Washington State Health Care Authority

STATE OF WASHINGTON

HEALTH CARE AUTHORITY

REQUEST FOR PROPOSALS (RFP)

RFP NO. 2516

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

PROJECT TITLE: Medicaid Managed Care Dental

PROPOSAL DUE DATE: June 29, 2018 by 2:00 p.m. Pacific Time, Olympia, Washington, USA.

Faxed bids will not be accepted.

ESTIMATED TIME PERIOD FOR CONTRACT: January 1, 2019 to December 31, 2020

The Health Care Authority reserves the right, in its sole discretion, to extend the contract for up to five (5) additional years in increments of one (1). Amendments to extend the period of performance of the contract may require network capacity increases.

BIDDER ELIGIBILITY: This procurement is open to those Bidders that satisfy the minimum qualifications stated herein and that are available for work in Washington State.

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1. INTRODUCTION

1.1. PURPOSE

As mandated by the Legislature in 2017, by passage of Substitute Senate Bill (SSB) 5883, Section 213(1)(c), the Washington State Health Care Authority (HCA) is initiating this Request for Proposals (RFP) to solicit proposals from Managed Care Entities (MCEs) interested in developing and implementing a Managed Care Dental Program for eligible Medicaid Clients beginning January 1, 2019.

HCA intends to award multiple contract(s), as needed, to provide the services described in this RFP. Contracts will be awarded on a Regional Service Areas (RSAs) basis, identified in Attachment 3. The goal of the procurement is statewide managed care coverage. HCA prefers, but does not require, that MCEs submit bids for all RSAs.

1.2. BACKGROUND

HCA contracts for physical health services with managed care plans and maintains a Fee-for-Service (FFS) network for Clients who are not eligible for managed care enrollment. HCA intends to use the same approach to ensure access to dental services for all Clients.

HCA currently provides comprehensive dental benefits for adults and children, including orthodontia for children age 20 and younger, under HCA's FFS program. In fiscal year 2016, HCA had 2.1 million Clients eligible for dental services. Of those, approximately 800,000 accessed some type of dental care, which is a 38.2% utilization rate.

Of the total eligible population, 1.1 million were 21 and older (adults) and 994,000 were 20 and under (children). The utilization for adults was 22.1%, and for children was 56.3%.

In 2010, the adult dental program was discontinued, except for emergency services. The emergency services covered were: emergency exams; diagnostic x-rays; pupal debridement; extractions; emergency office, house, or extended care facility visits; nitrous oxide; therapeutic drug injections; treatment of post-surgical complications; and palliative emergency treatment to treat dental pain, infection, or trauma. There was no coverage for restorative fillings, other therapeutic interventions, or preventative care services. Adult dental services were re-established in 2014, and as a result, there was an influx of adults seeking dental care.

Below is a comparison of access and utilization between 2010 and 2017.

- Adult dental users:
    - The percent of adult utilizers fell from 28% in 2010 to 22% in 2017.
    - The annual claim rate (per 1,000 Clients) decreased from 1,042 in 2010 to 772 in 2017.
- Consistency in utilization:

    - Most adults (51%) who went to the dentist in 2014 didn't return the following year.
    - 75% didn't return after 2015.
    - Out of approximately 243,000 adult dental users in 2017, 30,000 have consistent, annual dental utilization.
- Costs:
    - The cost per adult user increased from $389 in 2010 to $532 in 2017. This increase reflects the number of adults receiving services at tribal clinics and federally qualified health centers (FQHC).
    - In 2017, there was an increased percentage of adult claims paying at the FQHC and tribal clinic encounter rates (60%) compared to 2010 (30%).
    - Excluding encounter rate claims, adult dental utilization has fallen from 21% in 2010 to 11% in 2017. For these Clients, the cost per user is $270 and the annual number of claims per 1,000 Clients is 311.
- Access to providers:
    - The Client-to-provider ratio increased from 282 eligible per provider in 2010 to 679 eligible per provider in 2017.

Children's dental access and utilization has remained steady, and even improved, since 2010.

- Approximately 50-54% utilization each year.
- Steady provider-to-eligible ratios (approximately 458-546 Clients per provider).
- Claims and units per utilizer between 2010 and 2017.
    - Annual claims per 1,000 Clients in 2017: 1,555 (+3% from 2010).
    - Annual units per 1,000 Clients in 2017: 6,249 (+7% from 2010).
- Consistent encounter rate utilization.
    - Approximately 25% of claims pay at the higher rate.

Bidders who submit a Letter of Intent to Bid, in accordance with instructions located in Section 2.4, will receive access to the Dental Data Book, Exhibit F, which will include utilization data from 2016 and 2017.

HCA's current benefits package is comprehensive, including preventive, diagnostic, and restorative services (See Attachment 2, Benefit Package). The Legislature and HCA reserve the right in their sole discretion to change the Benefit Package, depending on policy and budgetary priorities.

There are many components of the current program that HCA intends to retain in the managed care program, including:

Access to Baby and Child Dentistry (ABCD) Program. The ABCD Program's purpose is to increase access to preventive dental services for infants, toddlers, and preschoolers age 5 and younger who are eligible for Washington Apple Health (Medicaid). SSB 6549 expanded the ABCD Program to include Clients age 6 to 12 with a disability. For this purpose, children with disabilities are defined as: all individuals under the age of 13 with a disability attributable to intellectual disability, cerebral palsy, epilepsy, autism, or another neurological condition closely

related to an intellectual disability, or that requires treatment similar to that required for persons with intellectual disabilities, which has continued or can be expected to continue indefinitely. Washington State has been on the leading edge of providing preventative services to children age 5 and under through the ABCD Program. The program's goal is to ensure that positive dental experiences in early childhood will lead to lifelong practices of good oral health. This is done, in part, by identifying and removing obstacles to early preventive treatment, such as the lack of transportation to a dental office, language interpretation issues, etc. HCA works closely with Arcora (previously known as Washington Dental Services Foundation (WDSF)) and the University of Washington (UW) to provide the ABCD Program. Arcora manages the program, recruits and assists with scheduling the dental provider training, and trains medical providers. UW provides technical and procedural consultation, trains, and certifies dental providers. HCA provides an enhanced rate for specific CDT codes (Code on Dental Procedures and Nomenclature) when performed by a certified ABCD trained provider. Certified ABCD providers may also provide some additional services. ABCD providers can also take enhanced training in Interim Therapeutic Restoration (ITR). See Attachment 7 for more details.

American Indians / Alaska Natives (AI/AN) and Indian Health Care Providers (IHCPs). HCA contracts with a number of Indian Health Care Providers (IHCPs), which are defined as Indian Health Service (IHS) facilities, Tribal 638 facilities, and Urban Indian Health Programs (UIHPs) to provide dental services to Medicaid Clients. IHCPs have provided dental services to Medicaid Clients over the years, regardless of tribal membership.

The Centers for Medicare and Medicaid Services (CMS) has compiled requirements applicable to IHCPs into the "Model Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers" (also known as the Indian Addendum). Bidders are required by federal law to comply with the various requirements in the Indian Addendum (https://www.medicaid.gov/medicaid/indian-health-and-medicaid/downloads/addendum-ihcps.pdf).

For more information on working with IHCPs: https://www.hca.wa.gov/assets/intro-indian-health-care-wa-state.pdf.

Dental Education in the Care of Persons with Disabilities (DECOD). The University of Washington DECOD Clinic provides dental care that is not otherwise available in the community for patients with developmental or acquired disabilities. DECOD is a teaching institution committed to improving quality of care for patients with disabilities. HCA has a contract with the University of Washington (UW) to provide a clinical training allowance for dental services rendered to qualified Medicaid Clients in approved UW dental clinic locations.

Developmental Disabilities Administration (DDA) Benefits. Designated dental services are allowed more frequently for DDA Clients. See Benefit Package, Attachment 2.

Federally Qualified Health Center(s) / Rural Health Center(s). Rural Health Clinics (RHCs) were established by the Rural Health Clinic Service Act of 1977 to address an inadequate supply of

physicians serving Medicare beneficiaries in underserved rural areas, and to increase the utilization of nurse practitioners (NP) and physician assistants (PA) in these areas. Federally Qualified Health Centers (FQHCs) were established in 1990 by section 4161 of the Omnibus Budget Reconciliation Act (OBRA) of 1990. Similarly to RHCs, they are facilities that are primarily engaged in providing services that are typically furnished in an outpatient clinic. Since January 1, 2016, all FQHCs are paid under the provisions of the FQHC Prospective Payment System (PPS), as required by Section 10501(i)(3)(B) of the Affordable Care Act (ACA).

