**STATE OF WASHINGTON**
**HEALTH CARE AUTHORITY**

# REQUEST FOR APPLICATIONS (RFA)

**RFA NO.** 2020HCA1

***NOTE:*** *If you download this RFA from the Health Care Authority (HCA) website, you are responsible for sending your name, address, e-mail address, and telephone number to the RFA Coordinator in order for your organization to receive any RFA amendments or applicant questions/agency answers. HCA is not responsible for any failure of your organization to send the information or for any repercussions that may result to your organization because of any such failure.*

**PROJECT TITLE: Cascade Care Public Option Plans (to be offered on the Washington Health Benefit Exchange)**

**PHASE 1 RESPONSES DUE:** April 17, 2020 by 2:00 p.m. *Pacific Time.*

**PHASE 2 RESPONSES DUE:** May 22, 2020 by 2:00 p.m. *Pacific Time*.

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

**ESTIMATED TIME PERIOD FOR CONTRACT:** HCA estimates the Contract(s) will be signed in September 2020 in order to begin contracted terms for open enrollment starting on November 1, 2020. The Coverage Start Date is January 1, 2021 and will extend through December 31, 2022.

HCA reserves the right, at its sole discretion, to extend the contract for up to two (2) additional two (2) year periods. HCA also reserves the right not to enter into any contracts as a result of this solicitation.

**APPLICANT ELIGIBILITY:** This solicitation is open to those Applicants that (1) meet all the requirements under the health plan certification laws stated herein, and (2) are available for work in Washington State.

Washington State Health Care Authority

# 1. INTRODUCTION

## 1.1. DEFINITIONS

Definitions for the purposes of this RFA include the following:

**All-Payer Claims Database** or **APCD** – 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.

**Annual Open Enrollment** – The period each year during which consumers may enroll or change coverage in a QHP and QDP through *Washington Healthplanfinder*. The open enrollment period for 2021 coverage is from November 1, 2020 through December 15, 2020, unless otherwise published by the Exchange as an amendment to the 2021 Guidance for Participation.

**Apparent Successful Applicant** or **ASA** – An Applicant selected as an entity to perform the anticipated services under this RFA, subject to completion of contract negotiations and execution of a written contract.

**Applicant** - An individual or company interested in the RFA that submits an application in order to attain a contract with the Health Care Authority.

**Application** – A formal offer submitted in response to this solicitation.

**Behavioral Health -** Mental health and/or Substance Use Disorders and/or conditions and related benefits.

**Behavioral Health Agency** - An entity licensed by the Department of Health to provide behavioral health services.

**Book-of-Business** – All commercial business of the Applicant, including any and all fully insured and self-insured products within the Applicant's accounts.

**Bree Collaborative** – The statewide public-private consortium established in 2011 by the 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 Collaborative are sent to HCA to guide state purchasing for programs such as Medicaid and PEBB. *See generally* RCW 70.250.

**Calendar Day** – Any day of the week, month, or year, including weekends and holidays. When the term "day" is not specified, this definition of Calendar Day shall prevail.

**Care Coordination** - 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.

**Carrier –** Carrier means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020. *See generally* RCW 48.43.005(27). An Applicant can provide documented proof of being in the process with OIC to become a Carrier.

**Case Management** - 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.

**Clinical Management** – 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.

**Clinically Integrated Network –** A health system or other formal structure of health care providers that has demonstrated clinical leadership by taking accountability for delivering integrated clinical care delivery models for defined populations designed to produce quality, cost-effectiveness, efficiency and value.

**Centers for Medicare and Medicaid Services** or **CMS** – The federal agency that administers the nation's major health care programs, including Medicare, Medicaid, and the Children's Health Insurance Program.

**CMS-Certified Other Payer Advanced Alternative Payment Models** or **APMs** – Payment arrangements that fall into one of the following categories and meet the Other-Payer Advanced APM criteria. These include: Medicaid; Medicare Health Plans (Medicare Advantage, Medicare-Medicaid Plans, 1876 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) plans); CMS Multi-Payer 4 Models; and Commercial and private payer arrangements. Annually CMS reviews payment arrangement information submitted by Carriers to determine whether it meets the Other-Payer Advanced APM criteria. Once reviewed and approved, CMS will post a list of Other-Payer Advanced APMs online before the QP Performance Period.

**Critical Access Hospitals** or **CAHs –** A designation given to eligible rural hospitals by CMS. Congress created the Critical Access Hospital (CAH) through the Balanced Budget Act of 1997 (Public Law 105-33) in response to a series of rural hospital closures during the 1980s and early 1990s.

**Contract** – A written agreement resulting from this solicitation between an ASA and HCA, including all exhibits, schedules, attachments, and other terms or documents referred to, incorporated by reference, or attached hereto.

**Contractor** – What an ASA becomes after a Contract (if any) has been executed. This includes the Contractor's employees and agents, and any firm, provider, organization, individual or other entity performing services under the Contract. It also includes any Subcontractor retained by the Contractor as may be permitted under the terms of the Contract.

**Coverage Start Date** – The day the ASA will begin providing benefit coverage and services under the Contract. The Coverage Start Date for this solicitation is currently scheduled for January 1, 2021.

**Covered Lives** - The number of people enrolled in a particular health insurance plan.

**Evidence of Coverage** – A summary of the essential features of the group coverage contract produced and made available to each covered person. The Evidence of Coverage is in effect during a given benefit year in which the date of service(s) received by the Member falls.

**Explanation of Benefits** or **EOB** – A statement sent to covered individuals explaining the medical treatments and/or services paid on their behalf.

**Health Benefit Exchange** or **HBE** – A public-private partnership created by the Legislature in 2011. HBE is responsible for the operation of the *Washington Healthplanfinder*, an easily accessible online marketplace, for individuals and families to find, compare and enroll in Qualified Health Plans (QHPs), Qualified Dental Plans (QDPs) and Washington Apple Health (Medicaid).

**Health Care Authority** or **HCA** – An executive agency of the state of Washington that is issuing this RFA.

**Health Equity** – A status that is achieved when all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or any other circumstance. Achieving full health potential must reflect all the dimensions of health, including behavioral, physical, and oral health. This requires removing obstacles to health such as poverty and discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

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

**Integrated Delivery System** or **IDS** – Also known as integrated delivery network (IDN), is a health system with a goal of logical integration of the delivery (provision) of health care or a specific network of health care organizations constituting a corporate group that integrates care and coordinates the patient journey across care transitions.

**Member** – Subscribers and their Dependents who are enrolled in a health plan with a Carrier that results from this RFA, and for whom premium payments have been made.

**Non-Standard Plans** – Current qualified health plans offered on the Exchange in 2020.

**Office of the Insurance Commissioner** or **OIC** – The state agency with regulatory oversight of the insurance industry. The OIC oversees Washington State's insurance industry to protect consumers and to ensure companies, agents, and brokers comply with governing law. The OIC protects consumers, the public interest and the state economy through fair and efficient regulation of the insurance industry.

**Patient Decision Aid –** A tool that can help people engage in shared health decisions with their health care provider. A list of Patient Decision Aids certified by HCA can be found here: https://www.hca.wa.gov/about-hca/healthier-washington/certified-aids.

**Patient Reported Outcomes –** A health outcome directly reported by the patient who experienced it.

**PHI –** Protected Health Information, as defined in 45 C.F.R. §160.103.

**Plan Year** – The twelve (12) month period beginning on January 1 of each year and ending December 31 of the same year.

**Public Option Plan** – A qualified health plan procured by the Health Care Authority and offered on the Health Benefit Exchange as described in RCW 41.05.410 that meets the standard plan design and additional affordability and quality metrics included in this solicitation.

**Quadruple Aim** – A framework that health institutions adopt to help in their efforts to improve patient care and quality outcomes. It is based on the Institute for Healthcare Improvement's (IHI) Triple Aim, which looks at the patient experience of care, reducing the total cost of care, and population health, and then adds a fourth focus of improving workforce well-being with the mindset that satisfied health care providers equate to satisfied patients.

**Quality Improvement** – A systematic and continuous set of actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

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

**RCW** – 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.

**Request for Applications** or **RFA** – A formal solicitation document in which a service or need is identified but no specific method to achieve it has been chosen. The purpose of an RFA is to permit the applicant community to suggest various approaches to meet the need through a given set of services.

**Request for Renewal** or **RFR** – The annual process and accompanying documents used by HCA when issuing requested and/or required changes to the benefits or Contractor's deliverables for the next Plan Year. Once the Contractor and HCA come to an agreement on the benefit change(s) or Contractor's deliverables, they will be incorporated into the Contract as an amendment.

**Shared Decision Making** – The 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.

**Social Determinants of Health** – Conditions in the places where people live, work, learn, and play that affect a wide range of health outcomes and risks. Examples include housing, education, transportation, employment, and social support.

**Sole Community Hospitals** or **SCHs –** A designation by CMS. *See generally* Section 1886(d)(5)(D) of the Social Security Act.

**Standard Plans –** A qualified health plan offered on the Health Benefit Exchange as described in RCW 41.05.410 that includes the standard plan benefit design requirements.

**Standard Benefit Design Plan** – A standardized health benefit plan design developed by the Health Benefit Exchange to provide consistent cost-sharing and benefit design across all Carriers; allows consumers the ability to compare plans across Carriers.

**Summary of Benefits and Coverage** – A document, required under the Affordable Care Act, that insurance companies and group health plans provide to consumers comparing benefits and coverage for different plans. The information provided must be concise, in plain language, and consistent with the health plans benefits and coverage information for consumers to easily compare different coverage options in order to select their health plan.

**Value-Based Payments – Defined by HCA as** payments to providers that are linked to cost and quality, as defined by CMS LAN Categories 2C-4B.

**Value-Based Purchasing** or **VBP** – Contractual arrangements between a purchaser (e.g., Apple Health, PEBB, CMS) and its contractors and partners (e.g., managed care organizations or third party administrators) that incentivize them to meet specified value-based targets which may include quality, cost, access, patient and provider experience, and other value-based metrics.

**WAC** – The Washington Administrative Code. References to specific titles, chapters, or sections of the WAC include any substitute, successor, or replacement title, chapter, or section.

***Washington Healthplanfinder*** – The marketplace in Washington State operated by the Washington Health Benefit Exchange where qualified individuals can shop for and enroll in qualified health plans (QHPs) and qualified dental plans (QDPs).

**Washington State Common Measure Set** – A set of statewide measures for Washington State that provide the foundation for health care accountability and measuring performance. Engrossed Second Substitute House Bill 2572 (Laws of 2014, Chapter 223) is the authorizing legislation that enabled the creation, ongoing evolution and implementation of the measure set.

## 1.2. **ESTIMATED SCHEDULE OF SOLICITATION**

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|---|---|
| HCA to Issue Request for Applications | February 27, 2020 |
| Applicants' to Submit Letters of Intent to Apply | March 13, 2020 – 2:00 p.m. PT |
| Applicants' to Submit Non-Disclosure Agreement (NDA) Due | March 13, 2020 – 2:00 p.m. PT |
| Applicants' Questions Due | March 16, 2020 – 2:00 p.m. PT |
| Pre-Solicitation Conference | March 20, 2020 – 11:00 a.m. – 12:00 p.m. PT |
| HCA Responses to Questions Posted | March 27, 2020 |
| Applicants' Phase 1 Responses Due | April 17, 2020 2:00 p.m. PT |
| Phase 1 Evaluation by HCA | April 22 – May 4, 2020 |
| Phase 1 Passing Notification to Applicants | May 11, 2020 |
| Applicants' OIC Filing Deadline for Rates and Network Access | May 21, 2020 |
| Applicants' Phase 2 Responses Due | May 22, 2020 – 2:00 p.m. PT |
| Phase 2 Evaluation by HCA | June 3 – June 30, 2020 |
| HCA to Announce Apparent Successful Applicant(s) (ASA) and send notification via e-mail to unsuccessful Applicants | July 7, 2020 |
| Applicants' Debrief Request Deadline | July 10, 2020 |
| Contract Negotiations | July – September, 2020 |
| OIC Filing Approval | September 2020 |
| HBE Board Certification | September 2020 |
| HCA's Verification of ASA's OIC Rates | September 2020 |
| HCA to Execute Contract | September 25-30, 2020 |
| HBE Open Enrollment | November 1-December 15, 2020 |
| Coverage Start Date | January 1, 2021 |

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

## 1.3. **PURPOSE**

The Washington State Health Care Authority (HCA), in partnership with the Washington State Health Benefit Exchange (HBE) and the Washington State Office of the Insurance Commissioner (OIC), is initiating this Request for Applications (RFA) to solicit applications from licensed Carriers interested in providing Standard Public Option health plans, ("Public Option Plans") on the individual market provided through *Washington Healthplanfinder* ("the Exchange") for coverage effective January 1, 2021.

Affordability and the cost of health care continue to be key issues for Americans regardless of income, class and insurance status. The United States (US) spends more money on health care than

any other country. Relative to the size of the US economy, health care spending has increased dramatically over the past few decades, from five (5) percent of the Gross Domestic Product (GDP) in 1960 to almost eighteen (18) percent in 2018, reaching $3.6 trillion or $11,172 per person.[1] Despite increased spending, the US does not consume more health care resources and has lower health outcomes relative to other countries.[2]

A wealth of research shows the price of health care is the primary reason why the US spends more on health care than any other country, despite the adoption of value-based purchasing strategies, health policy reforms and health system restructuring.[3,4] The dynamics surrounding health care prices (especially hospital services) are complex. Health care prices vary significantly in public sector insurance programs (such as state Medicaid programs and Medicare) and in private health programs, with state Medicaid programs paying lower hospital prices than the private sector.[5] This gap between what the public and private sectors pay for medical services has grown significantly in the past fifteen years.[6] Many commentators assert that hospitals charge private insurers more to make up for lower payments from public sector programs (known as cost-shifting); other studies show cost-shifting does not occur and, in fact, the opposite effect is occurring – when public programs pay hospitals less, so do private insurers.[7,8]

Even while having the highest overall health care spending and the highest hospital prices, the amount spent in the US on preventive and primary care is actually lower than rates in other developed nations. One study showed the US spent less on primary care, approximately five (5) to eight (8) percent of all health care spending, with an even lower percentage in Medicare – compared to approximately fourteen (14) percent of all health spending in most high-income nations.[9] Washington State spends even less, approximately four (4) to six (6) percent on primary care, according to 2018 data.[10] Primary care spending is important because greater use of primary care is associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality.[11] There is widespread agreement the proportion spent on primary care is insufficient given the high levels of overall health care spending in the US.

