points awarded for this section will be rounded to the whole point value and then added to the Non-Cost Elements and the remaining Cost Elements of the RFP to determine overall score for this stage of the HCA's evaluation. Negative points will be awarded once Bidder Pricing exceeds the Claims Target by one percent.

Here are two examples of the scoring results for Bidder Pricing in excess of the Claims Target:

Bidder A

$$1{,}250 - \left\{\left(\frac{\$433{,}000{,}000}{\$430{,}000{,}000} - 1\right) \times 125{,}000\right\} = 377.91\ rounded\ to\ 378$$

Bidder B

$$1{,}250 - \left\{\left(\frac{\$437{,}000{,}000}{\$430{,}000{,}000} - 1\right) \times 125{,}000\right\} = -784.88\ rounded\ to\ -785$$

As the above example for Bidder B demonstrates, if Bidder Pricing is above the Claims Target by more than 1%, that Bidder will be awarded negative points. There is no cap on the number of negative points that can be awarded.

Exhibit 5.2 Administrative Fee Proposal

Overview

Bidders must provide an Administrative Fee PSPM Proposal for each UMP Plan for each year of the expected initial term of the Contract. The Proposal should include all costs related to administering the UMP Plans, in sufficient detail to facilitate future discussions of Contract amendments affecting the scope of these services. All Proposals submitted in response to this Exhibit must align with the information provided in the Bidder's Proposal and should include all costs on a PSPM basis for each administrative service listed in the Excel template found in Appendix 6, Attachment 27.

Proposed fees must be on a "mature" basis such that, when the Contract is terminated, no additional charges will be incurred to provide for the processing of sixty (60) months of run-out Claims, and all associated customer service and provider network support activities. The HCA will not pay Administrative Fees to two administrators during the run-out period following the termination of the Contract. The Bidder's proposed fees need not include charges for any processing of run-in Claims from a prior TPA.

The Bidder should include in their proposed PSPM fees any and all amounts needed to cover the implementation costs described in the Bidder's Response to Exhibit 3.15. No payment will be made under the Contract until Claims processing starts on January 1, 2020.

All fee components must be rounded to the whole penny. The enrollment assumptions provided within Appendix 6, Attachment 27 will be used uniformly across all Bidders for evaluation of fee Proposals relative to a target cost. These enrollment assumptions are non-binding and used for evaluation purposes only. Conversion plan (see, Exhibit 3.14) fees are to be proposed on a per-conversion Contract basis at the bottom of Appendix 6, Attachment 27, and not on a PSPM basis.

Should the Contract resulting from this procurement extend beyond plan year 2029, the maximum annual increase to the Administrative Fee paid by the HCA during each annual extension will be less than 2% of the then-current Administrative Fee. The fee for all plan years after 2029 will be renegotiated by the HCA and the ASB twelve (12) months prior to the start of each plan year subject to this limit.

Specific Instructions

A. Complete the following tables included in the attached Excel workbook in Appendix 6, Attachment 27: "UMP Classic Non-Medicare (NMC)," "UMP Plus", "UMP Consumer-Directed Health Plan (CDHP)", and "UMP Classic Medicare." Failure to do so may result in Bidder's disqualification from evaluation.

B. Each row in such tables represents an individual administrative service that will be required under the Contract. On each row, enter an amount for each service for each plan year by entering a dollar value for each line item component (for convenience, these cells have been highlighted in light gray on the tables to be completed).

C. Confirm that the calculated values listed in the "PSPM Total" row for each table are accurate. The overall average PSPM in the "UMP Plans" table and the "2030 PSPM Fee" column of each table are calculated values. Review and confirm these figures are accurate.

D. Complete the table titled “Other Proposed Fees.” The amount provided for “Conversion Fee” will be the Bidder’s charges for performing the services referenced in Exhibit 3.14. The next row is the hourly blended rate the Bidder will charge for the performance of all services necessary to implement Work Orders in excess of Pooled Hours, as described in Exhibit 3.9. The final row in this table is the proposed percentage of recoveries retained by the Bidder to perform the subrogation services described in Exhibit 3.2.4.