MCEs may contract with FQHCs/RHCs to provide services under the Managed Care Dental Program. The MCE will pay the FQHC/RHC their applicable encounter rate for qualified services. Once HCA receives and accepts encounters for qualified services from the MCE, HCA will issue payment to the MCE for the difference between the FFS rate and the applicable encounter rate. To ensure that the appropriate amounts are paid to each FQHC/RHC, HCA performs a reconciliation of the encounter payments.

Medicaid Transformation. A five-year agreement between the state and CMS that provides federal investment dollars for regional health system transformation projects that benefit Medicaid Clients. HCA's Medicaid Transformation aims to transform the state's Medicaid delivery system through regional, collaborative efforts led by Accountable Communities of Health (ACHs) and new supportive services to address relevant social determinants of health.

ACHs selected from a variety of projects with the aim to meet these transformation goals, including Project 3C: Access to Oral Health Services. Project 3C aims to increase access to oral health services for all Medicaid Clients, but especially adults, to prevent or control the progression of oral disease and ensure that oral health is recognized as a fundamental component of whole-person care.

Mobile Anesthesia. HCA contracts with a variety of mobile anesthesia contractors to support access to dental services in the least restrictive setting (e.g., dental office) to pediatric dental Clients who are developmentally disabled and/or who require behavior management. In addition to paying the mobile anesthesia contractor for the anesthesia product, the contractor is paid an overhead fee for the provision of: (1) staff for administration of the anesthesia and recovery; (2) expenses related to medications, use of equipment (including maintenance), supplies, expendables, and disposables; and (3) venue-specific expenses, including set-up and tear-down of equipment on-site, hauling of equipment, vehicle expenses, travel, and lodging.

Oral Health Connections Pilot Project. In 2017, the Legislature directed HCA to implement the Oral Health Connections Pilot Project, which is aimed at enhancing oral health services and access for pregnant women and Clients with diabetes in three counties (Spokane, Thurston, and Cowlitz). The purpose of the Oral Health Connections Pilot Project is to test the effect of enhanced oral health services on the overall health of the two identified populations. As required by SSB 5883, Section 213(1)(nn), HCA is working with Arcora to develop the Oral Health Connections Pilot Project, with an implementation date of January 1, 2019. Apple Health Medicaid Clients (not including Dual-Eligibles) in the three listed counties who are pregnant or have diabetes will be

eligible for additional periodontal CDT codes payed at an enhanced rate at certified participating dentists within those three counties. Certified providers will receive special training to treat eligible Clients who are referred by their Primary Care Provider (PCP). Coordination of services between dental and medical systems and providers is required to ensure medical services are provided to complement the dental care and improve dental outcomes. See Attachment 8 for more details.

Orthodontics. For treatment involving the use of any appliance, in or out of the mouth, removable or fixed, or any surgical procedure to redirect teeth and surrounding tissues (WAC 182-535A-0010). Orthodontic services are only covered by HCA for Clients age 20 and younger. HCA currently requires prior authorization for orthodontic services with the exception of Clients diagnosed with Cleft Palate or Craniofacial anomalies. HCA utilizes a modified Handicapping Labiolingual Deviation (HLD) index to assist with Medically Necessary authorization determinations. Although the Apparently Successful Bidder(s) (ASBs) may choose an alternate payment methodology for orthodontia, HCA's practice has been to pay a percentage of the total at the beginning of treatment, with equal quarterly payments made to the orthodontists for eight quarters. This encourages providers to manage Clients through the orthodontic process. Coordination of services between dental and medical systems is required to ensure needed medical services are provided to complement the dental care and improved dental outcomes. HCA expects if an Enrollee changes MCEs during the course of treatment, the MCE with whom the Enrollee was originally enrolled will continue payment for the treatment, without change to Enrollee provider according to Section 16.4 of Attachment 1, Sample PAHP Apple Health Dental Services Contract.

Prior Authorizations. HCA expects ASB(s) to honor all HCA-approved prior authorizations for services covered under the resulting contract(s). HCA will provide all approved prior authorizations for MCE's assigned Enrollees.

Quality Measures. Quality Measures are tools to help HCA measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.

School Based Services. HCA, as the single state Medicaid agency, pays for certain dental services provided in a school setting, including early education settings, by either an independent licensed and agency-enrolled hygienist or a dentist practicing within his or her defined Washington Department of Health (DOH) scope of practice.

Skilled Nursing Facility (SNF) Benefits. Designated dental services are allowed more frequently for Clients who reside in a Skilled Nursing Facility. See Benefit Package, Attachment 2.

1.3. OBJECTIVES AND SCOPE OF WORK

HCA's goal in implementing a dental managed care program is to increase access to comprehensive dental care for Medicaid Clients. Recent research provides a correlation between good oral health and physical health, including cardiac health. The ASBs are required to meet the following goals and objectives of the Managed Care Dental Program:

A. Reduce emergency room visits for dental services and treatment of oral health conditions by facilitating increased access to consistent dental care;
B. Improve oral health outcomes for Medicaid Clients;
C. Retain innovative programs such as ABCD and the Oral Health Connections Pilot Project that improve access and care, and develop new programs that improve access to care and dental outcomes;
D. Increase the dental provider network and access to dental services resulting in increased utilization, particularly for adults; and
E. Provide timely access to dental services and coordination of dental and physical health services, as clinically indicated through care management.

The scope of services of this Dental Managed Care Program includes: diagnostic, preventive, restorative, endodontics, periodontics, prosthodontic, oral surgery, orthodontics and other general ancillary services, such as pediatric sedation. Currently, some services require prior authorization and/or have limits as detailed in the Billing Guide (https://www.hca.wa.gov/billers-providers/programs-and-services/dental-services).

Readiness Review: ASB(s) must have the systems referenced in Section 2.14, Contract and General Terms and Conditions, in place and functional at the time of HCA's Readiness Review. In accordance with federal regulation (42 C.F.R § 438.66(d)(2)) Readiness Review must be started no less than ninety (90) calendar days prior to program implementation. Documentation provided by the ASB in response to the RFP will be reviewed as part of the RFP evaluation process. If any additional information is needed, HCA will provide the ASB(s) with a list of materials needed prior to the on-site Readiness Review visit.

HCA will also provide the ASB(s) with an agenda for the Readiness Review, and a list of topics for discussion and interviews HCA will conduct as part of the process.

Working with Indian Health Care Providers (IHCPs): HCA expects Bidders to reach out and offer subcontracting arrangements to every tribe, IHS facility, and UIHP offering dental services in Washington 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. Tribes offering dental services include, but may not be limited to:

- Confederated Tribes of the Chehalis Reservation;
- Coeur d'Alene Tribe of Indians,

- Confederated Tribes of the Colville Reservation;
- Jamestown S'Klallam Tribe;
- Kalispel Tribe of Indians;
- Lower Elwha Klallam Tribe;
- Lummi Nation;
- Makah Tribe;
- Muckleshoot Indian Tribe;
- The NATIVE Project;
- Nez Perce Tribe;
- Nisqually Indian Tribe;
- Nooksack Indian Tribe;
- Port Gamble S'klallam Tribe;
- Puyallup Tribe;
- Quileute Tribe;
- Quinault Indian Nation;
- Seattle Indian Health Board;
- Shoalwater Bay Indian Tribe;
- Skokomish Indian Tribe;
- Spokane Tribe of Indians;
- Squaxin Island Tribe;
- Swinomish Indian Tribal Community;
- Tulalip Tribes;
- Confederated Tribes of the Umatilla Indian Reservation; and
- Confederated Tribes and Bands of the Yakama Nation.

For the purposes of this section, "Contract Health Service Delivery Areas" means those counties identified in accordance with 42 C.F.R. § 136.22. For a recent list see Federal Register Vol. 82, No. 144, Friday, July 28, 2017, pages 35227-35233, Attachment 9. Bidders must recognize the sovereign status of the tribes and the federal trust responsibility (25 U.S.C. Section 1602), that all IHCPs operate under and interact, including subcontracting, with all IHCPs in a manner respectful of this status and this responsibility. More information available at: https://www.medicaid.gov/medicaid/indian-health-and-medicaid/history/index.html.

The delivery model for dental services for AI/AN will include access to dental services and coordination of services provided by IHCPs with specialty care provided through community providers outside the IHCP clinics. AI/AN access to dental services through IHCPs will not be

limited by this RFP. The Bidder will provide information to IHCPs ensuring this program will benefit their patients.

All subcontracts negotiated with IHCPs must comply with the laws and regulations applicable to the IHCPs, including the requirements compiled in the Indian Addendum, and with the requirements of Section 15 in the attached Sample PAHP Apple Health Dental Services Contract.