States are increasingly focused on affordability strategies and health care costs across all state-financed programs and State Health Insurance Exchanges as premiums and consumer cost sharing continue to rise. Since 2010, health care premiums have grown more than twice as fast as income;

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[1] Centers for Medicare and Medicaid Services. National Health Expenditure Data. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical. Accessed February 4, 2020.
[2] Ibid.
[3] Reinhardt, UE. (2019). Priced Out: The Economic and Ethical Costs of American Health Care. Princeton, NJ: Princeton University Press.
[4] Anderson GF, Reinhardt UE, Hussey PS, Petrosyan V. It's the Prices, Stupid: Why the United States is so different from other countries. Health Aff (Millwood). 2003;22(3):89-105.
[5] Frakt A. "JAMA Forum: Hospitals Don't Shift Costs from Medicare or Medicaid to Private Insurers." *JAMA*, 4 Jan 2017.
[6] Anderson GF, Hussey PS, Petrosyan V. It's Still the Prices, Stupid: Why the US spends so much on health care, and a tribute to Uwe Reinhardt. Health Aff (Millwood). 2019;38(1):87-95.
[7] Frakt A. "JAMA Forum: Hospitals Don't Shift Costs from Medicare or Medicaid to Private Insurers." *JAMA*, 4 Jan 2017.
[8] White C. Contrary To Cost-Shirt Theory, Lower Medicare Hospital Payment Rates For Inpatient Care Lead To Lower Private Payment Rates. Health Aff (Millwood). 2013:32(5):935-943.
[9] American Academy of Family Physicians. Primary Care Spend. https://www.aafp.org/dam/AAFP/documents/advocacy/payment/apms/BKG-PrimaryCareSpend.pdf. Accessed January 20, 2020.
[10] Washington State Office of Financial Management. Primary Care Expenditures: Summary of current primary care expenditures and investment in Washington, a Report to the Legislature. Nov 22, 2019. https://www.ofm.wa.gov/pubs-reports/primary-care-expenditures-report-legislature. Accessed February 10, 2020.
[11] Patient-Centered Primary Care Collaborative. Spending for Primary Care. https://www.pcpcc.org/sites/default/files/resources/PCPCC%20Fact%20Sheet%20PC%20Spend%20Aug%202018.pdf. Accessed January 18, 2020.

deductibles are growing more than four times as fast.[12] Research shows rising consumer out-of-pocket costs are causing consumers to forgo care and/or insurance coverage altogether.[13]

The goal of Public Option Plans is to make health care more affordable for Washington residents and incentivize high-quality care, with an emphasis on primary care, starting with Washington's individual health insurance market. HCA is seeking to build meaningful mutually beneficial partnerships with Carriers across all populations for which it is responsible – including public employees, Medicaid eligible and Exchange enrollees – with a long term goals of improved population health (medical and social) and sustainable health care spending.

HCA intends to award one or more contracts for Public Option Plans in each county to provide the services described in this RFA for coverage beginning Plan Year 2021. Any contract awarded as a result of this RFA is contingent on approval from the OIC and certification from the HBE Board before execution.

This RFA does not prohibit an Apparent Successful Applicant (ASA) from also offering other health plans on the individual market.

## 1.4. BACKGROUND

### 1.4.1. Cascade Care

In 2019, the Washington State Legislature passed Engrossed Substitute Senate Bill (ESSB) 5526, known as Cascade Care.[14] The bill aims to increase availability of quality, affordable health coverage in the individual market in all counties of Washington State, by:

- Reducing deductible costs to residents, including providing more services before the deductible;
- Providing predictable cost sharing;
- Maximizing subsidies;
- Limiting adverse premium impacts;
- Reducing barriers to maintaining and improving health;
- Encouraging plan choice based on value, while limiting increases in health plan premium rates;
- Reducing administrative burden; and
- Incentivizing evidence-based care.

Under the Cascade Care legislation, beginning in Plan Year 2021 the Exchange will offer three types of QHPs; Non-Standard Plans (current offerings), Standard Plans, and Public Option Plans. Both Standard Plans and Public Option Plans are required to use the standard benefit design and will continue to meet the requirements of being a Qualified Health Plan (QHP). Carriers will be required to offer one Standard gold and one Standard silver Plan in each county in which they plan to participate. Carriers offering a Non-Standard bronze Plan must also offer a Standard bronze Plan in each county

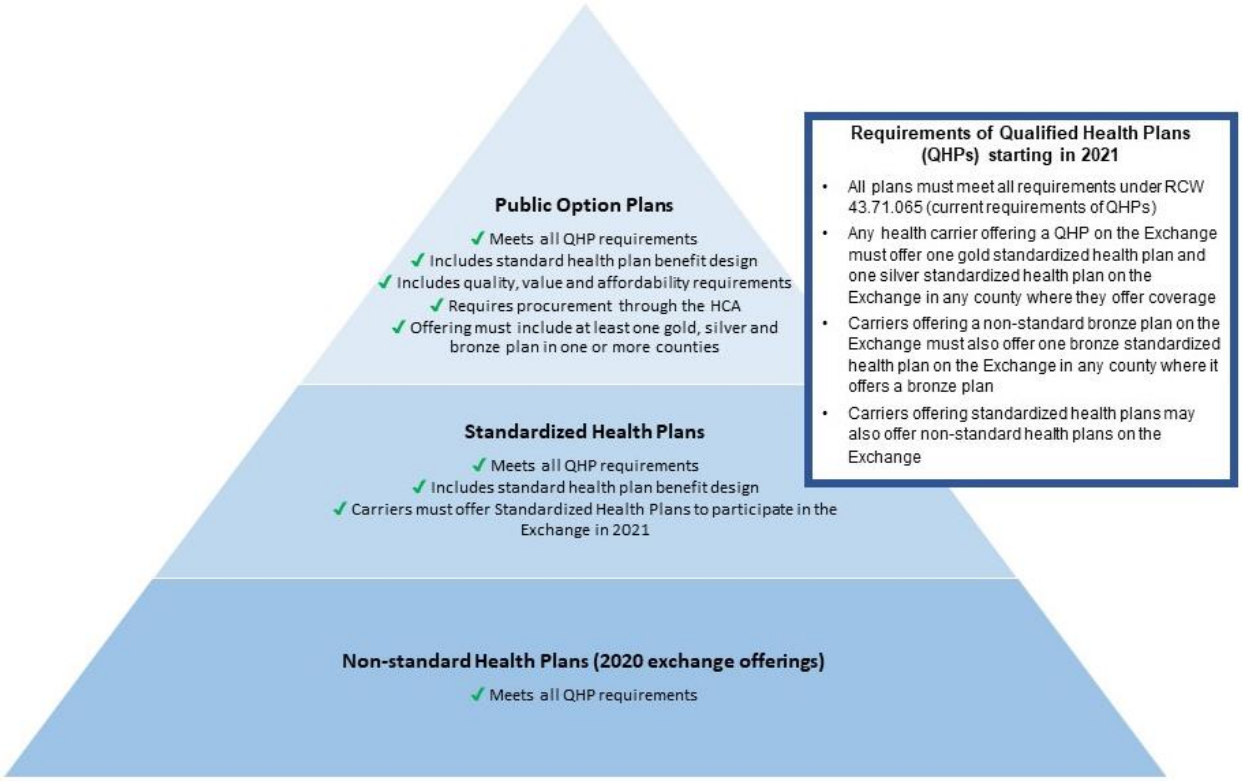
[12] Source: AHRQ Medical Expenditure Panel Survey –Insurance Component data for private-sector employees and individual plan premiums/deductibles; Federal Reserve Economic Data, Economic Research Division, Federal Reserve Bank of St. Louis data for real median personal income. Excerpt from Manatt webinar: "Blueprint for Building an Effective Statewide Healthcare Cost Benchmark: How Oregon and Other States can Build on the Massachusetts Model." Presented by Joel Ario, Kevin Casey McAvey, David Selz and Jeremy Vandehey, February 5, 2020.

[13] Collins SR, Bhupal HK, Doty MM. Health Insurance Coverage Eight Years after the ACA. The Commonwealth Fund, Feb 7, 2019. https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca. Accessed February 4, 2020.

[14] SB 5526: Increasing the availability of quality, affordable health coverage in the individual market - https://app.leg.wa.gov/billsummary?BillNumber=5526&Chamber=Senate&Year=2019

in which they intend to offer a bronze Plan. Offering the Public Option Plans meets the Carrier's obligation to offer a Standard Plan.

Chart 1: Summary of Qualified Health Plan Types to be Available beginning in Plan Year 2021




The table below outlines Cascade Care's three (3) main components:

| | Component | Lead Entity/Agency | Description | When | Progress to Date |
|---|---|---|---|---|---|
| 1 | Develop up to three Standardized Health Plans for gold, silver, and bronze levels | HBE in consultation with OIC, HCA and stakeholders<br><br>Two stakeholder groups formed to inform this work | Develop Benefit Design Plan packages for standardized health plans | Required for Standardized and Public Option Plans offered on the Exchange in 2021 | Benefit Designs for Standardized and Public Option Plans were approved by HBE Board December 5, 2019<br><br>Benefit Design Plans will be updated in Spring 2020 after release of final federal guidance with actuarial information<br><br>More information on final Benefit Design Plans and the stakeholder process can be found at the following link: https://www.wahbexchange.org/about-the-exchange/cascade-care-2021-implementation/ |
| 2 | Develop Public Option Plans to be offered on | HCA in consultation with HBE | Public Option Plans are required to include | Starting in 2021, offer at least one standardized | Selection of Public Option Plans administered through this RFA |

| | | | | | |
|---|---|---|---|---|---|
| | the Exchange in 2021 | | quality, value and affordability standards and will have the Standard Plan Benefit Design (Component #1) | health plan for each of the gold, silver and bronze levels anywhere Public Option Plans are offered on the Exchange | |
| 3 | Subsidy Study | HBE | HBE is directed to study and submit a plan for implementing premium subsidies through the Exchange for individuals at up to five-hundred (500) percent of the Federal Poverty Level (FPL) | The plan is due to the Legislature by November 15, 2020 | Work to develop this component will commence in Spring 2020 |

The Cascade Care legislation also requires HCA to submit a report and recommendations to the legislature on the impact of the public option procurement by December 1, 2022. This report will include information about market choice and affordability and recommendations on linking public option participation with participation in other programs administered by HCA for Carriers and providers.

### 1.4.2. Washington State Health Benefit Exchange – Overview and Current Landscape[15]

Providing a health benefit exchange is a key provision of the federal Patient Protection and Affordable Care Act (2010) that creates a new marketplace for each state to offer health and dental insurance coverage to individuals and families. Exchanges can be developed and implemented by the state or by the U.S. Department of Health and Human Services. Washington State chose to implement a state-based exchange.

The Washington Legislature created the Health Benefit Exchange (HBE) in 2011 as a public-private partnership. HBE is responsible for operating the Exchange, an easily accessible online marketplace for individuals and families to find, compare and enroll in QHPs, Qualified Dental Plans (QDPs) and Washington Apple Health (Medicaid). Washington residents will have the ability to choose and enroll in Public Option Plans through the Exchange beginning for Plan Year 2021.

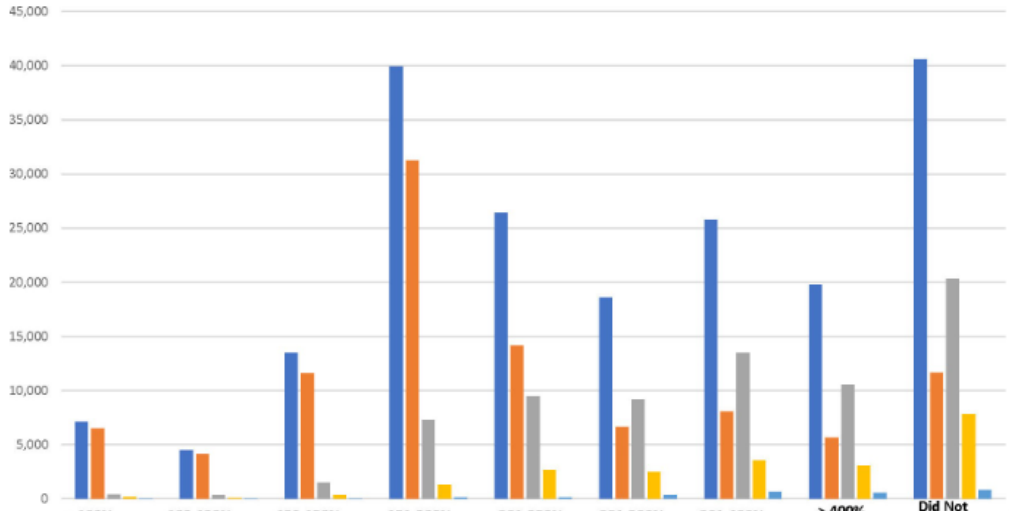
Current enrollment through the Exchange

As of January 2020, approximately 212,000 Washington residents selected a QHP through the Exchange, which is four (4) percent of the total insured population in Washington, accounting for approximately 41,000 new consumers and 171,000 returning *Washington Healthplanfinder* enrollees. The majority of enrollees are of working age, with a small

[15] All data points presented in this section provided by the HBE.

percentage over age sixty-four (64). Approximately 15,000 enrollees were below age nineteen (19). The majority (seventy-two (72) percent) of QHP households were single-member households, with the average household size being 1.3 members. In 2019, eleven (11) percent of enrollees selected a gold plan, fifty-one (51) percent selected a silver plan and thirty-seven (37) percent selected a bronze plan. The below graph provides a more detailed break out of plan selection by income.

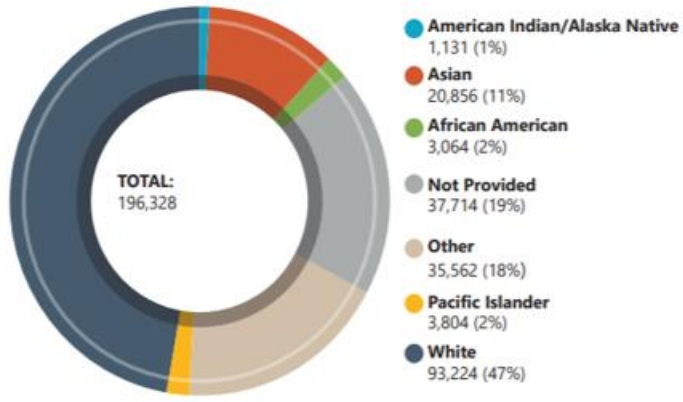
Graph 1: Federal Poverty Level (FPL) by Metal Tier




| FPL | < 100% | 100-138% | 139-150% | 151-200% | 201-250% | 251-300% | 301-400% | > 400% | Did Not Report | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Total | 7,104 | 4,519 | 13,492 | 39,942 | 26,427 | 18,603 | 25,811 | 19,804 | 40,626 | **196,328** |
| Silver | 6,479 | 4,109 | 11,612 | 31,279 | 14,156 | 6,635 | 8,081 | 5,629 | 11,662 | 99,642 |
| Bronze | 406 | 333 | 1,518 | 7,267 | 9,498 | 9,153 | 13,510 | 10,543 | 20,340 | 72,568 |
| Gold | 175 | 66 | 329 | 1,274 | 2,632 | 2,491 | 3,567 | 3,081 | 7,805 | 21,420 |
| Catastrophic | 44 | 11 | 33 | 122 | 141 | 324 | 653 | 551 | 819 | 2,698 |

The Exchange allows enrollees to self-report their race and ethnicity. Approximately eighty (80) percent of QHP enrollees self-reported information as shown in the below graph.