Key Elements to Be Addressed

Break the PSPM Administrative Fee Proposal into the line-item components noted in Appendix 6, Attachment 27. With the exception of implementation fees (which can be zero), each Administrative Fee component must be greater than zero dollars ($0.00).

Required Accompanying Documents

None.

Evaluation and Scoring Insight

Responses to this Exhibit will be scored based on a PSPM target pricing amount of $28.51 (“PSPM Target”) in relation to the average of PSPM in Bidder’s Response to this Exhibit across the ten (10) year period including the years 2020 and 2029. Bidders submitting an average proposed PSPM over such 10-year period (“Bidder PSPM”) for less than the PSPM Target amount will receive the full points available for this exhibit as listed in Section 3.2.A.1. Bidders submitting an average proposed PSPM over the 10-year period of more than $31.84 (“PSPM Threshold”) will be awarded negative points, proportional to the difference.

Bidder PSPM in excess of the PSPM Target will be awarded points based on the following formula:

$$1{,}000 - \left\{\left(\frac{(Bidder\ PSPM - PSPM\ Target)}{(PSPM\ Threshold - PSPM\ Target)}\right) \times 1{,}000\right\} = Bidder's\ Points$$

The Bidder’s Points awarded for this section, rounded to the whole point, will then be added to the Non-Cost Elements and the remaining Cost Elements of the RFP to determine Bidder’s overall score on the written stage of the HCA’s evaluation.

Here are two examples of the scoring results for Bidder Pricing in excess of the Claims Target:

Bidder A

$$1{,}000 - \left\{\left(\frac{\$30.00 - \$28.51}{\$31.84 - \$28.51}\right) \times 1{,}000\right\} = 552.55\ rounded\ 553$$

Bidder B

$$1{,}000 - \left\{\left(\frac{\$35.00 - \$28.51}{\$31.84 - \$28.51}\right) \times 1{,}000\right\} = -948.95\ rounded\ -949$$

As the above example for Bidder B demonstrates, if Bidder PSPM is above the PSPM Threshold, that Bidder will be awarded negative points. There is no cap on the number of negative points that can be awarded.

Bidder Response

Not to exceed five (5) pages, excluding Required Accompanying Documents.

Exhibit 5.3 Trend Guarantee

Overview

Bidders must demonstrate a plan for controlling both network-allowed unit cost and plan-specific utilization that contributes to the allowed cost trend for the UMP Plans' non-Medicare population. Any changes in benefit plan design will be at the discretion of the HCA and should not be considered a means to achieve lower allowed cost trends. The allowed cost trend guarantees will be used as part of the Performance Guarantees associated with this contract (see, Exhibit 3.16.7)).

The ASB must agree to the performance evaluation of overall allowed-cost PMPM changes from year to year. The trend changes for unit cost will be evaluated on a relative basis to Medicare trend. The Bidder will propose a Unit Cost Guarantee Margin for future unit cost performance. The HCA has two (2) publicly available reports written by our contracted actuary titled: (1) "*Medicare Lite – A Methodology for Evaluating Washington's Public Employee Benefit Plans*", and (2) *"UMP Historical Unit Cost Analysis under Medicare Lite."*

These reports will be made available through the Milliman SFTP website at the time all other files are made available, and describe the basis for benchmarking future unit cost performance and the most recent historical results of unit cost trend. The Bidder will also propose a Utilization Trend Guarantee for future utilization trend performance. Failure to meet or exceed the unit cost and the utilization trend performance will result in the issuance of Performance Credits.