Working with Accountable Communities of Health (ACHs) on Medicaid Transformation: HCA expects the ASB(s) will be prepared to work closely and collaboratively with the ACHs and any IHCPs choosing dental projects as part of their Medicaid Transformation work, on the related dental project within the Transformation Project Toolkit (https://www.hca.wa.gov/assets/program/project-toolkit-approved.pdf).

The Managed Care Dental Program will complement the ongoing Medicaid Transformation efforts by ACHs and IHCPs. Under Medicaid Transformation, ACHs select, design, and implement projects from the Transformation Project Toolkit. The Project Toolkit includes Project 3C: Access to Oral Health Services. IHCPs have Medicaid Transformation resources and may choose to implement dental projects of their own, based on individual assessment of needs and priorities. This project area focuses on providing oral health screening and assessment, intervention, and referral in the primary care setting, or through the deployment of mobile clinics and/or portable equipment. The project seeks to leverage the primary care workforce and to strengthen relationships between primary care and dental providers through stronger referral networks, improved communications, and shared incentives. This is a critical component for achieving a core objective of the Medicaid Transformation, which is the integration and coordination of whole-person care for Washington's Medicaid Clients.

1.4. MINIMUM QUALIFICATIONS

The following are the minimum qualifications for Bidders:

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

1.4.2. Registered with the Washington State Office of Insurance Commissioner (OIC) as an insurance carrier.

1.4.3. Have an office in the State of Washington staffed to manage the day-to-day operations to be responsive to providers, Clients, HCA, and other stakeholders.

1.4.4. Submit a Letter of Intent to Propose by the deadline in Section 2.2, *Estimated Schedule of Procurement Activities,* in order to submit a Response to this RFP.

1.4.5. Offer an adequate dental care network as described in this RFP, Section 3.3, and Attachment 1, Sample PAHP Apple Health Dental Services Contract.

1.4.6. Have actuarially sound rates as verified by HCA and/or HCA's contracted actuary.

1.4.7. The ability to send, receive, accept, and process HIPAA-compliant transaction files, to include but not limited to: 270 eligibility inquiry, 271 eligibility response, 820 payment files, 834 enrollment files, 835 payment advice files, and 837D dental healthcare claim files.

1.4.8. The ability to comply with all Encounter Data requirements, including: 1) ability to provide encounter data for all services delivered under the contract including diagnoses codes and risk codes; 2) encounter data must follow the standard electronic encounter data reporting process developed by HCA; 3) Bidder must use the Encounter Data Reporting Guide in conjunction with the 837 Healthcare Claim Guide Version 5010 for Dental when submitting encounters; and 4) Bidder must remain current on Encounter Data Reporting Guide's periodic updates and modifications related to dental encounters. Note: Encounter Guide will be updated to include dental encounters.

1.4.9. Comply with all federal requirements applicable to American Indian/Alaska Native Medicaid Clients and Indian Health Care Providers (IHCPs) and their referrals and claims, including those set forth in the "Model Medicaid Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers" most recently issued by CMS (https://www.medicaid.gov/medicaid/indian-health-and-medicaid/downloads/addendum-ihcps.pdf).

1.4.10. Comply with Washington State Office of the Chief Information Officer (OCIO) security standards to handle Category 4 Data (PHI) in accordance with OCIO Security Standard 141.10, Attachment 4, and Information Services Board (ISB) Identity Management User Authentication Standards, Attachment 5.

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

1.4.12. Agree to undergo and pass a Security Design Review conducted by HCA or Washington Technology Solutions (WaTech), if required. Office of CyberSecurity (OCS) Design Review Checklist, Attachment 6.

1.4.13. Be able to pass a Readiness Review prior to Implementation. Readiness Review will be scheduled by HCA with ASB(s).

Preferred Qualifications:

1.4.14. Three or more years' experience with providing Managed Medicaid Dental services in other states. Bonus points will be given to MCEs that are able to demonstrate this experience. See Exhibit E, Section 6 for the Bonus Questions.

1.4.15. Experience with utilizing other reimbursement methodologies besides Fee-for-Service (e.g., capitated reimbursement arrangement, full risk contract, shared risk contract, bundled payments, or value-based reimbursement, or a combination thereof). Bonus points will be given to MCEs that are able to demonstrate this experience. See Exhibit E, Section 6 for the Bonus Questions.

1.4.16. Required expectations with providers to document the treatment plan, including start and end dates of treatment. Bonus points will be given to MCEs that are able to demonstrate this requirement. See Exhibit E, Section 6 for the Bonus Questions.

1.4.17. Experience with outreach to vulnerable populations, which includes: the economically disadvantaged; racial and ethnic minorities; the uninsured; low-income children; the elderly; the homeless; and those with chronic health conditions, including severe mental illness, who have reduced access to health care services.

1.5. FUNDING

1.5.1. Any contract(s) awarded as a result of this procurement are contingent upon the availability of funding, which will be determined by HCA in its sole discretion.

1.5.2. Rates and Funding

Bidder must develop and submit a Cost Proposal as described in Section 3.8 using information provided by HCA's contracted actuaries, Milliman, in Exhibit F, Dental Data Book. Exhibit F is located on a Secure File Transfer (SFT). HCA will send the SFT password and logon in separate emails to all Bidders that submit a Letter of Intent to Propose and a signed Data Share Agreement (Exhibit G).

The Legislature requires the MCE(s) awarded a contract under this RFP to, "absorb all start-up costs associated with moving the program from fee-for-service to managed care[.]" See Substitute Senate Bill 5883, Section 213(1)(c) (2017). Therefore, the ASB(s) will be responsible for the costs of implementing the Managed Care Dental Program. This includes the costs incurred by HCA in notifying Clients eligible for the Managed Care Dental Program of the change from fee-for-service to managed care. HCA anticipates that such costs will include, but not necessarily be limited to: postage; paper and related materials; costs for translations; and staff time. HCA will not fund any implementation fees of the ASB(s).

HCA will not make any payments in advance or in anticipation of goods or services to be provided under any resulting contract will be made. Do not request early payment,

down payment or partial payment of any kind. The Contractor will only be compensated for services delivered and accepted by HCA under a properly executed contract beginning no earlier than January 1, 2019.

1.6. CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) APPROVAL

Any contract awarded to any ASB as a result of this RFP requires the approval of CMS. Should CMS fail to approve the contract resulting from this RFP, the contract may be terminated in accordance with the terms of the contract.

1.7. PERIOD OF PERFORMANCE

The period of performance of any contract resulting from this RFP is tentatively scheduled to begin on or about January 1, 2019 and to end on December 31, 2020. Amendments extending the period of performance, if any, will be at the sole discretion of HCA. Amendments to extend the period of performance of the contract may require network capacity increases.

HCA reserves the right to extend the contract for five (5) additional years, in one-year increments, at its sole discretion.

1.8. CONTRACTING WITH CURRENT OR FORMER STATE EMPLOYEES

Specific restrictions apply to contracting with current or former state employees pursuant to chapter 42.52 of the Revised Code of Washington (RCW). Bidders should familiarize themselves with the requirements prior to submitting a proposal that includes current or former state employees.

1.9. DEFINITIONS

Definitions for the purposes of this RFP include:

Accountable Community of Health (ACHs) – means a regionally governed, public-private collaborative or structure tailored by the region to align actions and initiatives of a diverse coalition of participants in order to achieve healthy communities and populations.

Actuarially Sound Capitation Rates – means capitation rates that have been developed in accordance with generally accepted actuarial principles and practices; are appropriate for the populations to be covered and the services to be furnished under the Contract; have been certified by an actuary as meeting requirements of 42 C.F.R. § 438.4; and otherwise meet all applicable requirements established in 42 C.F.R. § 438.4 and any other applicable law(s).

Adverse Benefit Determination – the denial or limited authorization of a requested service, including: the type or level of service; requirements for medical necessity; appropriateness; setting or effectiveness of a covered benefit; the reduction, suspension or termination of a previously

authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services or act in a timely manner as required herein; failure of the contractor to act within the timeframes for disposition, resolution, and notification of appeals and grievances; the denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities; or, for a rural area resident with only one Managed Care Entity (MCE) available, the denial of an Enrollee's request under 42 C.F.R. § 438.52(b)(2)(ii) to obtain services outside the contractor's network.

Ambulatory Surgery Center (ASC) – ASCs are certified by Medicare as an entity operating exclusively for the purpose of providing surgical services to patients not requiring hospitalization. See Billing Guide (https://www.hca.wa.gov/billers-providers/programs-and-services/dental-services). .