Graph 2: Exchange Enrollment by Race and Ethnicity




Reporting race/ethnicity is not required.
9,036 marked Hispanic | 132 marked Hawaiian | 841 marked Multi-Race

QHP Financial Assistance

Those applying for coverage through the Exchange may have access to federal financial assistance to help cover the cost of their monthly premium. Since October 2013, the Exchange has connected thousands of residents to federal subsidies to help them purchase and use their private coverage. In 2018, over $519 million in advance premium tax credits (APTCs) were obtained through *Washington Healthplanfinder*.

APTCs are available to individuals with income at up to four hundred (400) percent of the Federal Poverty Level (FPL) who meet other eligibility criteria under 45 CFR § 155.305. In addition to APTCs, eligible individuals with income up to two-hundred and fifty (250) percent FPL may enroll in plans with cost-sharing protections, reducing their out-of-pocket costs to receive care. Approximately sixty (60) percent of QHP enrollees receive APTCs, and approximately forty-five (45) percent are eligible for cost-sharing reduction plans. Forty (40) percent of QHP enrollees in Washington are not receiving APTCs which is currently the highest percentage in the nation.

Affordability of Health Insurance Options on the Exchange

Washington families and individuals purchasing health insurance through the Exchange and pay the full cost of their care saw premium increases on average of nearly fourteen (14) percent in 2019. Enrollees on the Exchange pay upwards of thirty-two (32) percent of their annual income solely on premiums with individuals in the qualifying income range who do not receive federal financial assistance most impacted. Those enrollees just over the threshold for federal assistance pay on average thirteen (13) percent of their income on premiums, compared to an average of ten (10) percent of income for those just below the qualifying income. In addition to premium costs, Exchange enrollees continue to face increasing out-of-pocket costs to seek care, with the prevalence of higher deductible plans increasing. In 2020, over fifty (50) percent of QHPs have a deductible over $5,000. In contrast, according to data from the Survey of Consumer Finances, the average American has just over $8,000 in annual savings – with a $5,000 deductible nearly wiping out a person's savings.[16] When looking at multiple person households, nearly sixty (60) percent are faced with a deductible of $9,000 or more, placing an even greater financial burden. Exchange enrollees lack the buying power (enjoyed by HCA and other large, self-insured purchasers) to negotiate discounts or lower out-of-pocket costs and prices.

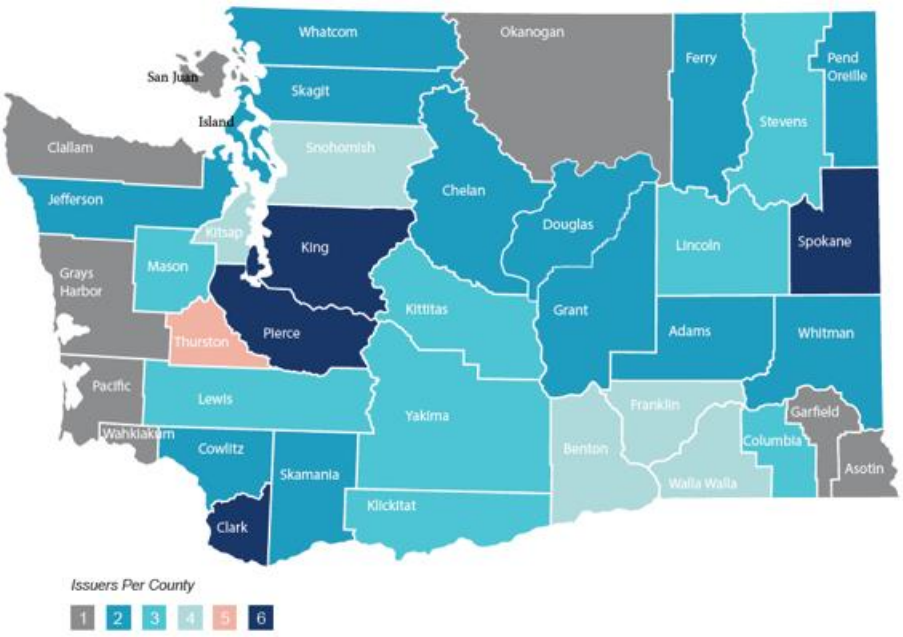
The cost of care heavily influences most customers' behavior on the Exchange, as evidenced through enrollment in 2020, where more customers chose bronze plans (plans with lower premiums but higher out-of-pocket costs). Also during the 2020 enrollment, more returning customers shopped for and switched to a lower priced option. In 2019, when consumers were surveyed about their reasons for dropping Exchange coverage: thirty-seven (37) percent reported "it didn't meet my budget." (Other answers included: fifty-three (53) percent found an alternative; four (4) percent moved out of Washington; three (3) percent said their plan did not cover prescriptions; and three (3) percent were other).

Current Qualified Health Plan (QHP) Offerings on the Exchange

In Plan Year 2020, nine (9) Carriers are offering QHP coverage through the Exchange through sixty-two (62) plans available across all thirty-nine (39) Washington counties. Offerings across counties range from single-Carrier counties to six-Carrier counties. Within a county, an enrollee may have between 4 and 35 health plan options. In 2020, all Carriers offered a bronze plan, giving more consumers the option of enrolling in a lower premium bronze plan. All QHPs are required to comply with federal requirements under 45 CFR § 155 and 45 CFR § 156 to meet state requirements.

[16] Board of Governors of the Federal Reserve System. Survey of Consumer Finances. https://www.federalreserve.gov/econres/scfindex.htm. Accessed February 11, 2020.

Chart 2: 2020 Number of Exchange Issuers by County




One Issuer:
Asotin, Clallam, Garfield, Grays Harbor, Okanogan, Pacific, San Juan, Wahkiakum

Two Issuers:
Adams, Chelan, Cowlitz, Douglas, Ferry, Grant, Island, Jefferson, Pend Oreille, Skagit, Skamania, Whatcom, Whitman

Three Issuers:
Columbia, Kittitas, Klickitat, Lewis, Lincoln, Mason, Stevens, Yakima

Four Issuers:
Benton, Franklin, Kitsap, Snohomish, Walla Walla

Five Issuers:
Thurston

Six Issuers:
Clark, King, Pierce, Spokane

Past Efforts to Increase Availability for Plan Options on the Exchange

In 2018, the Legislature passed Engrossed Substitute House Bill 2408 (Laws of 2018, Chapter 219). The bill requires Carriers covering state, school and Medicaid employees in any counties to offer at least one gold plan and one silver plan on the Exchange in those counties to help prevent "bare counties" (areas of the state without an insurance option on the Exchange). Contracts under HCA's School Employees Benefit Board (SEBB) program included this requirement beginning in 2020; all remaining fully insured contracts including HCA's Public Employee Benefit Board (PEBB) program will implement as contracts are revised.

### 1.4.3. Roles of HBE, HCA and OIC in Cascade Care Design and Implementation, per Legislation

HBE, OIC and HCA each have major roles in the development and implementation of the Public Option Plans.

- HBE, as described above, oversees *Washington Healthplanfinder*, the online enrollment portal where Washington residents will select and enroll in Public Option Plans. HBE also oversees the design and updating of the standard plan benefit design.

- The OIC is the state agency with regulatory oversight of the insurance industry. The OIC oversees Washington's insurance markets for the purpose of protecting consumers and ensuring companies, agents, and brokers follow applicable state and federal law. The OIC protects consumers, the public interest and the Washington economy through fair and efficient regulation of the insurance industry. The OIC oversees all health insurance Carriers operating in the commercial market in Washington, including those offering QHPs on the Exchange. Similar to the current QHP approval process, Public Option Plans selected by the HCA solicitation process will be required to receive final approval from the OIC for rates, forms, and network access. More information regarding OIC's health coverage filing instructions may be found at www.insurance.wa.gov/health-coverage-filing-instructions.

- HCA is a cabinet-level agency within Washington's executive branch and is governed by chapter 41.05 of the Revised Code of Washington (RCW) (among other applicable

laws). HCA procures and administers Apple Health (Medicaid and the Children's Health Insurance Program), the PEBB program, and the SEBB program for a total of two and half million (2.5m) Washingtonians. The Cascade Care legislation directs HCA in partnership with HBE to procure Public Option Plans beginning in Plan Year 2021 in an effort to align with the state's current value-based purchasing efforts.

## 1.5. HCA'S VALUE-BASED PURCHASING AND HEALTH TRANSFORMATION VISION

As the largest purchaser of health care in Washington, HCA is a recognized leader in transforming health and health care through value-based purchasing and payment strategies that reward better health, better care, and smarter spending. HCA's Value-based Purchasing efforts began in 2014 when the Legislature, through ESSB 2572, directed HCA to "increase the use of value-based contracting, alternative quality contracting, and other payment incentives that promote quality, efficiency, cost savings, and health improvement for Medicaid and public employee purchasing".

In 2014, Washington State's health transformation plan, led by HCA and supported by a four-year federal grant, proposed testing new models of care that drive population health improvements and fundamentally change how health care is provided and paid for. HCA produced its initial *Value-based Purchasing Roadmap* (VBP Roadmap) in June 2016 to outline a single approach to health care purchasing in alignment with HCA's health transformation projects.

The VBP Roadmap also articulates HCA's purchasing vision and goal: ninety (90) percent of provider payments under state-financed health care programs (Medicaid, PEBB and SEBB), and fifty (50) percent of provider payments in commercial health care arrangements will be linked to value by the end of 2021, as defined by Categories 2C through 4B. (*See* Appendix 1 – CMS Framework for Value-Based Payments of Alternative Payment Models (CMS LAN APM).

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

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

HCA's updated 2019 VBP Roadmap[17] is built on the following principles:

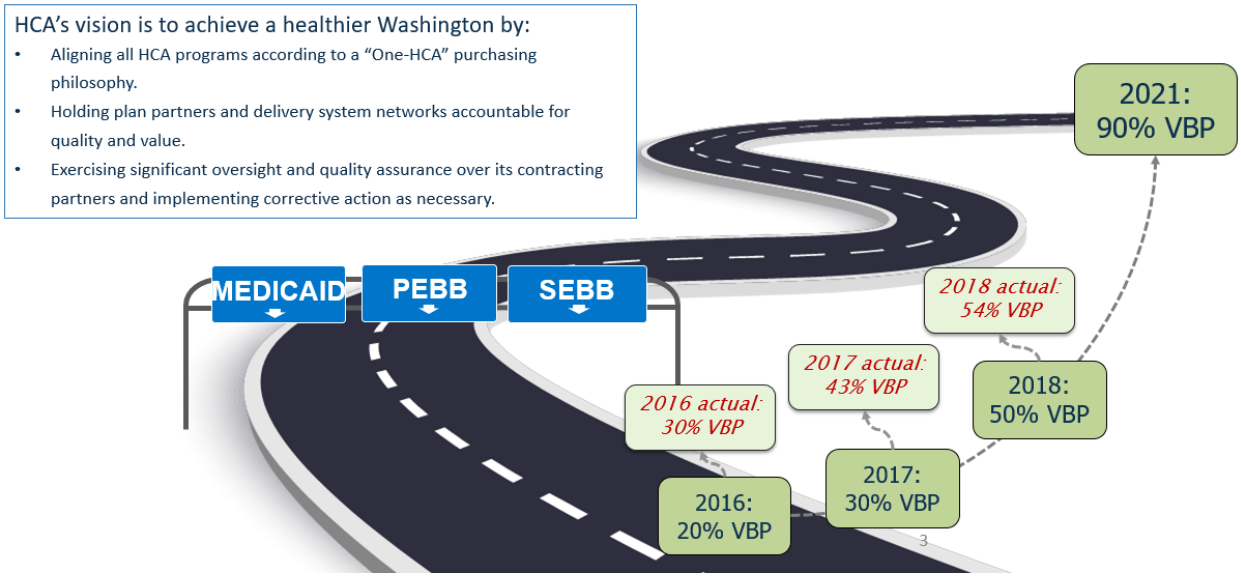
- Continually strive for lower costs, better outcomes, and better consumer and provider experience.
- Reward the delivery of patient-centered, high-value care and increased Quality Improvement.
- Reward HCA's Medicaid, PEBB, and SEBB Program health plans and their contracted providers according to performance on cost, quality, and patient experience.
- Align payment and delivery reform approaches with other purchasers and payers, where feasible, for greatest impact and to simplify implementation for providers.
- Drive standardization in clinical care based on evidence, including best-practice recommendations from the Bree Collaborative, and use standards to design benefits according to value.
- Increase long-term financial sustainability for state health programs.

[17] HCA VBP Roadmap link: https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf

### 1.5.1. **HCA's VBP Achievements**

As of 2018, HCA exceeded its VBP goal by four (4) percentage points, achieving fifty-four (54) percent of state-financed programs in VBP. HCA has also seen positive results across its value-based payment strategies, as described in the 2019 VBP Roadmap.

Chart 3: Health Care Authority Value-based Purchasing Roadmap Vision




### 1.5.2. **Next Steps in HCA's Value-based Purchasing Efforts**

HCA will continue to develop and implement new value-based payment and purchasing strategies, including strategies that recognize other non-medical elements of health, evolve existing value-based models of care, and leverage its purchasing power to drive statewide transformation and make health care more affordable. To achieve these strategies, HCA will continue to collaborate with Carriers, providers, Accountable Communities of Health and other purchasers where appropriate. In addition to value-based purchasing strategies, HCA will:

- Continue to seek ways to make health care more affordable for members of state-financed health care, building on past work that compared current PEBB and SEBB prices to Medicare;
- Continue working with Medicaid Managed Care Organizations (MCOs) and PEBB and SEBB Carriers to implement the contract requirement to measure Primary Care Expenditures in state-financed programs, which began in January 2020;
- Launch a comprehensive Washington State Primary Care Program with primary care providers and Carriers, which includes aligned quality metrics, value-based payment approaches, workforce support and sustainability, interoperability and analytics and practice transformation support;
- Create a Health Equity Roadmap to include strategies for addressing social determinants of health and build it into purchasing strategies;
- Work with rural communities to address community health and disparities to care; and
- Continue to align affordability, quality, and value strategies across Public Option Plans (offered in 2021 and in the future) and state-financed plans (Medicaid, PEBB and SEBB) through contracting arrangements.

## 1.6. CASCADE CARE PUBLIC OPTION QUALITY, VALUE, AND AFFORDABILITY STANDARDS

All Public Option Plans must include the quality, value, and affordability requirements outlined in Appendix 2. Input from the public comment period in December 2019 and January 2020 was carefully considered and standards were revised as a result.