The Bidder is to propose within Table 5.3 a Performance Guarantee of two trend component rates for each year of the Contract. These two trend components will be combined with the benchmark unit cost performance under Medicare Lite to develop the Allowed Trend Guarantee rate for each period. The first trend component is the Unit Cost Guarantee Margin, which represents the amount of trend beyond the benchmark unit cost trend needed for the performance year. The second trend component is the Utilization Trend Guarantee. The Allowed Trend Guarantee will be the resulting product of the Benchmark Medicare Lite Unit Cost Change, the Unit Cost Guarantee Margin and the Utilization Trend Guarantee. The Allowed Trend Guarantee will be used to develop a target Allowed cost PMPM considered in the Performance Guarantee from the prior year.

These Performance Guarantees are in addition to the Performance Guarantees listed in Exhibit 3.16. If actual Allowed cost PMPM is lower than target Allowed, there will be no penalty. If the actual Allowed cost PMPM is higher than target Allowed cost, then a Performance Credit as a percentage of the proposed Administrative Fee for the prior year will be issued.

For a simplified example, assume the following for the performance of 2025 in relation to 2024:

A. Considered Actual Allowed PMPM for 2024 is $590.50
B. Benchmark Medicare Lite Unit Cost Trend is 1.5 percent
C. The Bidder's Proposal for guaranteed trends in 2025 is:
    1. Unit Cost Guarantee Margin: 0.5 percent
    2. Utilization Trend Guarantee: 2 percent
D. Target Allowed PMPM for 2025 is calculated as:
    1. A x B x C = $590.50 x (1.015) x (1.005) x (1.02) = $614.40 PMPM
E. Considered Allowed PMPM for 2025 is $602.31 PMPM

In this simplified example, the Performance Guarantee for overall trend would be satisfied as the Considered Allowed PMPM for 2015 (E) is less than the Target Allowed PMPM of (D). The overall Trend Guarantee Rate will not be determined until the Medicare Lite evaluation for both years is

complete. In this example the overall Guaranteed Trend Rate is 4 percent, while actual performance of Allowed PMPM trend is 2 percent.

For determination of the Performance Credit and incentive, the Target and Actual Allowed PMPM will be compared. There will be no penalty if the Considered Allowed for the performance year is within 0.5% of Target Cost. In the simplified example, this threshold would be $617.47 ($614.40 x 1.005). The full penalty will be charged if Considered Allowed is greater than Target Cost + 2.5%. In the simplified example, this threshold would be $629.76 ($614.40 x 1.025). A proportional penalty of the amount at risk will be charged if the performance year Considered Allowed is greater than Target Cost + 0.5% but less than Target Cost + 2.5%. For a Considered Allowed that is equal to the Target Cost plus 1.5 percent this would result in a penalty of exactly half of the fees at risk. In the simplified example, a Considered Allowed PSPM of $623.62 would result in half of the penalty being assessed.

Assessment of the Performance Guarantee penalty in each year will be in proportion to 15% of the prior year's fees.

Specific Instructions

1. Propose an annual Unit Cost Guarantee Margin and Utilization Trend Guarantee for each year of the initial term of the Contract. Bids will be evaluated relative to the Target Trend of 20% and the Threshold Trend of 45%. The Unit Cost Guarantee Margin and the Utilization Trend Guarantee will be totaled for the ten (10)-year initial term of the Contract.
2. Refer to Section 3.2, Evaluation of Proposal, for more details on scoring insight for Exhibit 5.
3. If Bidder does not currently meet any of the Key Elements, please describe in the response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020.
4. Key Element questions must be included together in all responses and documentation.