American Indian / Alaska Native / Indian – means any individual defined at U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. 136.12. This means the individual: (1) is a member of a federally recognized Indian tribe; or (2) resides in an urban center and meets one or more of the following criteria: (a) is a member of a tribe, band, or other organized group of Indians, including those tribes, bands , or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member; (b) is an Eskimo or Aleut or other Alaska Native; (c) is determined to be an Indian under regulations issued by the Secretary; (d) is considered by the Secretary of the Interior to be an Indian for any purpose; or (e) is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

Apparently Successful Bidder(s) (ASBs) – The Bidder(s) selected as the entity(ies) to perform the anticipated services under this RFP, subject to completion of contract negotiations and execution of a written contract.

Appeal – review by the ASB of an Adverse Benefit Determination.

Bidder – Individual or company interested in the RFP submitting a proposal in order to attain a contract with HCA.

Business Hours – means 8:00 a.m. to 5:00 p.m. Pacific Time, Monday through Friday.

Care Coordination – an approach to healthcare in which all of an Enrollee's needs are coordinated with the assistance of a care coordinator. The care coordinator provides information to the Enrollee and the Enrollee's caregivers, and works with the Enrollee to make sure the Enrollee receives the most appropriate treatment, while ensuring health care is not duplicated.

Care Management – a set of services designed to improve the health of Enrollees. Care Management includes a health assessment, development of a care plan and monitoring of Enrollee status, care coordination, ongoing reassessment and consultation and crisis intervention and case conferencing as needed to facilitate improved outcomes and appropriate use of health services,

including moving the Enrollee to a less intensive level of population health management as warranted by Enrollee improvement and stabilization. Effective care management includes the following: 1) actively assisting Enrollees to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability; 2) utilization of evidence-based clinical practices in screening and intervention; 3) coordination of care across the continuum of medical, behavioral health, oral health, and long-term services and supports, including tracking referrals and outcomes of referrals; 4) ready access to integrated behavioral health and physical health services; and 5) use of appropriate community resources to support individual Enrollees, families, and caregivers in managing care.

Centers for Medicare and Medicaid Services (CMS) – the federal agency within the U.S. Department of Health and Human Services (DHHS) administering the Medicare program and working in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.

Cleft – An opening or fissure involving the dentition and supporting structures, especially those occurring in utero. These can be: (1) cleft lips; (2) cleft palates (involving the roof of the mouth); and (3) facial clefts (e.g. macrostomia).

Client – an individual who has been determined Medicaid-eligible by HCA but who has not enrolled in an Apple Health Managed Care Dental Program.

Clinical Management Services/Program – the group of services, which includes Utilization Management, Care Management, Care Coordination, and Quality of Care Improvement Initiatives.

Contractor – means a company whose Proposal has been accepted by HCA and is awarded a fully executed, written contract.

Covered Service – a health care service contained within a "service category" that is included in a Washington Apple Health benefits package.

Craniofacial Anomalies – abnormalities of the head and face, either congenital or acquired, involving disruption of the dentition and supporting structures.

Dental Health Aide Therapist (DHAT) – a person who has met the training and education requirements, and satisfies other conditions, to be certified as a dental health aide therapist by a federal community health aide program certification board or by a federally recognized Indian tribe that has adopted certification standards that meet or exceed the requirements of a federal community health aide program certification board. HCA cannot use federal funding for DHAT services.

Dentist – an individual licensed to practice dentistry in the state of Washington.

Dual-Eligible Clients – an individual client who is primary with Medicare, and enrolled in Medicaid.

Enrollee – an eligible Client who is enrolled in managed care dental through an MCE having a Contract with HCA (42 C.F.R. § 438.10(a)).

Exception to Rule (ETR) – a Client, or the Client's provider, may request the Medicaid agency or its designee pay for a non-covered health care service. This is called an exception to rule (ETR). The request for ETR must be made before the service is rendered (WAC 182-501-0160).

Excluded Service – a benefit not paid for, either based on state statute or under a Washington Apple Health Client eligibility package. Exception to Rule (ETR) is not applicable to an Excluded Service.

Fraud – an intentional deception or misrepresentation made by a person (individual or entity) with the knowledge that the deception could result in some unauthorized benefit to them or some other person. It includes any act that constitutes fraud under applicable federal or state law (42 C.F.R. § 455.2).

Grievance – an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee's rights (42 C.F.R. § 438.400(b)).

HCA – The Health Care Authority, an executive agency of the state of Washington issuing this RFP.

Health Insurance Portability and Accountability Act (HIPAA) – means the federal Health Insurance Portability and Accountability Act of 1996 and its amendments, an act designed in part to protect patient medical records and other health information provided to health care providers.

Indian/Tribal/Urban (I/T/U) Provider – means the Indian Health Service and/or any Tribe, Tribal organization, or Urban Indian Organization which provides Medicaid-reimbursable services.

Independent Hygienist – a licensed hygienist with at least two years' practical clinical experience with a licensed dentist within the previous five years. May be employed, retained, or contracted by health care facilities, senior centers, and schools to perform authorized dental hygiene operations and services without dental supervision (RCW 18.29.056 and 18.29.220). For the purposes of this definition, "health care facilities" are limited to hospitals; nursing homes; home health agencies: group homes serving the elderly, individuals with disabilities, and juveniles; state-operated institutions under the jurisdiction of the Department of Social and Health Services (DSHS) or the Department of Corrections (DOC); and federal, state, and local public health facilities, state or federally funded community and migrant health centers, and tribal clinics. For the purposes of this definition, "senior center" means a multipurpose community facility operated and maintained by a nonprofit organization or local government for the organization and provision of a combination of some of the following: health, social, nutritional, educational services, and recreational activities for persons sixty years of age or older.

Interim Therapeutic Restoration (ITR) – the placement of an adhesive restorative material following caries debridement by hand or other method for the management of early childhood caries. It is not considered a definitive restoration.

Limitation Extensions – a Client, or the Client's provider, may request the Medicaid agency or its designee pay for a health care service for which HCA or its designee has set a "soft" limit on scope, amount, or duration. Because HCA does not use "hard" limits on scope, amount, and duration, HCA uses prior authorization to grant services that exceed the limitations. HCA evaluates requests for limitation extension as identified in WAC 182-501-0165, and as Medically Necessary per WAC 182-501-0169.

Managed Care Entity (MCE) – Organizations contracting with HCA to be responsible for healthcare services for a group of Enrollees. MCEs can include Managed Care Organizations, Prepaid Inpatient Health Plans, Prepaid Ambulatory Health Plans, and Primary Care Case Management Entities.

Medically Necessary – a term for describing requested services which are reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the Client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the Client requesting the service. For the purposes of this, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all. HCA determines medical necessity consistent with the processes described in WAC 182-501-0169.

Non-Covered Service – a non-covered service is a specific health care service (e.g. cosmetic surgery), contained within a service category that is included in a Washington Apple Health benefits package. HCA or HCA's designee requires an approved Exception to Rule (ETR) for payment of a non-covered service. A non-covered service is not an Excluded Service.

Performance Improvement Projects (PIPs) – projects developed and implemented by MCEs to achieve significant improvement, sustained over time, in health outcomes and Enrollee satisfaction with some area of operations and must include the following elements: (1) measurement of performance using objective quality indicators; (2) implementation of interventions to achieve improvement in the access to and quality of care; (3) evaluation of the effectiveness of the interventions based on the performance measures; and (4) planning and initiation of activities for increasing or sustaining improvement.

Prior Authorization – the requirement that a provider must request, on behalf of a Client and when required by rule or agency billing instructions, the agency or the agency's designee's approval to provide a health care service before the Client receives the health care service, prescribed drug, device, or drug-related supply. The agency or agency's designee's approval is based on medical necessity.

Proposal – A formal offer submitted in response to this solicitation.

ProviderOne – the Medicaid Management Information System, which is the State's Medicaid payment system managed by HCA.

Quality of Care – the degree to which an ASB increases the likelihood of desired health outcomes of its Enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Assessment and Performance Improvement – a quality program for the dental benefits furnished to members. Must meet the provisions of 42 C.F.R § 438.240 and Section 7 of Attachment 1, Sample PAHP Apple Health Dental Services Contract.

Regional Service Areas (RSA) or Regions – means a geographic boundary that defines a region for which HCA will purchase dental healthcare through managed care contracts.

Request for Proposals (RFP) – Formal procurement document in which a service or need is identified but no specific method to achieve it has been chosen. The purpose of an RFP is to permit the bidder community to suggest various approaches to meet the need at a given price.

Taxonomy – National code used to identify provider type and scope of practice. HCA's payment system is configured to prevent service coverage/payment for services outside of the provider's scope of practice.

Third Party Liability – the legal responsibility of an identified third party or parties (e.g., certain individuals, entities, insurers, or programs) to pay all or part of the expenditures for medical assistance furnished under a Medicaid state plan. By law, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of a Medicaid Client. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services that are available under the Medicaid state plan. Payer of last resort means that the Medicaid program pays benefits secondary to all other public and private third-party payers who have an obligation to pay for such benefits.