### 1.6.1. Background

In accordance with RCW 41.05.410, Public Option Plans must follow the standard benefit design and meet additional quality, value, and affordability standards, including but not limited to the following:

- Meet all requirements under RCW 43.71.065, including requirements relating to rate review and network adequacy;
- Incorporate recommendations of the Dr. Robert Bree Collaborative[18] and the Health Technology Assessment program[19];
- Address affordability through:
    - A reimbursement ceiling for providers and facilities for all covered benefits in the statewide aggregate, excluding pharmacy benefits, not to exceed one-hundred sixty (160) percent of the total amount Medicare would have reimbursed providers and facilities for the same or similar services (because the ceiling is aggregate, certain providers may receive higher or lower reimbursements for services);
    - Reimbursement to Critical Access Hospitals (CAHs) and Sole Community Hospitals (SCHs) may not be less than one-hundred and one (101) percent of Medicare's allowable costs; and
    - Reimbursement for primary care services, defined by HCA, provided by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine, may not be less than one-hundred and thirty-five (135) percent of the amount that would have been reimbursed under Medicare for the same or similar services.
- Meet additional participation requirements that align with state agency value-based purchasing.

### 1.6.2. Public Option Plan Procurement Standards Design Process

Many of the quality and value standards and requirements applicable through state law to the Public Option Plans are current contract requirements of Medicaid MCOs and PEBB and SEBB Carriers.

HCA, HBE, and OIC considered demographics of populations likely to purchase Public Option Plans along with their health care patterns and utilization when designing the Public Option Plan standards and requirements (mainly the selection of the quality metrics). The requirements in current HCA contracts and HBE QHP standards were reviewed, and the operational impacts of recommended standards of Carriers and providers were considered.

HCA and HBE developed the following guiding principles to inform the design process:

- Strive to increase affordability and value, while aligning with state purchasing standards;

[18] The Dr. Robert Bree Collaborative is a group of health care leaders in Washington State that identifies and recommends evidence-based strategies for certain areas of health care services. More information can be found at http://www.breecollaborative.org/.
[19] The Health Technology Assessment program at HCA develops and makes available scientific, evidence-based reports on selected medical devices, procedures, and tests. More information can be found at https://www.hca.wa.gov/about-hca/health-technology-assessment.

- Recognize that success is dependent on Carrier and provider participation, and administrative barriers to participation should be minimized; and
- Program development and refinement will be a continual process, with the initial development laying the groundwork for future phase-in of requirements.

### 1.6.3. Public Option Affordability Reimbursement Methodology

The Cascade Care Pricing Methodology report provided in the affordability standards in Appendix 4 illustrates in detail how the Medicare Allowed Amount will be determined for different providers and service types.

## 1.7. WORKING WITH INDIAN HEALTH CARE PROVIDERS (IHCPs)

Applicants must reach out to tribes, Indian Health Service (IHS) facilities, and Urban Indian Health Programs (UIHPs) that offer services in each county in Washington in which they plan to participate and in out-of-state bordering cities (as defined in WAC 182-501-0175), including tribes with Contract Health Service Delivery Areas in those cities, to offer subcontracting arrangements. Applicants must recognize the sovereign status of the tribes that all Indian Health Care Providers (IHCPs) operate under and interact with all IHCPs in a manner that is respectful of this status and this responsibility.

As with other populations, the goal of Cascade Care is to increase access by American Indians/Alaska Natives (AI/AN) to services and to coordinate services provided by IHCPs with care provided outside the IHCP system. HCA does not intend to limit AI/AN access to services to IHCPs. It is up to the Applicant to provide information to IHCPs to ensure them that this program will benefit their members.

Carriers must comply with the laws and regulations that are applicable to the IHCPs.

## 1.8. PUBLIC OPTION PLANS IN *WASHINGTON HEALTHPLANFINDER*

HCA, HBE, and OIC understand the need to clarify for consumers the relevant differences between the three types of health plans that will be offered through the Exchange in 2021 (Public Option Plans, Standardized Plans, and Non-Standardized Plans), with the goal of minimizing confusion for consumers, highlighting the new features included in Public Option Plans and standardized plans, and conveying information necessary for consumers to make informed decisions about the best plan for their needs. HBE, in consultation with HCA and OIC, will develop logos, naming conventions, and other marketing standards that Carriers offering Public Option Plans will be required to adopt and apply. Those standards will be published by HBE in the Spring or Summer of 2020.

## 1.9. PROVIDER INCENTIVES – BUSINESS AND OCCUPATION (B&O) TAX EXEMPTION

In accordance with RCW 82.04.321, the state's business and occupation (B&O) tax is not imposed on the amounts that health care providers receive for services to Washington residents covered by Public Option Plan QHPs. In particular, the B&O tax is not imposed on payments received from the QHPs or any cost-sharing payments that the provider may receive. Public Option Plan Carriers will be required to revise the enrollee's insurance card to include a specific prefix in the member identification number to support the tax exemption as a benefit to their provider network, to be specified by HCA in contract.

## 1.10. OPTIONAL SAFE HARBOR TO FACILITATE PUBLIC OPTION PLAN OFFERINGS

HCA is offering a safe harbor to facilitate participation in year one by removing uncertainty and maximizing opportunities for bidding across geographic regions where costs vary. If an Applicant chooses the safe harbor, there is no penalty associated with retrospective review of the actual provider reimbursement. HCA will provide Applicants alternative reimbursement targets by OIC geographic rating area as designated in WAC 284-43-6701, based on 2018 market averages that meet Cascade Care's affordability requirement for a statewide reimbursement average of one-hundred and sixty (160) percent of Medicare reimbursement.

In order to participate in the safe harbor, Applicants must declare their participation in the optional safe harbor within their Letter of Intent (LOI) response as described in Section 2.3, *Letter of Intent to Apply,* and submit their Non-Disclosure Agreement (NDA) as described in Section 2.4, *Non-Disclosure Agreement (NDA).* After Applicants submit their LOI and return a signed NDA to HCA, the contracted actuary (Milliman) will send Medicare allowed reimbursement and payment target thresholds for provider payment. The target thresholds, by provider type (inpatient, outpatient and professional) are weighted based on projected enrollment in the OIC geographic rating area where proposed service areas are located.

For Applicants who responded to the HCA data modeling exercise in December 2019, the target reduction will be based on their individual experience. For Applicants who did not respond to the HCA data modeling exercise, the target reduction will be based on the individual market aggregate. To preserve confidentiality in some regions, individual market Carrier data is blended with HCA PEBB data, which did not result in a material change.

Applicants will attest that their projected reimbursement rates are equal to or below the target and will provide sample provider contracts as part of their Phase 2 response. If Applicants optionally agree to and meet the safe harbor, but subsequently do not meet the statewide reimbursement requirement, they will not be required to submit a corrective action plan. This process will be repeated again in Spring 2021 for Plan Year 2022.

Meaningful changes to the listing of the counties and/or enrollment information in which the applicant intends to participate, as provided through the LOI, will invalidate the reimbursement and payment target thresholds provided through the safe harbor and will eliminate the option to participate.

## 1.11. INCENTIVES FOR VALUE-BASED PAYMENT ARRANGEMENTS WITH PROVIDERS PROVIDED BY SAFE HARBOR

For Applicants that take advantage of the optional safe harbor, HCA will provide additional flexibility through adjusted safe harbor reimbursement targets to reward Carriers with Value-based Payments arrangements with providers for their Public Option Plans. Applicants will qualify for the VBP-adjusted safe harbor reimbursement targets if at least thirty (30) percent of provider payments in each Public Option Plan are in CMS LAN Categories 2C to 4B as demonstrated through the sample contracts provided in the Phase 2 response.

## 1.12. HCA'S VERIFICATION OF APPARENT SUCCESSFUL APPLICANTS' OIC RATES

In September 2020, as outlined in Section 1.2, *Estimated Schedule of Solicitation*, the OIC will provide HCA and HBE with confirmation of Public Option Plans that meet OIC's final rate approval. HBE will then complete their certification process identifying health plans meeting HBE's requirements for hosting on the Exchange.

HCA will verify that the ASA's OIC final approved rates resulted in a premium savings as provided in the ASA's submission of planned premium rates in Section 3.3, *Phase 2 Response – Proposed Service Areas and Affordability Strategies*, Phase 2 Section 1. Following the verification, HCA will execute contracts for Public Option Plans that meet the program goals outlined in Section 1.4.1, including a decrease in premium rates and savings, as solely defined by HCA.

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

## 1.13. ANNUAL VALIDATION AND RENEWAL PROCESS

On an annual basis (on or around August of each calendar year) HCA will conduct a validation and renewal process for existing Public Option Plans. Through the annual process, HCA will assess and adjust the Public Option Plans in the following areas:

1.13.1. Validating the quality and value components to ensure they have met required standards: Carriers are expected to provide reports, complete surveys and develop plans to meet the quality and value requirements as outlined in Appendix 2. Value and quality requirements include but are not limited to select Bree Recommendations, HTA decisions, quality measures and implementation of APMs and other VBP strategies.

1.13.2. The methodology under which affordability will be assessed is provided in Appendix 4.

1.13.3. Validation will take into account the optional safe harbor and/or value-based payment safe harbor adjustments as outlined in Section 1.10, *Optional Safe Harbor to Facilitate Public Option Plan Offerings*, and Section 1.11, *Incentives for Value-Based Payment Arrangements with Providers Provided by Safe Harbor*.

Initially, Applicants will be required to submit claims data and/or contracted unit cost information for their Public Option Plan provider network. Over time, to minimize administrative burden, HCA intends to explore other data sources including but not limited to the All Payer Claims Database (APCD). HCA may also explore other methodologies that demonstrate increased affordability. These methods may include, but are not limited to, offering Public Option Plans that provide actuarially sound premiums that are at least ten (10) percent lower than the previous Plan Year.

1.13.4. Addressing requirements gaps: Upon assessing the quality, value and affordability standards, HCA will provide a report to the Carrier confirming standards were met and/or outlining areas where improvement is needed. If improvement is needed, the Carrier will be required to develop a plan to demonstrate how and when they will close the gap in meeting the required standards.

1.13.5. Expanding quality and value standards: HCA will review and refine the Public Option Plan quality and value components. This approach allows standards to evolve and provides a mechanism of continual improvement and alignment with current state agency value-based purchasing. Examples may include incorporating additional Bree recommendations and VBP strategies or common measures. Additional components may be added including standards for population health management; high-value, proven care; health equity; primary care; care coordination and chronic disease management; wellness and prevention; prevention of wasteful and harmful care; and patient engagement.

The HBE and OIC will continue to conduct their annual processes including HBE's process to update the standard benefit design and annual plan certification, and the OIC's process to review and approve the rates, forms, and network access of health plans. HCA will continue to align with these processes.

## 1.14. MINIMUM QUALIFICATIONS

This RFA is open to Applicants that satisfy the following minimum qualifications:

1.14.1. Must be a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020. *See generally* RCW 48.43.005(27). An Applicant can provide documented proof of being in the process of becoming a Carrier.

1.14.2. Must be a Public Option Plan that meets all current and agrees to meet all future HBE certification requirements as outlined in QHP Guidance documents, including, but not limited to, all OIC requirements for participation in the individual market in Washington.

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

## 1.15. PERIOD OF PERFORMANCE

Contracts are estimated to be executed in September 2020 in order to begin contracted terms for open enrollment starting on November 1, 2020. The Coverage Start Date is January 1, 2021 and will extend through December 31, 2022.

HCA reserves the right, in its sole discretion, to extend the contract for two (2) periods of two (2) years each.

## 1.16. CONTRACTING WITH CURRENT OR FORMER STATE EMPLOYEES

Specific restrictions apply to contracting with current or former state employees pursuant to RCW 42.52. Applicants should familiarize themselves with the requirements prior to submitting an application that includes current or former state employees.

## 1.17. ADA

HCA complies with the Americans with Disabilities Act (ADA). Applicants may contact the RFA Coordinator to receive written information in another format (e.g., large print, audio, accessible electronic formats and other formats).

# 2. GENERAL INFORMATION FOR APPLICANTS

## 2.1. RFA COORDINATOR

The RFA Coordinator is the sole point of contact in HCA for this solicitation. All communication between the Applicant and HCA upon release of this RFA must be with the RFA Coordinator, as follows:

| | |
|---|---|
| RFA Coordinator | Laura Shayder |
| E-Mail Address | HCAProcurements@hca.wa.gov |

Any other communication will be considered unofficial and non-binding on HCA. Applicants are to rely only on written statements issued by the RFA Coordinator. Communication directed to parties other than the RFA Coordinator may result in disqualification of the Applicant.

## 2.2. PRE-SOLICITATION CONFERENCE (OPTIONAL)

A pre-solicitation conference is scheduled to be held on March 20, 2020 at 11:00 a.m. – 12:00 p.m. Pacific Time via conference phone call. All prospective Applicants should attend; however, attendance is not mandatory. Applicants who submit a Letter of Intent by the date described in Section 1.2, *Estimated Schedule of Solicitation*, will be provided call-in information by the RFA Coordinator.

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

## 2.3. LETTER OF INTENT TO APPLY (MANDATORY)

Applicants must submit a Letter of Intent (LOI) to be eligible to submit an Application in response to this RFA.

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

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

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

2.3.1. Applicant's Organization Name;

2.3.2. Applicant's authorized representative for this RFA (who must be named the authorized representative identified in the Applicant's Application);

2.3.3. Title of authorized representative;

2.3.4. Address, telephone number, and email address;

2.3.5. Statement of intent to apply;

2.3.6. Listing of the counties in which the applicant intends to participate with anticipated Plan Year 2021 enrollment;

2.3.7. Statement confirming whether Applicant is going to participate in the safe harbor as described in Section 1.10., *Optional Safe Harbor to Facilitate Public Option Plan Offerings*; and

2.3.8. Description of how the Applicant meets all of the Minimum Qualifications (see Section 1.14, *Minimum Qualifications*).

Applicants who do not submit an LOI will be disqualified from further consideration.

## 2.4. **NON-DISCLOSURE AGREEMENT (NDA)**

After Applicants have submitted an LOI, Applicants interested in safe harbor provisions must submit a Non-Disclosure Agreement (NDA), located in Exhibit E in order to receive data regarding the benchmark percent of Medicare ranges by geographic rating area that Applicants may use to meet the safe harbor provisions. The sooner the Applicant returns the NDA, the sooner they may be provided access to the safe harbor information.

The Applicant's signed NDA must be emailed to the RFA Coordinator, listed in Section 2.1., *RFA Coordinator* and must be received by the RFA Coordinator in order to receive the data from HCA's actuary. The subject line of the email must include the following: [Application #] – NDA – [Your entity's name].

The NDA may be attached to the email as a separate document, in Word or PDF.

## 2.5. **SUBMISSION OF APPLICATIONS**

The application must be received by the RFA Coordinator no later than the Applicants' Phase 1 Response Due deadline in Section 1.2, *Estimated Schedule of Solicitation*.