Table 5.3 - Please complete the following table for Bidder's Response:

Plan Year	Unit Cost Guarantee Margin	Utilization Trend Guarantee
2020		
2021		
2022		
2023		
2024		
2025		
2026		
2027		
2028		
2029		

Key Elements to Be Addressed

The allowed Claims used in the measurement of the overall Trend Guarantee will be inclusive of all Claims administered by the Bidder that are suitable for consideration in the Medicare Lite calculation. The following Claims may be excluded from calculations in response to this Exhibit 5.3:

A. Claims with Coordination of Benefit amounts that exceed 1% above than the Claim line
B. Claims for Members identified with End Stage Renal Disease (ESRD)

C. Claims that cannot be priced for Medicare Lite

Required Accompanying Documents

Provide a description and results of up to three trend guarantees of the same or similar design that were used with accounts of 20,000 members or more during the period 2010 to 2015.

Evaluation and Scoring Insight

Responses to this Exhibit will be scored based on the sum of both the Unit Cost Guarantee Margin and the Utilization Trend Guarantee across the ten (10) year period included in Appendix 6, Attachment 27 as compared to a cost trend target of 20% ("Trend Target"). Bidders submitting a guaranteed total trend rate over the 10-year period ("Bidder Trend") for less than the Trend Target amount will receive the full points available for this exhibit, as listed in Section 3.2.A.1. Bidders submitting a guaranteed total trend of more than 45% ("Trend Threshold") will be awarded negative points proportional to the overage. Bidder Trend in excess of the Trend Target will be awarded points based on the following formula:

$$750 - \left\{\left(\frac{(Bidder\ Trend - Trend\ Target)}{(Trend\ Threshold - Trend\ Target)}\right) \times 750\right\} = Bidder's\ Points$$

The Bidder's points awarded for this Exhibit, rounded to the whole point, will then be added to the Non-Cost Elements and the remaining Cost Elements of the RFP to determined Bidder's overall score on the written stage of the HCA's evaluation.

Here are two examples of the scoring results for Bidder Pricing in excess of the Claims Target:

Bidder A

$$750 - \left\{\left(\frac{27.33\% - 20\%}{45\% - 20\%}\right) \times 750\right\} = 530.10\ rounded\ 530$$

Bidder B

$$750 - \left\{\left(\frac{65.50\% - 20\%}{45\% - 20\%}\right) \times 750\right\} = -615.00\ rounded\ -615$$

As the above example for Bidder B demonstrates, if Bidder Trend is above the Trend Threshold, that Bidder will be awarded negative points. There is no cap on the number of negative points that can be awarded.

Bidder Response

Not to exceed five (5) pages, excluding Required Accompanying Documents.

EXHIBIT 6 – TECHNICAL DATA REQUIREMENTS

Overview

The HCA desires an ASB with a robust data platform that provides timely and accurate data and security capabilities.

The HCA will own all data resulting from a Contract awarded under this RFP. All pricing data will also be owned by the HCA and will include allowed, paid and billed amounts for all UMP Plans.

The Technical Data Requirements section requires a four-part Response from the Bidder, including:

A. Its ability to comply with Washington State Office of the Chief Information Officer (OCIO) standards.

B. Its ability to comply with the HCA's Data File Transfer and Access Requirements under Exhibit 6.2.

C. Its ability to comply with the HCA's Eligibility System Requirements.

D. Its intent to participate to Data Transfer with HCA Data Projects.

Specific Instructions

Provide a separate stand-alone narrative Response for Section 6.1 through 6.4 below. Bidder's Response to each exhibit will be scored independent of the content of the other Responses. Required accompanying documentation must be labeled to identify the corresponding Response. Key Element questions must be included together in all Responses and documentation.

Exhibit 6.1 Compliance with State Data Security Requirements

Key Elements to Be Addressed

Describe how the Bidder will comply with all OCIO standards for security and confidentiality.

A. The state of Washington has security requirements for handling "Confidential Information" as described in Appendix 5. Describe how the Bidder meets these security requirements in terms of personnel, physical, data, network, access, and administrative and application security.

B. For a self-service functionality, describe how the Bidder's organization meets the requirements of Appendix 5, and how it compensates for any gaps with additional controls.