Utilization Management – the evaluation of medical necessity, appropriateness, and efficiency of health care services, procedures, and facilities to manage health care costs by assessing the appropriateness of care prior to its provision.

1.10. ADA

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

2. GENERAL INFORMATION FOR BIDDERS

2.1. RFP COORDINATOR

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

Name	Angela Hanson
E-Mail Address	contracts@hca.wa.gov
Mailing Address:	PO Box 42702 Olympia, WA 98504-2702

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

2.2. ESTIMATED SCHEDULE OF PROCUREMENT ACTIVITIES

Pre-Bid Conference	Week of February 12, 2018
Issue Request for Proposals	May 3, 2018
Pre-Proposal Conference	May 9, 2018 – 8:00 A.M.
Bidder Questions Regarding RFP Due	May 10, 2018 – 2:00 P.M.
Letter of Intent to Propose, including Data Share Agreement (Exhibit G), Due	May 11, 2018 – 12:00 P.M.
Access to SFT Provided to Bidders who have submitted a Letter of Intent to Propose and signed Data Share Agreement, including Dental Data Book and Provider Network Submission	No sooner than May 14, 2018
HCA Answers Posted (Amendment to RFP)	May 25, 2018
Complaints Deadline	June 22, 2018
Proposal Due	June 29, 2018 – 2:00 P.M.
Proposal Final Network Due	June 29, 2018 – 2:00 P.M.
Evaluation of Written Proposals	July 2 – August 1, 2018
Announce “Apparently Successful Bidder(s)” and send notification via e-mail to unsuccessful Bidders	No later than August 6, 2018

Debriefing Period	August 13 – August 17, 2018
Protest Period End Date (date by which Bidder must file a bid protest)	August 24, 2018
HCA Readiness Review Materials Request Document to ASB(s)	August 27, 2018
Final Contracts Signed	October 1, 2018
Readiness Review	October 1 – October 31, 2018
Contract Start Date	January 1, 2019

The Contract start date is contingent upon timely approval by CMS.

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

2.3. PRE-PROPOSAL CONFERENCE

An in person pre-proposal conference is scheduled to be held on May 9, 2018 from 8:00 a.m. to 10:00 p.m. Pacific Time at HCA in Olympia, Washington. All prospective Bidders should participate; however, attendance is not mandatory. Specifics for the conference, including location, will be released via the RFP Coordinator at a later date, but no later than one (1) week prior to the meeting.

A copy of the questions and answers from the pre-proposal conference will be posted on HCA's website and on WEBS as an amendment to this RFP. Written questions may be submitted in advance to the RFP Coordinator at contracts@hca.wa.gov. HCA will be bound only by HCA's written answers to questions.

2.4. LETTER OF INTENT TO PROPOSE

To be eligible to submit a Proposal, a Bidder must submit a Letter of Intent to Propose. The Letter of Intent to Propose must be emailed to the RFP Coordinator, listed in Section 2.1, and must be received by the RFP Coordinator no later than the date and time stated in the Procurement Schedule, Section 2.2. The subject line of the email must include the following: ***RFP 2516 – Letter of Intent to Propose – [Your entity's name]***.

The Letter of Intent to Propose may be attached to the email as a separate document, in Microsoft Word or Adobe PDF, or the information may be contained in the body of the email.

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

A. Company Information

2.4.1. Bidder's Organization Name;

2.4.2. Bidder's authorized representative for this Procurement (this representative will also be named the authorized representative identified in the Bidder's Proposal and the representative requiring access to the SFT for Dental Data Book and Provider Network Submission);

2.4.3. Title of authorized representative;

2.4.4. Address, Telephone number, and Email address of authorized representative;

B. Statement of Intent to Propose.

C. A list of the RSA(s) for which Bidder intends to submit a Proposal.

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

E. Signed Data Share Agreement (DSA). This is required in order for HCA to provide Exhibit D, Provider Network Submission, necessary to complete Section 3.3; and Exhibit F, Dental Data Book, necessary to complete Section 3.8, Cost Proposal;. A copy of the DSA is provided as Exhibit G of this RFP.

HCA reserves the right to request clarification from any potential Bidder regarding its Letter of Intent to Propose. The request for clarification regarding the Letter of Intent to Propose will not extend the deadline for submission of responses to this RFP.

Only Bidders submitting a Letter of Intent to Propose will receive amendments and other information regarding this RFP.

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

2.5. PROVIDER NETWORK SUBMISSION AND DENTAL DATA BOOK

Bidders who submit a Letter of Intent to Propose and signed Data Share Agreement, Exhibit G, will receive access to the SFT site which includes, Exhibit D, Provider Network Submission and Exhibit F, Dental Data Book.

The Provider Network Submission, Exhibit D, will contain data necessary for Bidder to determine and ensure network adequacy, in accordance with Section 3.3. Provider Network Submission data and files assume the use of: GeoCoder, version 4.0; GeoNetworks, Release 4, 2011; Microsoft Office

Access 2007; and Microsoft Office Excel 2007, or the most current updated versions. Bidders are instructed to rely upon the Provider Network Submission Exhibit in assembling their Proposal.

The Dental Data Book will include data necessary to support the dental rate development. Data is limited to calendar years 2016 and 2017, with payments made through December 31, 2017, and based on fee-for-service claims data for dental services that will be covered under the Managed Care Dental Program, provided to Medicaid Clients who will be eligible to enroll in the Managed Care Dental Program. Bidders are instructed to rely upon the Dental Data Book in assembling their Proposal.

Both Exhibit D, Provider Network Submission, and Exhibit F, Dental Data Book, are solely for use in Bidder's development of their Proposal for this RFP.

2.6. SUBMISSION OF PROPOSALS

Bidders are required to submit one (1) hard copy of their Proposal with original signatures and two (2) identical copies of their entire Proposal on a USB Flash or thumb drive in Microsoft 2003 or later, or Adobe PDF. The USBs or thumb drives must be labeled with the date, RFP Title, RFP Number, and Bidder's Name, and packaged with the original copy of the Proposal.

The Proposal, whether mailed or hand delivered, must arrive at HCA no later than the Proposal Due deadline in Section 2.2, *Estimated Schedule of Procurement*.

The Proposal must be sent to the RFP Coordinator at the address noted in Section 2.1. The envelope must be clearly marked to the attention of the RFP Coordinator.

Bidders mailing Proposals should allow normal mail delivery time to ensure timely receipt of their Proposals by the RFP Coordinator. Bidders assume the risk for the method of delivery chosen. HCA assumes no responsibility for delays caused by any delivery service. Proposals may not be transmitted using facsimile transmission.

Late Proposals will not be accepted and will be automatically disqualified from further consideration. All Proposals and any accompanying documentation become the property of HCA and will not be returned.

2.7. PROPRIETARY INFORMATION / PUBLIC DISCLOSURE

Proposals submitted in response to this competitive procurement will become the property of HCA. All Proposals received will be considered "public records" under chapter 42.56 RCW. Proposals will be considered confidential and not subject to disclosure until the Apparently Successful Bidder(s) are announced; thereafter, the Proposals will be deemed subject to disclosure.

Any information in the Proposal that the Bidder desires to claim as proprietary and exempt from disclosure under the provisions of chapter 42.56 RCW, or other state or federal law that provides for

the nondisclosure of a document, must be clearly designated. The information must be clearly identified and the particular exemption from disclosure upon which the Bidder is making the claim must be cited. Each page containing the information claimed to be exempt from disclosure must be clearly identified by the words "**Proprietary Information**" printed on the lower right hand corner of the page. Marking the entire Proposal exempt from disclosure or as Proprietary Information will not be honored.

If a public records request is made that would encompass any information that the Bidder has marked as "Proprietary Information," HCA will notify the Bidder of the request and of the date that the records will be released to the requester unless the Bidder obtains an order from a court of competent jurisdiction enjoining that disclosure. If the Bidder fails to obtain a court order enjoining disclosure, HCA will release the requested information on the date specified. If a Bidder obtains a court order enjoining disclosure pursuant to chapter 42.56 RCW, or other state or federal law that provides for nondisclosure, HCA will maintain the confidentiality of the Bidder's information in accordance with the court order.

A charge may be made for copying and shipping, as outlined in RCW 42.56. No fee will be charged for inspection of contract files, but twenty-four (24) hours' notice to HCA is required. All requests for information should be directed to publicdisclosure@hca.wa.gov.

The submission of any public records requests to HCA pertaining in any way to this RFP will not affect the procurement schedule, as outlined in Section 2.2, unless HCA, in its sole discretion, determines that altering the schedule would be in HCA's best interests.