Applications must be submitted electronically as an attachment to an e-mail to the RFA Coordinator at the e-mail address listed in Section 2.1. *RFA Coordinator*. Attachments to e-mail should be in Word format or PDF. Zipped files cannot be received by HCA and cannot be used for submission of applications. The cover submittal letter and the Certifications and Assurances form must have a scanned signature of the individual within the organization authorized to bind the Applicant to the offer. HCA does not assume responsibility for problems with Applicant's e-mail. If HCA e-mail is not working, appropriate allowances will be made.

Applications may not be transmitted using facsimile transmission.

Applicants should allow sufficient time to ensure timely receipt of the application by the RFA Coordinator. Late applications will not be accepted and will be automatically disqualified from further consideration, unless HCA e-mail is found to be at fault. All applications and any accompanying documentation become the property of HCA and will not be returned.

## 2.6. **PROPRIETARY INFORMATION / PUBLIC DISCLOSURE**

Applications submitted in response to this RFA will become the property of HCA. All applications received will remain confidential until the ASA is announced; thereafter, the applications will be deemed public records as defined in RCW 42.56.

Any information in the application that the Applicant desires to claim as proprietary and exempt from disclosure under RCW 42.56 (or other state or federal law that provides for the nondisclosure of all or part of a document) must be clearly designated. The information must be clearly identified and the particular exemption from disclosure upon which the Applicant is making the claim must be cited. Each page containing the information claimed to be exempt from disclosure must be clearly identified

by the words “Proprietary Information” printed on the lower right-hand corner of the page. Marking the entire application exempt from disclosure or as Proprietary Information will not be honored.

As described in RCW 42.56.650(2) any data submitted by health Carriers to HCA for the purposes of RCW 41.05.410 is exempt from disclosure.

If a public records request is made for information the Applicant has marked as “Proprietary Information,” HCA will notify the Applicant of the request and of the date the records will be released to the requester unless the Applicant obtains a court order enjoining that disclosure. If the Applicant fails to obtain a court order enjoining disclosure, HCA will release the requested information on the date specified. If the Applicant obtains a court order from a court of competent jurisdiction enjoining disclosure pursuant to RCW 42.56 (or other applicable state or federal law), HCA will comply with the court order.

For public records requests, HCA charges for copying and shipping, in accordance with RCW 42.56.120 and WAC 182-04-045. No fee will be charged for the inspection of contract files, but 24 hours’ notice to the RFA Coordinator is required. All requests for information should be directed to the RFA Coordinator.

The submission of any public records request to HCA pertaining in any way to this RFA will not affect the solicitation schedule, as outlined in Section 1.2, *Estimated Schedule of Solicitation* unless HCA, in its sole discretion, determines that altering the schedule would be in HCA’s best interests.

## 2.7. **REVISIONS TO THE RFA**

HCA reserves the right to amend this RFA at any time prior to the award of any Contract. HCA will post any RFA amendments to WEBS, at https://fortress.wa.gov/ga/webs/. In addition to posting to WEBS, HCA may also, but is not obligated to post amendments to its internet page located at http://www.hca.wa.gov/about-hca/bids-and-contracts, and/or directly email amendments to Applicants that have expressed an interest in submitting an Application.

HCA also reserves the right to request additional information to determine if the Applicant can successfully meet the requirements of the RFA.

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

HCA reserves the right to cancel or to reissue the RFA in whole or in part, prior to execution of a Contract. HCA further reserves the right to not enter into any Contract in connection with this RFA.

## 2.8. **ACCEPTANCE PERIOD**

Applicant agrees that its response, attached hereto, is a firm offer which cannot be withdrawn for a period of one-hundred and eighty (180) days from and after the response due date specified in the Section 1.2, *Estimated Schedule of Solicitation*. HCA may accept such response, with or without further negotiation, at any time within such period. In the event of a protest, Applicant’s response shall remain valid for such period or until the protest and any related court action is resolved, whichever is later.

## 2.9. **COMPLAINT PROCESS**

2.9.1. Applicants may submit a complaint to HCA based on any of the following reasons (but no others):

2.9.1.1. The RFA unnecessarily restricts competition;

2.9.1.2. The RFA evaluation or scoring process is unfair or unclear; or

2.9.1.3. The RFA requirements are inadequate or insufficient to prepare a response.

2.9.2. A complaint must be submitted to HCA at least five business days before the application response deadline. The complaint must:

2.9.2.1. Be in writing;

2.9.2.2. Be sent to the RFA Coordinator in a timely manner;

2.9.2.3. Clearly articulate the basis for the complaint; and

2.9.2.4. Include a proposed remedy.

The RFA Coordinator will respond to the complaint in writing. The response to the complaint and any changes to the RFA will be posted on WEBS. The Director of HCA will be notified of all complaints and will be provided a copy of HCA's response.

HCA's action or inaction in response to a complaint will be final; there will be no appeal process.

As part of any application protest, an Applicant or potential Applicant cannot raise any issue that the Applicant or potential Applicant raised in a complaint or could have raised in a complaint.

## 2.10. RESPONSIVENESS

The RFA Coordinator will review all applications to determine compliance with administrative requirements and instructions specified in this RFA. An Applicant's failure to comply with any part of the RFA may result in rejection of the application as non-responsive.

HCA also reserves the right at its sole discretion to waive minor administrative irregularities.

## 2.11. MOST FAVORABLE TERMS

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

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

The ASA should be prepared to accept this RFA for incorporation into a contract resulting from this RFA. The contract resulting from this RFA will incorporate some, or all, of the Applicant's application. The application will become a part of the official solicitation file on this matter without obligation to HCA.

## 2.12. CONTRACT AND GENERAL TERMS & CONDITIONS

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

If, after the announcement of the ASA, and after a reasonable period of time, the ASA and HCA cannot reach agreement on acceptable terms for the Contract, HCA may cancel the selection and award the Contract to the next most qualified Applicant(s). HCA also reserves the right to not enter into any contract with any Applicant.

## 2.13. CONTRACT DELAY CONTINGENCY

If the Coverage Start Date under a Contract is delayed for any reason, HCA reserves the right to terminate the Contract at its sole discretion. HCA may also choose to make a good faith effort to maintain the contractual relationship and to amend the Contract as necessary to address the delay.

## 2.14. COSTS TO PROPOSE

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

## 2.15. RECEIPT OF INSUFFICIENT NUMBER OF APPLICATIONS

If HCA receives only one responsive application as a result of this RFA, HCA reserves the right to either: 1) directly negotiate and contract with the Applicant; or 2) not award any contract at all. HCA may continue to have the Applicant complete the entire RFA. HCA is under no obligation to tell the Applicant if it is the only Applicant.

## 2.16. NO OBLIGATION TO CONTRACT

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

## 2.17. REJECTION OF APPLICATIONS

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

## 2.18. COMMITMENT OF FUNDS

The Director of HCA or his/her delegate is the only individual who may legally commit HCA to the expenditures of funds for a contract resulting from this RFA. No cost chargeable to the proposed contract may be incurred before receipt of a fully executed contract.

## 2.19. INSURANCE COVERAGE (AS REQUIRED)

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

The ASA must, at its own expense, obtain and keep in force insurance coverage which will be maintained in full force and effect during the term of the contract. The ASA must furnish evidence in the form of a Certificate of Insurance that insurance will be provided, and a copy must be forwarded to HCA within 15 days of the contract effective date.

### 2.19.1. Liability Insurance

2.19.1.1. Commercial General Liability Insurance: ASA will maintain commercial general liability (CGL) insurance and, if necessary, commercial umbrella insurance, with a limit of not less than $1,000,000 per each occurrence. If CGL insurance contains aggregate limits, the General Aggregate limit must be at least twice the "each occurrence" limit. CGL insurance must have products-completed operations aggregate limit of at least two times the "each occurrence" limit. CGL insurance must be written on ISO occurrence from CG 00 01 (or a substitute form providing equivalent coverage). All insurance must cover liability assumed under an insured contract (including the tort liability of another assumed in a business contract), and contain separation of insureds (cross liability) condition.

Additionally, the ASA is responsible for ensuring that any subcontractors provide adequate insurance coverage for the activities arising out of subcontracts.

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

2.19.2. Employers Liability ("Stop Gap") Insurance

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

2.19.3. Cyber-Liability Insurance / Privacy Breach Coverage. For the purposes of this section the following definitions apply:

**Breach –** means the unauthorized acquisition, access, use, or disclosure of Data shared under any resulting Contract that compromises the security, confidentiality, or integrity of the Data.

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

**Data –** means information that is disclosed or exchanged between HCA and ASA. Data includes Confidential Information.

**Personal Information –** means information identifiable to any person, including but not limited to, information that relates to a person's name, health, finances, education, business, use, or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver's license numbers, credit card numbers, any other identifying numbers, and any financial identifiers.

**Protected Health Information (PHI) –** means information that relates to the provision of health care to an individual, the past, present, or future physical or mental health or condition of an individual, the past, present, or future payment for provision of health care to an individual. PHI includes demographic information that identifies the individual or about which there is reasonable basis to believe, can be used to identify the individual. PHI is information transmitted, maintained, or stored in any form or medium. PHI does not include education records covered by the Family Educational Right and Privacy Act, as amended.

For the term of any resulting Contract and three (3) years following its termination or expiration, ASA must maintain insurance to cover costs incurred in connection with a security incident, privacy Breach, or potential compromise of Data, including:

2.19.3.1. Computer forensics assistance to assess the impact of a Data Breach, determine root cause, and help determine whether and the extent to which notification must be provided to comply with Breach notification laws;

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

2.19.3.3. Breach resolution and mitigation services for individuals affected by a security incident or privacy Breach, including fraud prevention, credit monitoring, and identity theft assistance; and

2.19.3.4. Regulatory defense, fines, and penalties from any claim in the form of a regulatory proceeding resulting from a violation of any applicable privacy or security law(s) or regulation(s).

2.19.4. Additional Provisions

Above insurance policy must include the following provisions:

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

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

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

2.19.4.4. Insurance Carrier Rating. All insurance and bonds should be issued by companies admitted to do business within the state of Washington and have a rating of A-, Class VII or better in the most recently published edition of Best's Reports. Any exception must be reviewed and approved by the Health Care Authority Risk Manager, or the Risk Manager for the state of Washington, before the contract is accepted or work may begin. If an insurer is not admitted, all insurance policies and procedures for issuing the insurance policies must comply with chapter 48.15 RCW and 284-15 WAC.

2.19.4.5. Excess Coverage. By requiring insurance herein, the state does not represent that coverage and limits will be adequate to protect ASA, and such coverage and limits will not limit ASA's liability under the indemnities and reimbursements granted to the state in this Contract.

2.19.5. Workers' Compensation Coverage

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

# 3. APPLICATION CONTENTS

Applications must be written in English and submitted electronically to the RFA Coordinator in the order noted below:

**Due at the time of Applicant's Phase 1 Response:**

A. Letter of Submittal (See Section 3.1)
B. Phase 1 Response (See Section 3.2); including:
    a. Applicant's Proposed Service Area(s) (Exhibit C to this RFA)
    b. Attestation of Standards (Exhibit D to this RFA)
    c. HTTC Decisions Matrix (Exhibit F to this RFA)
C. Certifications and Assurances (Exhibit A to this RFA)
D. Executive Order 18-03 (Exhibit B to this RFA)

**Due at the time of Applicant's Phase 2 Response (for those Applicants who pass Phase 1):**

A. Phase 2 Response (See Section 3.3); including:
    a. Premium Rates
    b. Value-based Payment Arrangements and Sample Contracts

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

Items marked "mandatory" must be included as part of the application for the application to be considered responsive; however, these items are not scored. Items marked "scored" are those that are awarded points as part of the evaluation conducted by the evaluation team.

## 3.1. LETTER OF SUBMITTAL (MANDATORY)

The Letter of Submittal and the attached Certifications and Assurances form (Exhibit A to this RFA) must be signed and dated by a person authorized to legally bind the Applicant to a contractual relationship, e.g., the President or Executive Director if a corporation, the managing partner if a partnership, or the proprietor if a sole proprietorship. Along with introductory remarks, the Letter of Submittal is to include by attachment the following information about the Applicant and any proposed subcontractors:

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

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

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

3.1.4. Federal Employer Tax Identification number or Social Security number and the Washington Uniform Business Identification (UBI) number issued by the state of Washington Department of Revenue. If the Applicant does not have a UBI number, the Applicant must state that it will become licensed in Washington within 30 Calendar Days of being selected as the ASA.

3.1.5. Location of the facility from which the Applicant would operate.

3.1.6. Identify any state employees or former state employees employed or on the firm's governing board as of the date of the application. Include their position and responsibilities within the Applicant's organization. If following a review of this information, it is determined by HCA that a conflict of interest exists, the Applicant may be disqualified from further consideration for the award of a contract.

3.1.7. Any information in the application that the Applicant desires to claim as proprietary and exempt from disclosure under the provisions of RCW 42.56, or any other applicable law, must be clearly designated. The page must be identified and the particular exemption from disclosure upon which the Applicant is making the claim must be listed. Each page claimed to be exempt from disclosure must be clearly identified by the word "Proprietary Information" printed on the lower right hand corner of the page. In your Letter of Submittal, please list which pages and sections that have been marked "Proprietary Information" and the particular exemption from disclosure upon which the Applicant is making the claim.

## 3.2. PHASE 1 RESPONSE – (MANDATORY/SCORED)

Please limit responses to twenty (20) double-sided pages, minimum 10 font size, excluding any requested charts, tables, samples, etc.

**Section 1**

1. Applicant's Proposed Service Area(s) and projected enrollment for each county (97 points maximum available)

   Complete Exhibit C, Applicant's Proposed Service Area(s).

**Section 2**

1. Quality and Value Strategies

   a. Bree Collaborative (15 points maximum available)

      Describe actions and steps your organization has already taken to implement the five mandatory Bree Collaborative topics identified in Appendix 2, *Value, Quality and Affordability Requirements*, as well as any planned activities for 2020. In your response please describe how you track your progress and the tools, resources and supports your organization offers to providers to support their implementation of these topics and of Bree recommendations in general.

   b. HTA Program (10 points maximum available)

      Does your organization have its own evidence-based coverage decision process for new technologies? If yes, please describe and include the length of time the process has been in place and how coverage decisions are implemented.

   c. Value-based Payment and Integrated Care Strategies (20 points maximum available)

      i. Does your proposed network(s) in any of your proposed Public Option Plans include one or multiple integrated delivery systems?

ii. Does your proposed network include any Clinically Integrated Networks in your Public Option Plans? If yes, please list the name of the network, major network providers, and the network service area.

iii. Does your organization offer any health plans that are CMS-certified "Other Payer Advanced APMs" in 2018 or 2019? If so, how many?

2. American Indian/Alaska Native (5 points maximum available)

   a. Describe how you will ensure choice to enrollees who are American Indians/Alaska Natives, through access to covered medical and behavioral health services and referred services provided by or referred by Indian health care providers. Carriers must ensure that such enrollees may obtain covered medical and behavioral health services from the Indian health care provider at no greater than in-network cost.

   b. Describe how you will reach out to every tribe, IHS facility, and UIHP that offers services in each county in Washington in which you plan to participate and in out-of-state bordering cities, (as defined in WAC 182-501-0175), including tribes with Contract Health Service Delivery Areas in those cities, to offer subcontracting arrangements. Be sure to include how you will maintain relationships with contracted and non-contracted IHCPs, obtain training on the Indian health care delivery system and comply with HBE's Sponsorship Policy as it applies to tribal sponsors.