C. Bidder must agree that all Claims data will be the sole property of the HCA.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Required Accompanying Documents

Provide a copy of Bidder's standard data security policies and standards, as well as a SOC 2 Type II report completed within twelve (12) months prior to the date of Response. If Bidder does not have a SOC 2 Type II report from such time frame, please provide any audit report of data security policies and standards completed within twelve (12) months prior to the date of Bidder's Response. If no such audit report has been completed in that timeframe, indicate this in the Bidder's Response.

Evaluation and Scoring Insight

Preference will be given to Bidders who currently have standards in place that comply with OCIO requirements.

Bidder Response

Not to exceed three (3) pages, excluding Required Accompanying Documents.

Exhibit 6.2 Data File Transfer and Access Requirements

Key Elements to Be Addressed

Describe how the Bidder will comply with all of the following Data File Transfer and Access Requirements:

A. Pick up and process electronic data files from Washington State's secure file transfer service.

B. Accept and execute electronic data file transfers on behalf of the HCA to business associates of HCA when requested.

C. Refuse to accept or transfer data with any other vendor unless that vendor has an executed BAA in place with the HCA.

D. No requirement for other HCA contractors to execute separate data sharing contracts with the ASB for purposes of sharing HCA data.

E. Administer Member information in compliance with HIPAA and OCIO standards for privacy, security, and electronic data interchange.

F. Comply with HCA data requests for any internal or external audits.

G. Give network and non-network providers access to eligibility and Claims look-up through OneHealthPort.

H. Create a current version HIPAA 834 standard transaction to send to the PBM and HCA business partners, including any optional fields requested by the HCA, at no additional cost.

I. Transmit and/or retrieve PEBB data directly to/from external contracted vendors and other HCA business associates as determined by the HCA.

J. Provide Claims data extracts to the HCA at no additional cost. HCA business associates include but are not limited to: the HCA's actuarial consultants, polypharmacy vendor and data warehouse vendor. Data transfers may occur on a weekly or monthly basis, as specified by the HCA.

K. Build data files and transfer separately-defined eligibility and Claims files to the data warehouse vendor on a monthly basis in the format it requests. This process must be established by June 1, 2019. The HCA data warehouse vendor's file specifications will be

provided to the ASB under a non-disclosure agreement, or if the vendor changes, will be supplied within four (4) weeks of the transfer of vendor.

Required Accompanying Documents

None.

Evaluation and Scoring Insight

Preference will be given to Bidders who can meet all HCA data transfer requirements.

Bidder Response

Not to exceed three (3) pages, excluding Required Accompanying Documents.

Exhibit 6.3 Eligibility Systems Requirements

Key Elements to Be Addressed

Provide an overview of the Bidder's capability to comply with all of the following Eligibility System Requirements:

A. Member ID Numbers

1. The Bidder will generate a unique, permanently assigned, HIPAA compliant non-Social Security Number (SSN) based ID number for each Subscriber. If the Bidder uses its own algorithm to assign ID numbers, that algorithm must be approved in advance by the HCA. It must guarantee a random number, from which the SSN and other PHI cannot be determined or approximated; it must be nine (9) or ten (10) characters; it cannot duplicate other IDs used by the ASB; and it must include a check digit.
2. The HCA requires that the Bidder use the existing ID numbers assigned to current Members, as well as the same algorithm now in use to create the non-SSN ID numbers for new Members. The ID must be in the form below:

   W7CXXXXXXX
   Where: W7 = constant
   C = calculated check digit
   XXXXXXX = ascending 7 digit sequential number beginning with zero

B. Eligibility Files

The Bidder must:

1. Create a current version HIPAA 834 standard transaction to send to the PBM and the HCA's business partners, including any optional fields requested by the HCA, at no additional cost.
2. Conduct a quarterly full eligibility file match with the HCA and the PBM, promptly reconcile any differences and report any reconciled differences and any other discrepancies to the HCA.
3. Accept and process PEBB eligibility files daily in the form outlined in the PEBB Eligibility File Format found in Appendix 5, Attachment 8