2.8. REVISIONS TO THE RFP

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

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

2.9. DIVERSE BUSINESS INCLUSION PLAN

Bidders will be required to submit a Diverse Business Inclusion Plan with their Proposal. In accordance with legislative findings and policies set forth in RCW 39.19, the state of Washington encourages participation in all contracts by firms certified by the Office of Minority and Women's Business Enterprises (OMWBE), set forth in RCW 43.60A.200 for firms certified by the Washington State Department of Veterans Affairs, and set forth in RCW 39.26.005 for firms that are Washington

Small Businesses. Participation may be either on a direct basis or on a subcontractor basis. However, no preference on the basis of participation is included in the evaluation of Diverse Business Inclusion Plans submitted, and no minimum level of minority- and women-owned business enterprise, Washington Small Business, or Washington State certified Veteran Business participation is required as a condition for receiving an award. Any affirmative action requirements set forth in any federal Governmental Rules included or referenced in the contract documents will apply.

2.10. ACCEPTANCE PERIOD

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

2.11. COMPLAINT PROCESS

2.11.1. Bidders may submit a complaint to the RFP Coordinator at the email specified in Section 2.1 based on any of the following:

2.11.1.1. The RFP unnecessarily restricts competition;

2.11.1.2. The RFP evaluation or scoring process is unfair; or

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

2.11.2. A complaint must be submitted to HCA prior to five (5) business days before the bid response deadline (see Section 2.2). The complaint must:

2.11.2.1. be in writing;

2.11.2.2. be sent to the RFP Coordinator in a timely manner;

2.11.2.3. clearly articulate the basis for the complaint; and

2.11.2.4. include a proposed remedy.

The RFP Coordinator will respond to the complaint in writing. The response to the complaint and any changes to the RFP will be posted on WEBS and HCA's external procurement website. The Director of HCA will be notified of all complaints and will be provided a copy of HCA's response. The Director of HCA reserves the right to make the final decision on the complaint.

The issues listed in Section 2.11.1 can be raised only during the complaint process; those issues cannot be raised during a bid protest, even if a Bidder failed to raise them as a complaint. HCA's action or inaction in response to the complaint will be final. There will be no appeal process.

2.12. RESPONSIVENESS

All Proposals will be reviewed by the RFP Coordinator to determine compliance with administrative requirements and instructions specified in this RFP. The Bidder is specifically notified that failure to comply with any part of the RFP may result in rejection of the Proposal as non-responsive.

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

2.13. MOST FAVORABLE TERMS

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

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

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

2.14. CONTRACT AND GENERAL TERMS & CONDITIONS

The Contract(s) awarded under this procurement will be considered Prepaid Ambulatory Health Plans (PAHPs) under 42 C.F.R. 438.

A PAHP is defined as an entity that:

2.14.1. Does not provide a full scope of benefits – provides a limited benefit, in this case dental services;

2.14.2. Under a contract with the state, provides services to Enrollees on the basis of capitation payments, or other payment arrangements that do not use state plan payment rates;

2.14.3. Does not provide or arrange for, and is not otherwise responsible for, the provision of any inpatient hospital or institutional services for its Enrollees; and

2.14.4. Does not have a comprehensive risk contract (42 C.F.R. 438.2).

Bidders must comply with the terms of the attached Sample PAHP Apple Health Dental Services Contract, Attachment 1, for Managed Care Dental Services, including well-developed systems for:

- Receiving HIPAA-compliant enrollment and payment files;

- Customer Service;
- Claims adjudication and payment;
- Grievances and Appeals;
- Quality Improvement and Oversight;
- Development and maintenance of a robust network;
- Utilization Management; and
- Care Coordination.

The Apparently Successful Bidder(s) will be expected to enter into a contract which is substantially the same as the draft Sample PAHP Apple Health Dental Services Contract and its general terms and conditions attached as Attachment 1. In no event is a Bidder to submit its own standard contract terms and conditions in response to this solicitation. The Bidder may submit exceptions as allowed in the Certifications and Assurances form, Exhibit C to this solicitation. All exceptions to the contract terms and conditions must be submitted as an attachment to Exhibit C, Certifications and Assurances form. If the Bidder fails to identify or object to any particular term or condition, that term or condition will be deemed agreed to by the Bidder, and will not be further discussed by HCA. HCA reserves the right to discuss any Bidder proposed change to terms or conditions and to clarify and supplement such Proposal.

Please note that HCA will expect the ASB(s) to agree to honor and pay for Prior Authorizations that HCA has approved and are non-expired by implementation on January 1, 2019. HCA will provide all applicable approved authorizations to ASB(s) for their respective Enrollees.

If, after the announcement of the ASB(s), and after a reasonable period of time, the ASB(s) 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 Bidder. HCA may also, in its sole discretion, decide not to enter into any contract at all.

2.15. COSTS TO PROPOSE

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

2.16. RECEIPT OF INSUFFICIENT NUMBER OF PROPOSALS

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

2.17. NO OBLIGATION TO CONTRACT

This RFP does not obligate the state of Washington or HCA to contract for services specified herein.

2.18. REJECTION OF PROPOSALS

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

2.19. COMMITMENT OF FUNDS

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

2.20. ELECTRONIC PAYMENT

The state of Washington prefers to utilize electronic payment in its transactions. The ASB(s) will be provided a form to complete with the contract to authorize such payment method.

2.21. INSURANCE COVERAGE

As a requirement of the resultant contract, the ASB(s) 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 ASB(s) must, at its own expense, obtain and keep in force insurance coverage which will be maintained in full force and effect during the term of the contract. The ASB(s) 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 calendar days of the contract effective date.

The ASB(s) must, at all times, comply with the following insurance requirements:

2.21.1. Commercial General Liability Insurance (CGL): The ASB(s) must maintain CGL insurance, including coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence – $1,000,000; General Aggregate – $2,000,000. The policy must include liability arising out of premises, operations, independent contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured Contract. The state of Washington, HCA, its elected and appointed officials, agents, and employees must be named as additional insureds expressly for, and limited to, the ASB(s)' services provided under the contract.

2.21.2. Professional Liability Insurance (PL): The ASB(s) must maintain PL, including coverage for losses caused by errors and omissions, with the following minimum limits: Each Occurrence – $1,000,000; General Aggregate – $2,000,000.

2.21.3. Worker's Compensation: The ASB(s) must comply with all applicable worker's compensation, occupational disease, and occupational health and safety laws and regulations. The state of Washington and HCA will not be held responsible as an employer for claims filed by the Contractor or its employees under such laws and regulations.

2.21.4. Employees and Volunteers: Insurance required of the ASB(s) under the Contract must include coverage for the acts and omissions of the ASB(s)' employees and volunteers.

2.21.5. Subcontractors: The ASB(s) must ensure that all subcontractors have and maintain insurance appropriate to the services to be performed. The Contractor will make available copies of Certificates of Insurance for subcontractors to HCA, if requested.

2.21.6. Separation of Insured's: All insurance Commercial General Liability policies must contain a "separation of insured's" provision.

2.21.7. Insurers: The ASB(s) will obtain insurance from insurance companies authorized to do business within the state of Washington, with a "Best's Reports" rating of A-, Class VII or better. Any exception must be approved by HCA. Exceptions include placement with a "Surplus Lines" insurer or an insurer with a rating lower than A-, Class VII.

2.21.8. Evidence of Coverage: The ASB(s) must submit Certificates of Insurance in accord with the Notices section of the General Terms and Conditions, for each coverage required under this Contract upon execution of this Contract. Each Certificate of Insurance must be executed by a duly authorized representative of each insurer.

2.21.9. Material Changes: The ASB(s) will give HCA, in accord with the Notices section of the General Terms and Conditions, forty-five (45) calendar days advance notice of cancellation or non-renewal of any insurance in the Certificate of Coverage. If cancellation is due to non-payment of premium, the ASB(s) must give HCA ten (10) calendar days advance notice of cancellation.

2.21.10. General: By requiring insurance, the state of Washington and HCA do not represent that coverage and limits specified will be adequate to protect the ASB(s). Such coverage and limits will not be construed to relieve the ASB(s) from liability in excess of the required coverage and limits and will not limit the ASB(s)' liability under the indemnities and reimbursements granted to the State and HCA in the Contract. All insurance provided in compliance with the Contract will be primary as to any other insurance or self-insurance programs afforded to or maintained by the State.