3. Business and Occupation Tax Exemption (5 points maximum available)

   Describe how you plan to help providers identify amounts received for services provided through the Public Option Plan beginning in Plan Year 2021. Include a plan to revise the insurance card for enrollees to include a specific prefix in the member identification number.

**Section 3**

1. Attestation of Standards (10 points maximum available)

   Applicants are to complete Exhibit D, Attestation of Standards.

**Section 4**

1. HTA Coverage Decisions (8 points maximum available)

   Applicants are to complete the HTCC Decisions Matrix located in Exhibit F, *HTTC Decisions Matrix*, providing information in Columns F & G in order to establish baseline levels of compliance.

## 3.3. PHASE 2 RESPONSE – PROPOSED SERVICE AREAS AND AFFORDABILITY STRATEGIES (MANDATORY/SCORED)

Phase 2 is Mandatory/Scored for Applicants who pass Phase 1.

Please limit responses to ten (10) pages double-sided pages, minimum 10 font size, excluding any requested charts, tables, samples, etc.

**Section 1**

**Premium Rates** (90 points maximum available)

Applicants are to provide their planned premium rates for a 40-year-old, non-smoker for Plan Year 2021 Public Option Plans at the gold, silver, and bronze metal levels for each county in which the Applicant intends to participate as indicated in their Phase 1 submission. Applicants are to describe how their premium rates meet one or more of the following three affordability options:

1. Each Public Option Plan must have an actuarially sound proposed premium rate that is at least five (5) percent lower than the Applicant's lowest-cost plan of same metal level in Plan Year 2020.

2. Each Public Option Plan must have an actuarially sound proposed premium rate that is at least ten (10) percent lower than the proposed rate of their standard (non-Public Option) plan of same metal level for Plan Year 2021. If a non-Public Option Standard Plan for Plan Year 2021 is not proposed, each Public Option Plan must have a proposed premium rate that is at least ten (10) percent lower than the proposed rate of Applicant's lowest-premium plan at the same metal level for Plan Year 2021.

3. For an Applicant that did not participate in the individual market in Plan Year 2020 and does not propose a non-Public Option Standard Plan, the Applicant must have a Public Option Plan that has an actuarially sound proposed premium rate that is at least equal to, or lower than, the new Carrier benchmark premium rate. The new Carrier premium threshold is equivalent to five (5) percent below the average individual market premium of the same metal level in Plan Year 2020 for each county, listed in Appendix 3.

**Section 2**

**Value-based Payment Arrangements and Sample Contracts** (80 points maximum available)

Please provide at least seventy-five (75) percent of all of the Applicant's current 2021 Public Option Plan Year provider contracts submitted to and approved by the OIC for the counties proposed during Phase 1. With the Applicant's example contracts, include an explanation of how they demonstrate Value-Based payment arrangements and unit cost reductions in contracting with providers.

Confirm whether at least thirty (30) percent of the Applicant's 2021 Plan Year provider contracts for Public Option Plans include Value-Based payment arrangements as defined by CMS LAN Categories 2C to 4B. Applicants are to confirm Yes/No.

## 3.4. EXECUTIVE ORDER 18-03 (MANDATORY/SCORED)

Pursuant to RCW 39.26.160(3) and consistent with Executive Order 18-03 – Supporting Workers' Rights to Effectively Address Workplace Violations (dated June 12, 2018), HCA will evaluate applications for best value and provide an application preference in the amount of 20 points to any Applicant who certifies, pursuant to the certification attached as Exhibit B, that their firm does NOT require its employees, as a condition of employment, to sign or agree to mandatory individual arbitration clauses or class or collective action waiver. Applicants that do require their employees, as a condition of employment, to sign or agree to mandatory individual arbitration clauses or class or collective action waiver will not be disqualified evaluation of this RFA, however they will receive 0 out of 20 points for this section.

# 4. EVALUATION AND CONTRACT AWARD

## 4.1. EVALUATION PROCEDURE

Responsive Applications will be evaluated strictly in accordance with the requirements stated in this RFA and any addenda issued. The evaluation of applications will be accomplished by an evaluation team(s) made up of representatives of HCA and HBE designated by HCA, which will determine the ranking of the applications. Evaluations will only be based upon information provided in the Applicant's Application.

All applications received by the stated deadline, Section 1.2, *Estimated Schedule of Solicitation*, will be reviewed by the RFA Coordinator to ensure that the Applications contain all of the required information requested in the RFA. Only responsive Applications that meet the requirements will be evaluated by the evaluation team. Any Applicant who does not meet the stated qualifications or any Application that does not contain all of the required information will be rejected as non-responsive.

The RFA Coordinator may, at his or her sole discretion, contact the Applicant for clarification of any portion of the Applicant's Application. Applicants should take every precaution to ensure that all answers are clear, complete, and directly address the specific requirement.

Responsive Applications will be reviewed and scored by an evaluation team using a weighted scoring system, Section 4.2, *Evaluation Weighting and Scoring*. Applications will be evaluated strictly in accordance with the requirements set forth in this RFA and any addenda issued.

## 4.2. EVALUATION WEIGHTING AND SCORING

### A. Phase 1 Scoring

Applicants must pass Phase 1 in order to advance to Phase 2. For an Applicant to advance to Phase 2, they must receive at least one point or receive at least a score of one (1) for each question in each Section of Phase 1.

Phase 1 Section 1 – Scoring

Applicants will receive the points associated with each county for which they confirm "Yes" within Exhibit C, *Applicant's Proposed Service Area* AND provide the associated county's description of building a network AND provide the enrollment data for the associated county. The points received will be summed to determine the Applicant's score.

Phase 1 Section 2 – Scoring

Each question under Phase 1 Section 2 has been assigned a weight factor as shown in the Evaluation Table below. Points will be assigned to each question by the evaluators based upon the scoring matrix in Section 4.3, *Scoring Methodology for Phase 1 - Section 2*. The assigned points will be multiplied by the weight to determine the awarded points. The RFA Coordinator will compute the Applicant's final score for this section by totaling the question scores from all evaluators and then averaging.

Phase 1 Section 3 – Scoring

Applicants who complete Exhibit D, Attestation of Standards, with all "Yes" responses will receive the full 10 points; Applicants who complete Exhibit D, Attestation of Standards with any "No" responses will receive 0 points.

Phase 1 Section 4 – Scoring

Applicants who complete Exhibit F, *HTTC Decisions Matrix,* with information in all requested cells of Columns F & G will receive 8 points; Applicants who do not complete all requested fields will receive 0 points.

The resulting Phase 1 maximum points per section are as follows:

| **Evaluation Table – Phase 1** | | |
|---|---|---|
| **Phase/Section** | **Weight** | **Maximum Points** |
| **Phase 1 Section 1** | | |
| Applicant's Proposed Area(s) | N/A | 97 |
| **Phase 1 Section 2** | | |
| Quality and Value Strategies - Bree Collaborative | 1.5 | 15 |
| Quality and Value Strategies - HTA Program | 1.0 | 10 |
| Quality and Value Strategies - Value-based Payment & Integrated Care Strategies | 2.0 | 20 |
| American Indian/Alaska Native | 0.5 | 5 |
| Business and Occupation Tax Exemption | 0.5 | 5 |
| **Phase 1 Section 3** | | |
| Attestation of Standards | N/A | 10 |
| **Phase 1 Section 4** | | |
| HTA Coverage Decisions | N/A | 8 |
| **Phase 1 Maximum Points** | | **170** |

**B. Phase 2 Scoring**

After the evaluation of Phase 1, the RFA Coordinator will communicate individually in writing to Applicants regarding whether their Application passed Phase 1. Applicants who pass Phase 1 will be required to submit their Phase 2 response by the date and time described in Section 1.2, *Estimated Schedule of Solicitation.*

HCA reserves the right, at its sole discretion, to not award the contract(s) to the Applicant(s) who do not receive at least 45 points in Phase 2 Section 1.

Phase 2 Section 1 – Scoring

Applicants receive points for each of the three options in which stated requirements are met in Phase 2 Section 1, Premium Rates. If only one of the three options are met, 45 points will be awarded. The maximum of 90 points will be awarded when a combination of both option 1 and option 2 are met. Option 3 cannot be combined with either option 1 or option 2.

Phase 2 Section 2 – Scoring

Demonstration of VBP Arrangements - Applicants providing requested sample contracts demonstrating VBP arrangements will receive 40 points; Applicants who do NOT provide sample contracts demonstrating VBP arrangements will receive 0 points.

Demonstration of at least thirty (30) percent of 2021 Plan Year provider Contracts contain VBP Arrangements - Subject to verification through requested sample contracts, Applicants answering

"Yes" to indicating at least thirty (30) percent of the Applicant's 2021 Plan Year provider contracts include Value-Based payment arrangements will receive 20 points. Applicants who answer "No" and/or HCA is unable to verify that at least thirty (30) percent of the Applicant's sample contracts do not demonstrate Value-Based payment arrangements will receive 0 points.

Demonstration of Cost Reductions - Applicants who provide sample contracts demonstrating unit cost reductions will receive 20 points; Applicants who do not provide sample contracts demonstrating unit cost reductions will receive 0 points.

The points from VBP arrangements and unit cost reductions will be added together to determine the total points for Phase 2 Section 2.

The resulting Phase 2 maximum points per section are as follows:

| **Evaluation Table – Phase 2** | |
|---|---|
| **Phase 2/Section** | **Maximum Points** |
| **Phase 2 Section 1** | |
| Premium Rates | 90 |
| **Phase 2 Section 2 – Value-based Payment Arrangements and Sample Contracts** | |
| Demonstration of VBP Arrangements | 40 |
| Demonstration of at least thirty (30) percent of 2021 Plan Year provider Contracts contain VBP Arrangements | 20 |
| Demonstration of Cost Reductions | 20 |
| **Phase 2 Maximum Points** | 170 |

### C. Total Score

Scores for Phase 1, Phase 2, and Executive Order 18-03 will be summed to determine the Applicant's total score for their Application. The top two (2) scoring Applicants may be eligible for incentives in Plan Year 2022. HCA may offer incentives including, but not limited to:

- Special communications by HCA highlighting participation in Public Option Plans; and
- Potential preference to expand in select counties and/or OIC geographic rating areas.

The Applicant's aggregate score may be factored into future Plan Years in the consideration of ongoing Public Option Plan participation, selection and service area expansions.

| **Evaluation Elements – Combined Total** | |
|---|---|
| Phase 1 | 170 |
| Phase 2 | 170 |
| Executive Order 18-03 | 20 |
| Maximum Points Possible | 360 |

HCA reserves the right to award the contract to the Applicant whose application is deemed to be in the best interest of HCA and the state of Washington.

## 4.3. SCORING METHODOLOGY FOR PHASE 1 - SECTION 2

Evaluators will assign a score from 0-10 to each question within Phase 1 – Section 2, based on the scoring matrix below.

| Scoring Methodology | | |
|---|---|---|
| **Score** | **Description** | **Scoring Criteria** |
| 10 | Far Exceeds Requirements | The Applicant has provided an innovative, detailed, and thorough response to the requirement, and clearly demonstrates a high level of experience with, or understanding of the requirement. |
| 7 | Exceeds Requirements | The Applicant has demonstrated an above-average capability, approach, or solution and has provided a complete description of the capability, approach, or solution. |
| 5 | Meets Requirements | The Applicant has an acceptable capability of solution to meet this criterion and has described its approach in sufficient detail to be considered “as substantially meeting the requirements”. |
| 3 | Below Requirements | The Applicant has established some capability to perform the requirement but descriptions regarding their approach are not sufficient to demonstrate the Applicant will be fully able to meet the requirements. |
| 1 | Substantially Below Requirements | The Applicant has not established the capability to perform the requirement, has marginally described its approach. |
| 0 | No Value | The Applicant does not address any component of the requirement, no information was provided, or has simply restated the requirement. |

## 4.4. SUBSTANTIALLY EQUIVALENT SCORES

Substantially equivalent scores are scores separated by two (2) percent or less in total points. If multiple Applications receive a Substantially Equivalent Score, HCA may leave the matter as scored, or select as the ASA(s) the one or more Applications that is deemed by HCA, in its sole discretion, to be in HCA’s best interest relative to the overall purpose and objective as stated in Sections 1.3, *Purpose* and 1.4, *Background* of this RFA.

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

## 4.5. NOTIFICATION TO APPLICANTS

HCA will notify the ASA(s) of their selection in writing upon completion of the evaluation process. Applicants whose applications were not selected for further negotiation or award will be notified separately by e-mail.

## 4.6. DEBRIEFING OF UNSUCCESSFUL APPLICANTS

Any Applicant who has submitted an Application may request a debriefing. The request for a debriefing conference must be received by the RFA Coordinator no later than 5:00 p.m., local time, in Olympia, Washington, within three business days after the Unsuccessful Applicant Notification is e-

mailed to the Applicant. The debriefing will be held within three business days of the request, or as schedules allow.

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

4.6.1. Evaluation and scoring of the Applicant's application;

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

4.6.3. Review of the Applicant's final score in comparison with other final scores without identifying the other Applicants.

Topics an Applicant could have raised as part of the complaint process (Section 2.9, *Complaint Process*) cannot be discussed as part of the debriefing conference, even if the Applicant did not submit a complaint.

Comparisons between applications, or evaluations of the other applications, will not be allowed. Debriefing conferences may be conducted in person or on the telephone and will be scheduled for a maximum of thirty (30) minutes.

## 4.7. **PROTEST PROCEDURE**

An application protest may be made only by Applicants who submitted a response to this RFA and who have participated in a debriefing conference. Upon completing the debriefing conference, the Applicant is allowed five business days to file a protest with the RFA Coordinator. Protests must be received by the RFA Coordinator no later than 4:30 p.m., local time, in Olympia, Washington on the fifth business day following the debriefing. Protests may be submitted by e-mail or by U.S. mail (postage prepaid).

Applicants protesting this RFA must follow the procedures described below. Protests that do not follow these procedures will not be considered. This protest procedure constitutes the sole administrative remedy available to Applicants under this RFA.

All protests must be in writing, addressed to the RFA Coordinator, and signed by the protesting party or an authorized agent. The protest must state (1) the RFA number, (2) the grounds for the protest with specific facts, (3) complete statements of the action(s) being protested, and (4) the relief or corrective action being requested.

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

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

4.7.1.2. Errors in computing the score; or

4.7.1.3. Non-compliance with procedures described in the RFA or HCA requirements.

Protests based on anything other than those items listed above will not be considered. Protests will be rejected as without merit to the extent they address issues such as: 1) an evaluator's professional judgment on the quality of an Application; or 2) HCA's assessment of its own needs or requirements.