4. Store Member data, including SSNs, along with non-SSN and other non-PHI algorithm-generated Member IDs, in order to communicate with PEBB eligibility staff and perform quarterly eligibility audits.
5. Transmit eligibility and 'Other Coverage' data in a HIPAA-compliant format to the PBM at least weekly in a format acceptable to the PBM. Transmit similar files to other PEBB business associates as directed by the HCA.
6. Transfer SSNs of Employees and their Dependents to other HCA vendors and Subcontractors, as that is the HCA Member ID within its eligibility system.
7. Provide Member SSNs for transfer from the ASB to other HCA vendors, as requested by the HCA.
8. Create and transmit eligibility data in a format defined by the HCA study partner, as requested by the HCA.

C. Eligibility Files and Matches

1. Conduct a reconciliation of the full eligibility file with HCA each calendar quarter. Within seven (7) business days of the start of each calendar quarter, request a full enrollment file via email to the HCA (send to an email address specified by the HCA, and forward a copy to HCA Senior Account Sponsor(s)). Conduct the full file audit by comparing ASB enrollment records with enrollment records supplied in the full file from the PEBB. Complete and submit the full eligibility file audit within twenty (20) business days from receipt of the file.
2. Reconcile any differences within ten (10) business days of the completion of the quarterly file audit.
3. The match must include matching each member-level data element of the PEBB HIPAA 834 Eligibility File Format, found in Appendix 5, Attachment 8, and must reconcile all data fields that do not match. Report all unreconciled differences and any other discrepancies to HCA Senior Account Sponsor(s) and PBM Contract Managers within seven (7) business days of completion of the quarterly full file match. Upon completion of the full file match and reconciliation, prepare the full file and submit it to the PBM within seven (7) business days of completion.
4. Conduct a quarterly full eligibility file match with the PBM after completion of the match and reconciliation process under (a), (b), and (c) above. The PBM is required to reconcile any file differences with ASB within ten (10) business days of completion of the PBM's full file match.

Required Accompanying Documents

A. Provide a copy of a standard Member ID card.

B. Include a list of any customization limitations for Member ID cards.

Evaluation and Scoring Insight

Preference will be given to Bidders who can keep current UMP Member ID numbers.

Bidder Response

Not to exceed three (3) pages, excluding Required Accompanying Documents.

Exhibit 6.4 Data Transfer Participation with HCA Data Projects

Overview

The ASB will participate and provide data in compliance with HIPAA within the existing PSPM with various current and future HCA programs that require data on UMP Members. Examples of HCA initiatives include but are not limited to Healthier Washington's Analytics, Interoperability, and Measurement (AIM) function including program evaluation, Healthier Washington Test Models 3 (Accountable Care Program) and 4 (Multi-Payer), and Link4Health (Clinical Data Repository). The HCA will work with the ASB regarding each initiative to determine specific parameters and needs as they develop. The ASB must work with HCA staff to determine necessary data flows and processes, and to ensure the safeguarding of data.

Specific Instructions

The Bidder's Response must demonstrate strong knowledge and experience, while affirming the organization's ability to meet each of the Key Elements. The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

The Bidder must:

A. Develop and maintain data transfers for all current and future HCA vendors (including Limeade, SmartHealth and Diabetes Prevention and Control Alliance), as well as future HCA programs and/or partnerships.

B. Use current UMP ID numbers to maintain clear relations between associated vendors.

Required Accompanying Documents

None.

Evaluation and Scoring Insight

Preference will be given to Bidders who agree to participate with current and future HCA programs.

Bidder Response

Not to exceed three (3) pages, excluding Required Accompanying Documents.