2.21.11. ASB may waive the requirements as described in the Commercial General Liability Insurance, Professional Liability Insurance, Insurers, and Evidence of Coverage provisions of this Section if self-insured. In the event the ASB(s) is self-insured, the ASB(s) must send to HCA by the third Wednesday of January in each Contract year, a signed written document, which certifies that the ASB(s) is self-insured, carries coverage adequate to meet the requirements of this Section, will treat HCA as an additional insured, expressly for, and limited to, the ASB(s)' services provided under the Contract, and provides a point of contact for HCA.

2.21.12. Privacy Breach Response Coverage: For the term of the Contract and three (3) years following its termination, the ASB(s) must maintain insurance to cover costs incurred in connection with a security incident, privacy Breach, or potential compromise of Data including:

2.21.12.1. 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 (45 C.F.R Part 164, Subpart D; RCW 42.56.590; RCW 19.255.010; and WAC 284-04-625.

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

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

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

3. PROPOSAL CONTENTS

3.1. PROPOSAL FORMAT (MANDATORY)

Proposals must be written in English and submitted on eight and one-half by eleven inch (8 ½" x 11") paper with tabs separating the major sections of the Proposal. The eight major sections of the Proposal are to be submitted in the order noted below:

- Letter of Transmission;
- Exhibit A, Letter of Submittal;
- Exhibit B, Signed Minimum Qualifications Certification;
- Exhibit C, Signed Certifications and Assurances;
- Exhibit D, Provider Network Submission;
- Exhibit E, Evaluation Questions;
- Cost Proposal Template, included in Exhibit F, Dental Data; and
- Exhibit H, Diverse Business Inclusion Plan.

Proposals 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 Proposal for the Proposal 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.

3.2. LETTER OF TRANSMISSION (MANDATORY)

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

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

3.2.2. The Certification of Minimum Qualifications, Exhibit B, confirming Bidder meets, or will meet by the required timeline(s), ALL of the Minimum Requirements specified in Section 1.4 of the RFP, must be signed and dated by a person authorized to legally bind the Bidder to a contractual relationship.

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

3.2.4. A red-lined copy of the draft Sample PAHP Apple Health Dental Services Contract, Attachment 1, identifying issues or proposed alternate text that reflects the actual content of the Bidder's Proposal (Section 2.14).

3.2.5. Completed Diverse Business Inclusion Plan, Exhibit H.

3.2.6. A statement attesting Bidder downloaded, and used in development of their Proposal, the Provider Network Submission (Exhibit D) and Dental Data Book (Exhibit F) from SFT.

3.3. PROVIDER NETWORK (PASS/FAIL)

Reference Attachment 3, Regional Service Areas, and Exhibit D, Provider Network Submission (available via SFT site), for submission of Bidder's Provider Network. For the purposes of this Section, "Adult" is defined as twenty-one years of age and older; "Children" is defined as twenty years of age and younger.

3.3.1. [Pass/Fail] For the purpose of this RFP, the Bidder's network must include enough providers to serve 7% of Adults and 18% of Children in each service area being bid on at the time of Proposal submission. If Bidder does not meet this requirement, the Proposal will not be evaluated further. Please note: Bidder will need to meet the following network capacity at the time of Readiness Review, see Section 2.2, Estimated Procurement Schedule: 25% for Adults, and 60% for Children.

3.3.1.1. The provider network submission must include only those providers with whom the Bidder has a current contract for providing services under the Washington Medicaid Managed Care Dental Program identified in this RFP. Bidders are required to submit the signature pages of current contracts for all provider types.

3.3.1.2. The contracts must be compliant with federal Medicaid regulations.

3.3.1.3. The Bidder must submit an attestation verifying: (a) attempts to contract with 100% of tribes, IHS facilities, and UIHPs delivering dental services in Washington 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; and (b) meeting contractually required distance standards set out below (3.3.2) and in Attachment 1, Sample PAHP Apple Health Dental Services Contract. Please include the number of attempts and a detailed description of the effort made to contract with the tribes, IHS facilities, and UIHPs delivering dental services in and out of Washington State.

3.3.2. [Pass/Fail] Bidder's network must allow Enrollee access to general and specialist providers, including pediatric dental specialists as described below. If Bidder does not meet this requirement, the Proposal will not be evaluated further. Please include

templates of the standard contracts used by Bidder for each type of dental provider, including specialists.

3.3.2.1. Distance

- General Dentists: 1 in 10 miles Urban, 1 in 25 miles Rural
- Pediatric Dentists: 1 in 10 miles Urban, 1 in 25 miles Rural
- Oral Surgeons: 1 in 25 miles Urban and Rural
- Orthodontists: 1 in 25 miles Urban and Rural
- Denturists: 1 in 25 miles Urban and Rural

3.3.2.2. Time

- General Dentists: 1 in 10 minutes Urban, 1 in 25 minutes Rural
- Pediatric Dentists: 1 in 10 minutes Urban, 1 in 25 minutes Rural
- Oral Surgeons: 1 in 25 minutes Urban and Rural
- Orthodontists: 1 in 25 minutes Urban and Rural
- Denturists: 1 in 25 minutes Urban and Rural

3.4. PROVIDER NETWORK (SCORED) (MAX 480 POINTS) (PAGE LIMIT: 15)

For the purposes of this Section, "Adult" is defined as twenty-one years of age and older; "Children" is defined as twenty years of age and younger.

3.4.1. [Scored, Max 160 points] What steps will Bidder's organization take to develop, monitor, and maintain a network that meets time and distance standards described above within the first year after Contract implementation, and meets the following milestones:

	Date (Due by)	Adult Network Capacity (% of Clients in RSA)	Children Network Capacity (% of Clients in RSA)
Starting	*June 29, 2018 – Proposal Due Date*	*7*	*15*
3.4.1.1	August 17, 2018	15	35
3.4.1.2	October 1, 2018 – Readiness Review	25	60
3.4.1.3	June 30, 2019 – 6 months post implementation	35	65
3.4.1.4	December 31, 2019 – 12 months post implementation	45	65
3.4.1.5	Each Quarter of Year 2	+1	

Amendments to extend the period of performance of the contract may require additional network capacity increases.

3.4.2. [Scored, Max 112 points] How will Bidder develop a network reflecting the diversity of the population being served?

3.4.3. [Scored, Max 80 points] What written policies does Bidder's organization have regarding the selection and retention of providers? How will Bidder's organization attract and retain providers that serve high-risk populations (including Developmental Disabilities Administration (DDA), mental health issues, addiction issues, etc.)?

3.4.4. [Scored, Max 48 points] How will Bidder's organization coordinate services for Enrollees who may need to go outside their service area to obtain services in areas where Bidder may have an inadequate network or where an out-of-network provider has specialized expertise? For example: working with special needs children; non-English speaking Enrollees; or an Enrollee in need of maxilla-facial surgery to correct defects caused by accident or illness.

3.4.5. [Scored, Max 16 points] How will Bidder's organization ensure Enrollees have access to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for dental services?

3.4.6. [Scored, Max 64 points] Does Bidder's organization have the ability to initiate "Single Case Agreements" for situations in which a provider chooses not to contract with Bidder's organization, but his or her services are needed to address an Enrollee need? Please describe the process for negotiating a Single Case Agreement.

3.5. EVALUATION QUESTIONS (EXHIBIT E) (SCORED)

Bidder must respond to the Evaluation Questions as outlined in Exhibit E.

Bidder must respond and provide detailed information for all items and provide all information in the exact order specified in each section. The section numbers and titles must be restated in the Bidder's Proposal. Page limits for each question are noted. Please do not cut and paste responses into Exhibit E. Instead, provide a response as a separate document using the corresponding item number listed.

Failure to meet an individual requirement will not be the sole basis for disqualification; however, failure to provide a response to any scored requirements may be considered non-responsive and be the basis for disqualification of the application.

3.6. EXPERIENCE (SCORED) (MAX 160 POINTS)

Provide two examples of large, complex programs that were successfully implemented by Bidder. Include lessons learned from past implementations. At least one example must be related to a managed care program.

Page Limit: five (5) pages.

3.7. REFERENCES (MANDATORY)

Include the names, addresses, telephone numbers, and email addresses of staff with whom the Bidder coordinated during the development and implementation of the above program examples, Section 3.6). Do not include current HCA staff as references.

By submitting a Proposal in response to this RFP, the Bidder and team members grant permission to HCA to contact these references and others, who from HCA's perspective, may have pertinent information. HCA may or may not, at HCA's discretion, contact references. HCA may evaluate references at HCA's discretion.

3.8. COST PROPOSAL (SCORED) (MAX 320 POINTS)

3.8.1. Cost Proposal Process Overview

A. Bidders that submit a Letter of Intent to Propose will be provided access to Exhibit F, Dental Data Book. Included in Exhibit F is a narrative entitled "Managed Care RFP Data Book", which provides: (a) detailed information about specific components of the Washington dental program; (b) a description of the data and methodology underlying the Dental Data Book; and (c) instructions for populating the Cost Proposal Template.