Upon receipt of a protest, HCA will undertake a protest review. The HCA Director, or an HCA employee delegated by the HCA Director who was not involved in the RFA, will consider the record and all available facts. If the HCA Director delegates the protest review to an HCA employee, the Director nonetheless reserves the right to make the final agency decision on the protest. The HCA Director or his or her designee will have the right to seek additional information from sources he or she deems appropriate in order to fully consider the protest.

If HCA determines in its sole discretion that a protest from one Applicant may affect the interests of another Applicant, then HCA may invite such Applicant to submit its views and any relevant information on the protest to the RFA Coordinator. In such a situation, the protest materials submitted by each Applicant will be made available to all other Applicants upon request.

4.7.2. The final determination of the protest will:

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

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

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

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

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

4.7.2.3.3. Make other findings and determine other courses of action as appropriate.

If the protest is not successful, HCA will enter into a contract with the ASA(s), assuming the parties reach agreement on the contract's terms.

# 5. RFA EXHIBITS & APPENDICES

| | |
|---|---|
| Exhibit A | Certifications and Assurances |
| Exhibit B | Executive Order 18-03 |
| Exhibit C | Applicant's Proposed Service Area(s) |
| Exhibit D | Attestation of Standards |
| Exhibit E | Non-Disclosure Agreement (NDA) |
| Exhibit F | HTTC Decisions Matrix **(separate attachment)** |
| Appendix 1 | CMS Framework for Value-Based Payments of Alternative Payment Models (CMS LAN APM) |
| Appendix 2 | Value, Quality and Affordability Requirements |
| Appendix 3 | Average 2020 Premium with five (5) percent Reduction by County and Metal Level for a 40-Year-Old Non-Smoker |
| Appendix 4 | Medicare Pricing Methodology Report **(separate attachment)** |

**EXHIBIT A**

## CERTIFICATIONS AND ASSURANCES

I/we make the following certifications and assurances as a required element of the application to which it is attached, understanding that the truthfulness of the facts affirmed here and the continuing compliance with these requirements are conditions precedent to the award or continuation of the related contract:

1. I/we declare that all answers and statements made in the application are true and correct.

2. The prices and/or cost data have been determined independently, without consultation, communication, or agreement with others for the purpose of restricting competition. However, I/we may freely join with other persons or organizations for the purpose of presenting a single application.

3. The attached application is a firm offer for a period of 180 days following receipt, and it may be accepted by HCA without further negotiation (except where obviously required by lack of certainty in key terms) at any time within the 180-day period.

4. In preparing this application, I/we have not been assisted by any current or former employee of the state of Washington whose duties relate (or did relate) to this application or prospective contract, and who was assisting in other than his or her official, public capacity. If there are exceptions to these assurances, I/we have described them in full detail on a separate page attached to this document.

5. I/we understand that HCA will not reimburse me/us for any costs incurred in the preparation of this application. All applications become the property of HCA, and I/we claim no proprietary right to the ideas, writings, items, or samples, unless so stated in this application.

6. Unless otherwise required by law, the prices and/or cost data which have been submitted have not been knowingly disclosed by the Applicant and will not knowingly be disclosed by him/her prior to opening, directly or indirectly, to any other Applicant or to any competitor.

7. I/we agree that submission of the attached application constitutes acceptance of the solicitation contents and the attached sample contract and general terms and conditions. If there are any exceptions to these terms, I/we have described those exceptions in detail on a page attached to this document.

8. No attempt has been made or will be made by the Applicant to induce any other person or firm to submit or not to submit an application for the purpose of restricting competition.

9. I/we grant HCA the right to contact references and other, who may have pertinent information regarding the ability of the Applicant and the lead staff person to perform the services contemplated by this RFA.

10. If any staff member(s) who will perform work on this contract has retired from the State of Washington under the provisions of the 2008 Early Retirement Factors legislation, his/her name(s) is noted on a separately attached page.

We (circle one) **are / are not** submitting proposed Contract exceptions. (See Section 2.12, *Contract and General Terms and Conditions*.) If Contract exceptions are being submitted, I/we have attached them to this form.

**On behalf of the Applicant submitting this application, my name below attests to the accuracy of the above statement. *If electronic, also include*: We are submitting a scanned signature of this form with our application.**

_____
Signature of Applicant

_____
Title Date

**CONTRACTOR CERTIFICATION**
**EXECUTIVE ORDER 18-03 – WORKERS' RIGHTS**
**WASHINGTON STATE GOODS & SERVICES CONTRACTS**

*Pursuant to the Washington State Governor's Executive Order 18-03 (dated June 12, 2018), the Washington State Health Care Authority is seeking to contract with qualified entities and business owners who certify that their employees are not, as a condition of employment, subject to mandatory individual arbitration clauses and class or collective action waivers.*

Solicitation No.: RFA# 2020HCA1

I hereby certify, on behalf of the firm identified below, as follows (check one):

☐ **NO MANDATORY INDIVIDUAL ARBITRATION CLAUSES AND CLASS OR COLLECTIVE ACTION WAIVERS FOR EMPLOYEES**. This firm does NOT require its employees, as a condition of employment, to sign or agree to mandatory individual arbitration clauses or class or collective action waivers.

OR

☐ **MANDATORY INDIVIDUAL ARBITRATION CLAUSES AND CLASS OR COLLECTIVE ACTION WAIVERS FOR EMPLOYEES**. This firm requires its employees, as a condition of employment, to sign or agree to mandatory individual arbitration clauses or class or collective action waivers.

I hereby certify, under penalty of perjury under the laws of the State of Washington, that the certifications herein are true and correct and that I am authorized to make these certifications on behalf of the firm listed herein.

FIRM NAME: _____
Name of Contractor/Applicant – Print full legal entity name of firm

By: _____ _____
Signature of authorized person Print Name of person making certifications for firm

Title: Place:

_____ _____
Title of person signing certificate Print city and state where signed

Date:

_____

**EXHIBIT C**

## APPLICANT'S PROPOSED SERVICE AREA(s)

A. In the chart below, please confirm the County(ies) in which the Applicant will provide a Public Option Plan beginning in 2021 by indicating one of the two options in the 'Applicant will provide a Public Option Plan beginning in Plan Year 2021' column:

   1. Yes, I confirm my organization will provide a Public Option Plan in this county beginning in 2021.
   2. No, I confirm my organization will NOT provide a Public Option Plan in this county beginning in 2021.

B. For each proposed county, Applicants are required to describe their experience building a network and working with providers in those counties.

C. For each proposed county, Applicants are required to provide their anticipated Plan Year 2021 enrollment.

| County | Points awarded per County | Applicant will provide a Public Option Plan beginning in Plan Year 2021 (Yes/No) | Applicant's anticipated Plan Year 2021 enrollment |
|---|---|---|---|
| **Adams** | **3** | | |
| **Asotin** | **3** | | |
| **Benton** | **1** | | |
| **Chelan** | **3** | | |
| **Clallam** | **3** | | |
| **Clark** | **1** | | |
| **Columbia** | **3** | | |
| **Cowlitz** | **3** | | |
| **Douglas** | **3** | | |
| **Ferry** | **3** | | |
| **Franklin** | **1** | | |
| **Garfield** | **3** | | |
| **Grant** | **3** | | |
| **Grays Harbor** | **3** | | |
| **Island** | **3** | | |
| **Jefferson** | **3** | | |
| **King** | **1** | | |
| **Kitsap** | **1** | | |
| **Kittitas** | **3** | | |
| **Klickitat** | **3** | | |
| **Lewis** | **3** | | |
| **Lincoln** | **3** | | |
| **Mason** | **3** | | |
| **Okanogan** | **3** | | |
| **Pacific** | **3** | | |
| **Pend Oreille** | **3** | | |
| **Pierce** | **1** | | |
| **San Juan** | **3** | | |
| **Skagit** | **3** | | |
| **Skamania** | **3** | | |
| **Snohomish** | **1** | | |
| **Spokane** | **1** | | |
| **Stevens** | **3** | | |
| **Thurston** | **1** | | |
| **Wahkiakum** | **3** | | |
| **Walla Walla** | **1** | | |
| **Whatcom** | **3** | | |
| **Whitman** | **3** | | |
| **Yakima** | **3** | | |

## ATTESTATION OF STANDARDS

### Attestations of Standards in Public Option Plans effective 2021

In the chart below, please attest to each value, quality and affordability requirement below by indicating one of the two options in the 'Attestation' column:

3. Yes, I attest my organization will comply with this standard and/or the Public Option Plan(s) will include this standard.
4. No, I cannot attest that my organization will comply with this standard and/or the Public Option Plan(s) will not include this standard.

| Value, Quality and Affordability Requirements | Attestation |
|---|---|
| Recommendations of the Dr. Robert Bree Collaborative | |
| 1. Participating Cascade Care Public Option Carriers are required to report on progress and implement Bree Collaborative 'health plan' recommendations on selected topics *(per Appendix 2, requirement 1).*<br><br>Anticipated in July, 2021, or due date in contract – Report will be submitted to HCA using HCA-developed template. Report will cover progress beginning January 1, 2021 through June 30, 2021.<br><br>Anticipated in July, 2022, or due date in contract – Report will be submitted to HCA using HCA-developed template. Report will cover information demonstrating how the required Bree Collaborative 'health plan' recommendations were implemented in Plan Year 2021. | |
| Health Technology Assessment Decisions | |
| 2. Participating Cascade Care Public Option Carriers are required to provide a baseline report on alignment of their coverage criteria to Health Technology Clinical Committee (HTCC) decisions in their procurement response. For year one, Carrier is required to be aligned with at least twenty-five (25) percent of decisions and submit a plan for aligning to HTCC decisions *(per Appendix 2, requirement 2).*<br><br>Anticipated in July, 2021, or due date in contract – Report will be submitted to HCA using HCA-developed template. Report will cover progress on alignment beginning January 1, 2021 through June 30, 2021.<br><br>Anticipated in July, 2022, or due date in contract – Report on alignment will be submitted to HCA using HCA-developed template for Plan Year 2021. | |
| Washington State Common Measure Set Quality Metrics | |
| 3 In addition to the Quality Rating System (QRS) measures required for all plans offered on the Exchange, participating Cascade Care Public Option Carriers are required to report on specified quality metrics and, for administrative measures only, to report on these metrics by region, sex, and age group, and, to the extent the Carrier is in possession of the data, by race, ethnicity, and language *(per Appendix 2, requirement 3).* | |

| | |
|---|---|
| Anticipated in July, 2022, or due date in contract – Report on quality metrics will be submitted to HCA using HCA-developed template for Plan Year 2021. | |
| 4. Carriers that report that they are not in possession of race, ethnicity, and language data for their Qualified Health Plan (QHP) population must submit and implement a plan to collect this data for their population enrolled in a procured QHP *(per Appendix 2, requirement 4).*<br><br>Anticipated in July, 2022, or due date in contract – The plan to implement REL collection will be submitted to HCA using HCA-developed template. | |
| Maintaining and Improving Health and Alignment to State Agency Value-based Purchasing | |
| 5. Carriers will be deemed to meet requirements to align with state agency value-based purchasing by participating in HCA's annual paying for value survey *(per Appendix 2, requirement 5).*<br><br>Anticipated in July/August annually, or due date in contract - The survey will be submitted to HCA using an HCA-developed template. | |
| 6. Participating Cascade Care Public Option Carriers are required to complete the HCA Primary Care Expenditure template for the population enrolled in Public Option Plans *(per Appendix 2, requirement 6).*<br><br>Anticipated in July/August annually, or due date in contract - Primary Care Expenditure template will be submitted to HCA using HCA-developed template. | |
| 7. Carriers will be required to submit a report including descriptions on utilizing and/or implementing Health Improvement activities *(per Appendix 2, requirement 7).*<br><br>Anticipated in July/August annually, or due date in contract - Health Improvement Report will be submitted to HCA using HCA-developed template. | |
| Affordability Standards | |
| 8. Carriers are required to demonstrate adherence to the affordability requirements *(per Appendix 2, requirement 8).*<br><br>Anticipated in July, 2021, or due date in contract – Claims data will be submitted using HCA-developed template. Report will cover claims beginning January 1, 2021 through March 31, 2021.<br><br>Anticipated in July, 2022, or due date in contract – Claims data will be submitted using HCA-developed template. Report will cover claims beginning January 1, 2021 through December 31, 2021.<br><br>Anticipated in July, 2022, or due date in contract – Claims data will be submitted using HCA-developed template. Report will cover claims beginning January 1, 2022 through March 31, 2022. | |

Exhibit E - NON-DISCLOSURE AGREEMENT

# Statement of Confidentiality

Between

**WASHINGTON STATE HEALTH CARE AUTHORITY (HCA)**

And

**[Insert Vendor's Legal Name and remove brackets: EXAMPLE: ABC COMPANY]**

Vendor's Employee Name and/or Subcontractor or Subcontractor's Employee Name:

_____

(Please Print)

[Insert Company Legal Name AND remove brackets] will have access to the following private and confidential information for the purpose of submitting a response to Request for Applications (RFA) 2020HCA1:

- Medicare allowed reimbursement and payment target thresholds for provider payment. The target thresholds are market average reimbursement reductions weighted based on projected enrollment in the OIC geographic rating area where proposed service areas are located.

This data is to be used strictly for the purposes of submitting a response to RFA 2020HCA1, Cascade Care Public Option Plans (to be offered on the Washington Health Benefit Exchange). This information is confidential and private and Vendor is responsible for maintaining this confidentiality and privacy. Before Vendor is allowed access to this information, Vendor is required to sign this statement.

Please note that the experience and enrollment summary data used to develop the Medicare allowed reimbursement and payment target thresholds are aggregations based on collected individual market Carrier data blended with the Public Employee Benefit Board (PEBB) Program Health Plans, This data does not encompass a complete picture of the populations to be served under this RFA. HCA is not liable in any way to any applicant with respect to the data conveyed by HCA to the applicants under this RFA.

**Confidentiality/Safeguarding Of Information** -- The Vendor shall not use or disclose this information for any purpose not directly connected with the response to RFA 2020HA1, except with prior written consent of HCA, or as may be required by law.

**Privacy** -- This information shall be used solely for the purposes of this RFA. Vendor agrees not to release, divulge, publish, transfer, sell or otherwise make known to unauthorized persons this information without the express written consent of the HCA or as provided by law. Vendor agrees to implement physical, electronic and managerial safeguards to prevent unauthorized access to this information.