EXHIBIT 7– MARKET PRESENCE

Overview

The HCA seeks an ASB that recognizes the value and importance of having an account with the size and quality of the UMP Health Plans and their status as Washington State's principal, self-funded employee Health Plans. The Bidder must understand the potential impact of the state's political environment and the importance of actively participating as a major player in the local health care market in terms of number of members, statewide Member distribution, and diversity of client sizes, including both public- and private-sector clients representing large numbers of Members.

As the sponsor of a major employee benefits program, the HCA desires an ASB that has recent experience administering services similar to those covered by this RFP for one (1) or more self-funded PPOs for clients with 20,000 or more Members, preferably in the state of Washington. The HCA is most interested in experience that (a) occurred in 2011 through 2016, (b) was continuous during that period, (c) involved Washington-based PPOs and ACNs, (d) included Members with a broad geographic distribution in the state, and (e) involved public sector Health Plans.

The HCA is looking for a forward-thinking, long-term partner with significant regional market presence that will influence providers caring for the majority of UMP members located in and around Washington State. The UMP includes a large, complex group of plans with Members located in every county of Washington and with active and retired members living and working in most states and in several foreign countries.

It is unique from other self-funded employer-sponsored plans in that it is bound by additional state compliance statutes and insurance regulations that generally only apply to insured Health Plans. The ASB should have experience with unique public-sector legal requirements, as well as the flexibility to adapt as requirements change over time.

Specific Instructions

Demonstrate the Bidder's experience administering self-funded Health Plans of the size and scope of the UMP Plans, as well as its significant and diverse presence in the Washington state health care market.

A. Use only the table provided below for the Bidder's Response.

B. List a maximum of ten (10) PPOs. Disclose PPO client names on the list in order for it to be counted as demonstrated experience.

C. Specifically identify PPOs as being based in the state of Washington in order to receive credit as such.

D. Because the HCA seeks a partner that can build upon the PEBB market share to increase opportunity to drive health care reform in Washington, do not use existing contracted PEBB accounts when reporting the Bidder's Washington Book-of-Business market share.

E. Share the Bidder's current number of Covered Lives across the United States and worldwide.

The Response must identify any areas of concern or inability to comply with the Key Elements. If Bidder does not currently meet any of the Key Elements, please describe in the Response how Bidder proposes to do so, including a description of any current efforts or future plans, key milestones with dates, any known issues and risks, and Bidder's management's assessment of

the likelihood of complying with the Key Elements by January 1, 2020. Key Elements must be restated by the Bidder in all Responses and documentation.

Key Elements to Be Addressed

See Table 7.1 below.

Required Accompanying Documents

None.

Evaluation and Scoring Insight

Credit will be given for each of the following factors and value will increase in relation to the number of included factors. In all cases, additional value will be awarded when the factor is associated with Washington PPOs.

A. Number of self-funded PPOs administered during the period 2011-2016.

B. Length of continuous service as an administrative services contractor who have provided services over a continuous five (5)-year span.

C. Experience administering self-funded public sector PPOs.

D. Experience administering self-funded PPOs for clients with more than 20,000 Covered Lives or more.

E. Experience migrating self-funded plans from a PPO model to an ACO or similar alternative payment/delivery model

F. Number of self-funded covered Members represented by clients with more than 20,000 Covered Lives.

G. Number of members in Washington State in excess of 100,000

H. Public sector clients included in client base.

I. Overall market share in terms of total covered Members (not counting PEBB accounts).

J. Geographical presence throughout Washington State.

K. Ability to provide a provider network throughout the United States and worldwide.

Bidder Response

Not to exceed three (3) pages, excluding Required Accompanying Documents**.**

Table 7.1 Experience Managing Self-funded PPOs

Self-Insured Client Name and Contact Information	Plan Type*	Plan Member Geography**	If "yes," Number of WA Counties Served	Public or Private Sector Plan	Number of Covered Lives	Services Provided (Limit of 15 services)	Year Began Services	Year Ended Services	Number of lives within an ACN?
		(A) (B) (C)							
		(A) (B) (C)							
		(A) (B) (C)							
		(A) (B) (C)							
		(A) (B) (C)							
		(A) (B) (C)							
		(A) (B) (C)							
		(A) (B) (C)							

*Please select a Plan Type from the following: Self-Funded PPO, Fully-Insured PPO.
**List the number of Members (A) within Washington State, (B) outside Washington State (indicate state(s)), and (C) outside the United States.