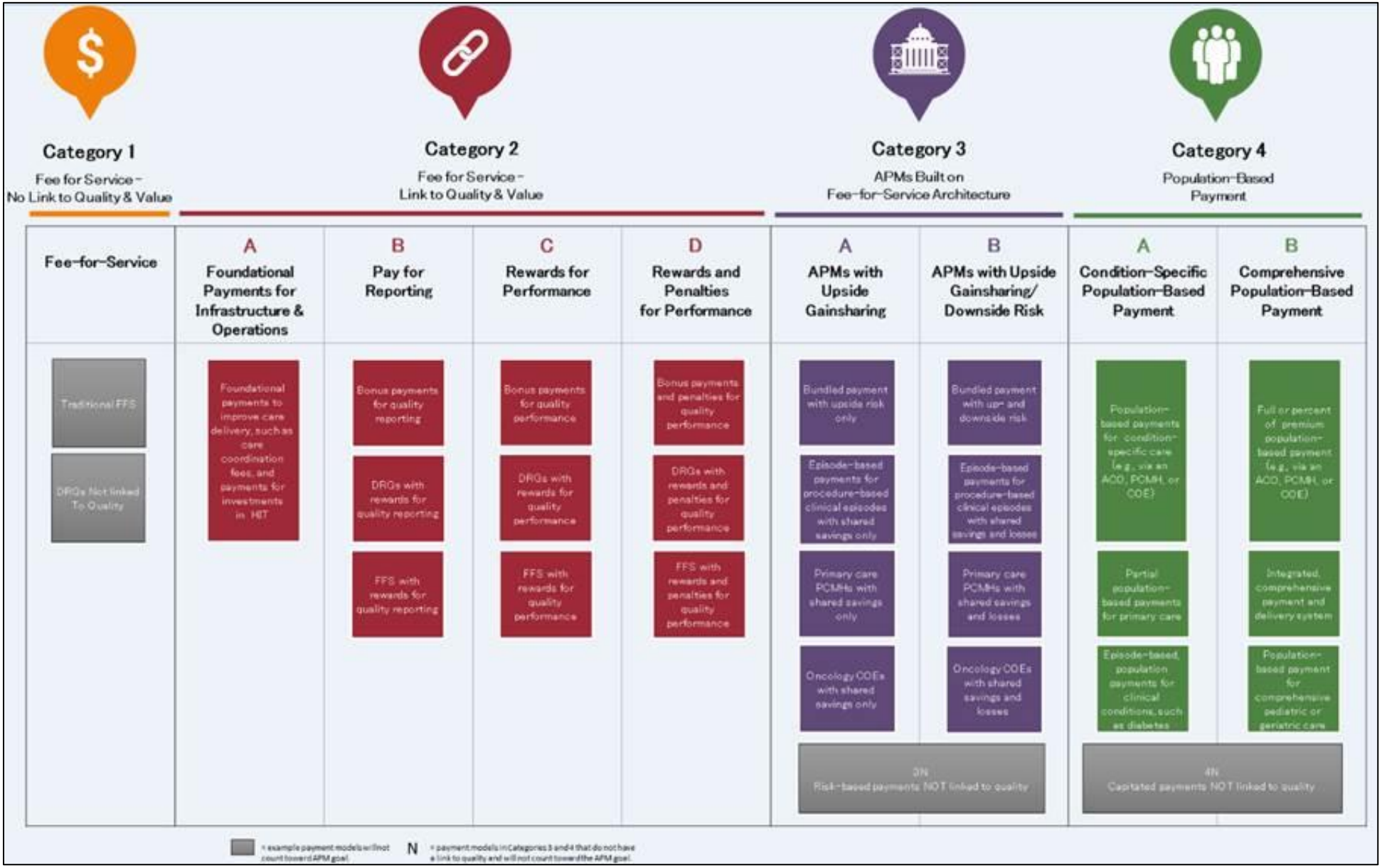
The HCA reserves the right to monitor, to audit, or investigate the use of this information. The monitoring, auditing or investigating may include but is not limited to "salting" by the HCA. Salting is the act of placing a record containing unique but false information in a database that can be used later to identify inappropriate disclosure of data contained in the database.

Any breach of this provision may result in actions to be determined by the HCA, and the demand for return of all information. The Vendor agrees to indemnify and hold harmless the HCA for any damages related to the Vendor's unauthorized use of this information.

_____ _____

Signature of Employee/Subcontractor Date

## 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*

## VALUE, QUALITY AND AFFORDABILITY REQUIREMENTS

**Recommendations of the Dr. Robert Bree Collaborative:**

| Requirements |
|---|
| 1. Participating Cascade Care Public Option Carriers are required to report on progress and implement Bree Collaborative 'health plan' recommendations. In year one, all Carriers are required to report on the following five (5) topics:<br>• Elective total knee and total hip replacement bundle and warranty (2013 and 2017) - clinical standards only;*<br>• Hospital readmissions (2014);<br>• Behavioral health integration (2017);<br>• Opioid use disorder treatment (2017); and<br>• Low back pain (2013).<br>Of the twenty-two total Bree recommendations, the above topics were selected to align with other statewide initiatives and priorities.<br>*Note: For the elective total knee and total hip replacement bundle and warranty, HCA is interested in the application and implementation of the Bree clinical standards for fitness, appropriateness, and clinical care, and not on the application of a payment methodology (bundle or other APM). |
| Resources |
| • Bree Collaborative: http://www.breecollaborative.org<br>• Implementation of Bree Collaborative Health Plan Recommendations website: http://www.breecollaborative.org/implementation/health-plans/ |

**Health Technology Assessment Decisions:**

| Requirements |
|---|
| 2. Participating Cascade Care Public Option Carriers are required to provide a baseline report on alignment of their coverage criteria to Washington State Health Technology Clinical Committee (HTCC) decisions in their procurement response. For the initial Plan Year in 2021, the Carrier is required to be aligned with at least twenty-five (25) percent of decisions and submit a plan for aligning to HTCC decisions. |
| Resources |
| • HTCC Decisions Matrix located in Exhibit F.<br>• Summary of HTA topics: https://www.hca.wa.gov/about-hca/health-technology-assessment |

**Washington State Common Measure Set Quality Metrics:**

Requirements

3. In addition to the Quality Rating System (QRS) measures required for all plans offered on the Exchange, participating Carriers are required to report on the following quality metrics from the Washington State Common Measure Set for their Public Option Plans. For administrative measures, Carriers must report each metric listed below by region, sex, and age group, and, to the extent the Carrier is in possession of the data, by race, ethnicity, and language.
4. Carriers that report that they are not in possession of race, ethnicity, and language data for their Qualified Health Plan (QHP) population must submit and implement a plan to collect this data for their population enrolled in a procured QHP.

Additional information:

For any metric on which a Carrier does not have and cannot reasonably obtain sufficient data, the HCA will provide the Carrier flexibility to demonstrate how it intends to improve the collection of data associated with that metric.

For the Mental Health Service Penetration (Broad Version) metric, DSHS's Research and Data Analytics (RDA) unit will provide specifications.

HCA will entertain modifications to metrics with low denominators and numerators.

| Measure Name | Measure Steward | NQF-Endorsed | Description |
|---|---|---|---|
| Ambulatory Care (AMB) – Emergency Department Visits per 1,000 | NCQA (HEDIS) | No | Number of emergency department visits per 1,000 population and is calculated in member years for commercial data and member months for Medicaid data. Excludes encounters with any of the following: principal diagnosis of mental health or chemical dependency, psychiatry, electroconvulsive therapy, alcohol or drug rehab or detoxification. |
| Comprehensive Diabetes Care (CDC) – Blood Pressure Control (<140/90 mm Hg) | NCQA (HEDIS) | Yes 0061 | The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure level taken during the measurement year is <140/90 mm Hg. |
| Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) | NCQA (HEDIS) | Yes 2605 | The percentage of emergency department visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow-up visit for AOD within 30 days of the ED visit. |
| Follow-up After Emergency Department Visit for Mental Illness (FUM) | NCQA (HEDIS) | Yes 2605 | The percentage of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness who had a follow-up visit for mental illness within 30 days of the ED visit. |
| Asthma Medication Ratio (AMR) | NCQA (HEDIS) | Yes 1800 | The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. |
| Mental Health Service Penetration (Broad Version) | DSHS | No | The percentage of members with a mental health service need who received mental health services in the measurement year. Separate reporting for two age groups: 6-17 years and 18 years and older. |
| Patient Experience with Primary Care: How Well | AHRQ | Yes 0005 | The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan |

| | | | |
|---|---|---|---|
| Providers Communicate with Patients | | | Survey 3.0 is a standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding 6 months. |
| Patient Experience with Primary Care: How Well Providers Use Information to Coordinate Patient Care | AHRQ | Yes 0005 | The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 3.0 is a standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding 6 months. |
| Inpatient 30-day Psychiatric Inpatient Readmissions | DSHS | No | For members 18 years of age and older, the number of acute inpatient psychiatric stays that were followed by an acute readmission for a psychiatric diagnosis within 30 days. |
| Statin Therapy for Patients with Cardiovascular Disease | NCQA (HEDIS) | No | Percentage of males 21-75 years of age and females 40-75 years of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria: (1) Received statin therapy: Members who were dispensed at least one high or moderate-intensity statin medication. |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) | NCQA (HEDIS) | Yes 0577 | The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. |

The above selected metrics from the Statewide Common Measure Set are relevant to the individual market, allow efficiency in Carrier reporting, and align with metrics in state purchasing contracts.

Resources

- Washington Statewide Common Measure Set: https://www.hca.wa.gov/about-hca/healthier-washington/performance-measures
- National Quality Forum: http://www.qualityforum.org/About_NQF/

**Maintaining and Improving Health and Alignment to State Agency Value-based Purchasing:**

Participating Cascade Care Public Option Carriers must meet additional participation requirements to reduce barriers to maintaining and improving health and align to state agency value-based purchasing. These requirements may include, but are not limited to, standards for utilization management to reduce administrative burden and increase transparency and clinical effectiveness; population health management; high-value, proven care; health equity; primary care; care coordination and chronic disease management; wellness and prevention; prevention of wasteful and harmful care; and patient engagement.

| Requirements |
|---|
| 5. Carriers will be deemed to meet requirements to align with state agency value-based purchasing by participating in HCA's annual paying for value survey.<br>6. In addition to the survey, Carriers are required to complete the HCA Primary Care Expenditure template for the population enrolled in Public Option Plans.<br>7. Carriers will also be required to submit a report including descriptions on utilizing and/or implementing the following:<br>• Utilization review selection criteria and process, and which national accreditation standard(s) were achieved;<br>• Complex case and chronic condition management;<br>• Population health management strategies, including closure of care gaps and promotion of preventive services;<br>• Strategies to identify and address health inequities;<br>• Web-based or other tools utilized to encourage patient engagement, such as application to allow patients to schedule appointments, refill prescriptions, and other functions;<br>• Shared decision making programs (see information at HCA Shared Decision Making and/or the Bree Collaborative Shared Decision Making Report);<br>• Approach to encourage provider use of certified Electronic Health Record (EHR) systems as defined by the Office of the National Coordinator and providers' contribution of clinical data from its EHR system to the state Clinical Data Repository (CDR) hosted by OneHealthPort;<br>• Programs to support active participation of providers in at least one Accountable Community of Health, including various workgroups and committees; and<br>• Participation in multi-payer and data sharing initiatives to reduce variation in care, improve value and reduce overall cost of care. |
| Resources |
| • Annual Paying for Value Survey: https://www.hca.wa.gov/about-hca/healthier-washington/paying-value#value-based-payment-survey<br>• Example of current PEBB/SEBB Primary Care Expenditure template: public://program/pebb-and-sebb-primary-care-spend-template.xlsx<br>• HCA's Value-based Purchasing Roadmap: https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf |

**Affordability Standards:**

| Requirements |
| --- |
| 8. Carriers are required to demonstrate adherence to the following affordability requirements:<br>a. A reimbursement ceiling for providers and facilities for all covered benefits in the statewide aggregate, excluding pharmacy benefits, not to exceed one-hundred and sixty (160) percent of the total amount Medicare would have reimbursed providers and facilities for the same or similar services (because the ceiling is aggregate, certain providers may receive higher or lower reimbursements for services);<br>b. Reimbursement to Critical Access Hospitals and Sole Community Hospitals may not be less than one-hundred and one (101) percent of Medicare's allowable costs; and<br>c. Reimbursement for primary care services, defined by HCA, provided by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine, may not be less than one-hundred and thirty-five (135) percent of the amount that would have been reimbursed under Medicare for the same or similar services.<br>Carriers will be required to submit claims information and premium rates to demonstrate required threshold levels have been achieved. |
| Resources |
| • Cascade Care Medicare Pricing Methodology, See Appendix 4. |

## AVERAGE 2020 PREMIUM WITH FIVE (5) PERCENT REDUCTION BY COUNTY AND METAL LEVELFOR A 40-YEAR-OLD NON-SMOKER

| County | Bronze Average Rate | Silver Average Rate | Gold Average Rate |
|---|---|---|---|
| Adams | $314.66 | $393.96 | $443.51 |
| Asotin | $314.31 | $420.28 | $452.74 |
| Benton | $323.23 | $381.33 | $442.10 |
| Chelan | $314.66 | $393.96 | $443.51 |
| Clallam | $349.60 | $467.46 | $503.57 |
| Clark | $327.07 | $451.67 | $493.34 |
| Columbia | $325.18 | $391.58 | $446.79 |
| Cowlitz | $342.72 | $478.81 | $506.92 |
| Douglas | $314.66 | $393.96 | $443.51 |
| Ferry | $288.84 | $381.65 | $407.66 |
| Franklin | $346.07 | $383.89 | $475.30 |
| Garfield | $314.31 | $420.28 | $452.74 |
| Grant | $314.66 | $393.96 | $443.51 |
| Grays Harbor | $397.45 | $506.15 | $577.66 |
| Island | $330.49 | $439.29 | $482.96 |
| Jefferson | $349.60 | $380.01 | $436.60 |
| King | $303.96 | $383.48 | $444.62 |
| Kitsap | $355.43 | $388.96 | $464.92 |
| Kittitas | $320.07 | $376.57 | $431.95 |
| Klickitat | $326.65 | $450.07 | $494.93 |
| Lewis | $342.82 | $391.66 | $451.92 |
| Lincoln | $288.84 | $349.64 | $394.54 |
| Mason | $324.84 | $429.24 | $465.68 |
| Okanogan | $314.66 | $420.75 | $453.25 |
| Pacific | $397.45 | $506.15 | $577.66 |
| Pend Oreille | $288.84 | $381.65 | $407.66 |
| Pierce | $308.62 | $397.11 | $456.52 |
| San Juan | $324.93 | $434.47 | $468.04 |
| Skagit | $330.49 | $434.97 | $482.96 |
| Skamania | $372.39 | $456.46 | $514.63 |
| Snohomish | $320.11 | $388.75 | $438.15 |
| Spokane | $306.57 | $369.13 | $427.79 |
| Stevens | $288.84 | $349.64 | $394.54 |
| Thurston | $323.86 | $399.66 | $457.98 |
| Wahkiakum | $397.45 | $506.15 | $577.66 |
| Walla Walla | $327.30 | $395.10 | $453.98 |
| Whatcom | $330.49 | $439.29 | $482.96 |
| Whitman | $325.18 | $432.19 | $475.31 |
| Yakima | $300.84 | $376.57 | $431.95 |