APPENDIX 1 PEBB UMP PLAN PROFILES

APPENDIX 2 PEBB ENROLLMENT REPORT

Attachment 1 – All UMP Plans
Attachment 2 – UMP Classic-Non-Medicare
Attachment 3 – UMP Classic-Medicare
Attachment 4 – UMP CDHP, UMP Plus

APPENDIX 3 IMPLEMENTATION PLAN

APPENDIX 4 HTCC DETERMINATIONS

Attachment 1 - HTCC Description and Reviews/Selected Technologies
Attachment 2 – Appropriate Imaging for Breast Cancer Screening
Attachment 3 – Imaging for Rhinosinusitis
Attachment 4 – Novocure
Attachment 5 – Proton Beam Therapy
Attachment 6 – Spinal Injections

APPENDIX 5 OCIO SECURITY REQUIREMENTS

Attachment 1 – Securing Information Technology Assets
Attachment 2 – Securing Information Technology Assets Standards
Attachment 3 – Securing Information Technology Assets Standards Appendix A
Attachment 4 - Securing Information Technology Assets Standards Appendix B
Attachment 5 - Securing Information Technology Assets Standards Appendix C
Attachment 6 – Media Handling and Data Disposal Best Practices
Attachment 7 – HCA Office of Security Services – Design Review Guidance
Attachment 8 – PEBB Eligibility File Format

APPENDIX 6 INCORPORATED ATTACHMENTS

Attachment 1 - RFP Checklist
Attachment 2 – Draft Contract (to be provided by Amendment to the RFP)
Attachment 3 – PEBB Members by County, by Plan
Attachment 4 – UMP Classic 2017 Certificate of Coverage
Attachment 5 - UMP CDHP 2017 Certificate of Coverage
Attachment 6 - UMP Plus Puget Sound High Value Network 2017 Certificate of Coverage
Attachment 7 - UMP Plus UW Medicine 2017 Certificate of Coverage
Attachment 8 – UMP Operations Manual
Attachment 9 – HCA Value-based Roadmap
Attachment 10 – PEBB Performance Quality Measures
Attachment 11 – Example Work Order
Attachment 12 – Data Exchanges
Attachment 13 – Health Benefits K-12 Reporting
Attachment 14 –K-12 Document Employee Benefits Report
Attachment 15 – ACN Operations Manual
Attachment 16 - ACN - Network Consent for Non-Network and Out of Network Services
Attachment 17 – ACN - Sample UMP Plus Business Rules
Attachment 18 - ACN – Adding ACN Affiliate or ACN Partner Providers
Attachment 19 - ACN – Adding TIN Provider to Partner or Affiliate
Attachment 20 - ACN – Provider Data End to End Process
Attachment 21 - ACN – HCA Review Monthly Provider
Attachment 22 - ACN – Remove ACN Affiliate or ACN Partner Provider
Attachment 23 - ACN – Monthly Provider Change Roster
Attachment 24 - Paying for Value Survey
Attachment 25 – Completion Dates for Quarterly Eligibility Reconciliation
Attachment 26 – Common Measure Set
Attachment 27 – Administrative Fees
Attachment 28 – Proposal Scoring and Weights
Attachment 29 – WA Provider Network Analysis
Attachment 30 – Repricing of Claims Summary

APPENDIX 7 FORMS PACKAGE

Form A – Data Share Agreement
Form B – Washington State Vendor Registration
Form C – IRS W-9 Tax Form
Form D – Certifications and Assurances
Form E – Diverse Business Inclusion Plan