B. Cost Proposals must be based on the program design and requirements as outlined in the RFP and Attachment 1, Sample PAHP Apple Health Dental Services Contract. Cost Proposals must not include any program design or policy not addressed in the RFP and the sample contract. The following are examples of items that should not be included in the Cost Proposals:

- Patient Protection and Affordable Care Act (PPACA) insurer fees.
- Any potential changes to the program that have not been established in a final HCA rule and posted on HCA's website.
- Service Based Enhancements, including FQHC/Tribal and DECOD.

In addition, the following list provides examples of items Bidders must not include in their Cost Proposals. Instead, HCA will develop additional monthly payments for these items, which will be included on top of accepted Cost Proposal rates:

- ABCD Expansion;
- Oral Health Connections Pilot Project; and
- Dental Access Payments (DAP).

For any significant program change occurring after HCA awards any contract(s) under this RFP, HCA and its actuary will calculate the impact on the rate ranges established for Bidder's Cost Proposal and the rates for the ABS(s) will be adjusted to reflect the impact relative to the awarded capitation payments.

3.8.2. Requirements for Submitting Cost Proposals

This section outlines the submission of the Bidder's Cost Proposal. Cost Proposal Instructions are included in Section IV of the "Managed Care Dental RFP Data Book", included in Exhibit F.

A. Cost Proposal Templates

The Cost Proposal Template is a Microsoft Excel workbook that consists of multiple worksheet tabs. This template has been provided solely to facilitate completion of the Cost Proposal. It is the Bidder's responsibility to review all Cost Proposal Template tabs, prior to submission, for reasonableness and validity of the amounts being submitted.

Bidders are required to submit their Cost Proposal in the prescribed template, and the submission must not deviate from the template provided. **Deviation from the prescribed format will result in potential disqualification of the Proposal.**

The Cost Proposal Template is populated with Calendar Years 2016 and 2017 base period FFS experience, paid through December 31, 2017. Member months from October 2017 to December 2017 are used to composite PMPM values and to allow Bidders to estimate market share.

Bidders must develop and submit capitation rate cost proposals for the programs and rate cohorts outlined in the Cost Proposal Template.

The following table describes each of the tabs in the Cost Proposal Template. For each of the regional tabs, capitation rates are calculated as the result of rating assumption inputs made by Bidders. Bidders must provide documentation in support of all rating assumptions included in their Cost Proposal.

Tab Name	Description of Input
Instructions	Respondent Name
TOC	If a respondent is not bidding in a region, they can make the corresponding sheet hidden
Network Inputs	Adjustments for unit cost and utilization corresponding to varying network capacity levels
Region 1	Southwest Washington Rating Assumptions
Region 2	North Central Rating Assumptions
Region 3	King County Rating Assumptions
Region 4	Great Rivers Rating Assumptions
Region 5	Greater Columbia Rating Assumptions
Region 6	North Sound Rating Assumptions
Region 7	Thurston-Mason Rating Assumptions
Region 8	Salish Rating Assumptions
Region 9	Spokane Rating Assumptions
Region 10	Pierce Rating Assumptions

B. Actuarial Certification and Supporting Memorandum

Bidders must provide an actuarial certification and memorandum documenting data, methodology, and assumptions underlying the proposed capitation rates. The memorandum must demonstration compliance with federal regulations under 42 C.F.R. § 438, and generally accepted actuarial principles and practices including those outlined in actuarial standard of practice (ASOP) 49. Bidders should refer to the following documents in preparing Cost Proposals:

42 C.F.R. § 438 (https://www.medicaid.gov/medicaid/managed-care/downloads/managed-care-regulations-42-cfr-part-438.pdf);

ASOP 49 (http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf);

CMS 2018-2019 Medicaid Managed Care Rate Development Guide (https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/2019-medicaid-rate-guide.pdf).

At a minimum, the Bidders must provide the following information:

- Changes in utilization from the underlying source data by category of service resulting from an assumed difference in the level of health care management.
- Changes in utilization or unit costs resulting from the one-time shift from State FFS program to the Managed Care plan network.
- Assumptions regarding changes in utilization or average unit cost for each change in contractual requirements. Only contractual requirements referenced in the RFP or Attachment 1, Sample PAHP Apple Health Dental Services Contract, that impact rates should be included in this list.
- An explanation of assumptions due to network expansion, leading to increased access.
- Justification for assumptions regarding administrative expenses. Administrative expenses should be reported in a manner consistent with CMS guidance and include the amounts allocated to profit and risk margin.

HCA, or HCA's contracted actuary, will develop the following factors, which will be incorporated with Bidder's adjusted rate factors, and Final Proposed Rates will be provided to Bidder as described below (3.8.3(A)):

- Adjustments for claims assumed to be incurred by not reported in the data.
- The weight given to each base year.
- Annual unit cost and utilization rate trends.
- Assumptions related to a shift in case mix or change in population acuity.
- A detailed discussion and supporting calculations for any smoothing or credibility weighting methods.
- Modifications to account for the differences in risk between the FFS baseline population and the population which will ultimately enroll in managed care. For example, acuity differences expected related to voluntary enrollment of AI/AN members or Medicaid population churn.

Bidders can fill in input values on their Cost Proposal Template for the factors that will be developed by HCA, or HCA's contracted actuary, but are not required to.

Any input values included by Bidder for those factors will not be considered in the Final Proposed Rates.

3.8.3. Evaluation and Cost Proposal Scoring Methodology

Cost Proposals will be scored with a preference for statewide coverage, with each Regional Service Area (RSA) being worth a maximum of 32 points and all ten RSAs being worth the maximum of 320 points.

A. Scoring. Bidder will submit the Cost Proposal Template by proposing a set of rate factors to HCA. HCA, or HCA's contracted actuary, will develop assumptions for the remaining rate factors. HCA, or HCA's contracted actuary, will review, and incorporate HCA rate factors and any adjustments to Bidder's proposed rate factors. This adjustment may involve a request for more information or feedback from the Bidder regarding rate assumptions. The final rates for each Bidder will be submitted to Bidder for acceptance. Accepted rates will be the Final Proposed Rates. Final Proposed Rates score will be computed for each program by dividing the lowest cost Final Proposed Rate, for each program in each RSA, by the Bidder's Final Proposed Rate, for each program in each RSA. The resulting number(s) for each region in each program, will be multiplied by one tenth of the maximum possible points for the cost section (32). The bidder's statewide total for each of the programs will be averaged to determine the bidder's final cost proposal score.

   An Excel spreadsheet, *Managed Care Dental Cost Proposal Scoring*, will be provided as part of the Dental Data Book to show the methodology of scoring of Final Proposed Rates.

B. Final Rates Paid. The Cost Proposal submissions will be utilized to score and award points to Bidders. Cost submission points are one component of the overall available points outlined in this RFP. Final Proposed Rate bids represent the prospective monthly capitation payment for January 1, 2019 through December 31, 2019 that the HCA may pay the Apparent Successful Bidder(s).

   The monthly capitation base rate paid to ASB(s) may be adjusted, at the discretion of HCA, prior to implementation due to a variety of factors currently unknown, which could include the following:

   - CMS feedback
   - Payments expected to function as pass-through items
   - Modifications to the benefit package or administrative expectations
   - Other material items that may impact the rate ranges

4. EVALUATION AND CONTRACT AWARD

4.1. EVALUATION PROCEDURE

Responsive Proposals will be evaluated strictly in accordance with the requirements stated in this solicitation and any addenda issued. The evaluation of Proposals will be accomplished by an evaluation team(s), to be designated by HCA, which will determine the ranking of the Proposals. Evaluations will only be based upon information provided in the Bidder's Proposal.

All Proposals received by the stated deadline, Section 2.2, *Estimated Schedule of Procurement Activities*, will be reviewed by the RFP Coordinator to ensure that the Proposals contain all of the required information requested in the RFP. Only responsive Proposals that meet the requirements will be evaluated by the evaluation team. Any Bidder who does not meet the stated qualifications or any Proposal that does not contain all of the required information will be rejected as non-responsive.

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

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

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

4.2. EVALUATION WEIGHTING AND SCORING

4.2.1. The Mandatory Requirements are evaluated on a pass/fail basis. The following weighted points will be assigned to the Proposal for evaluation purposes.

Evaluation Criteria	**Maximum Weighted Points Possible**
RFP Compliance	N/A
Mandatory Management Review Including Letter of Transmission and Certification and Assurances	N/A
Provider Network (Section 3.3)	Pass/Fail
Provider Network Questions (Section 3.4)	25% / 400 points

Evaluation Questions (Exhibit E)	40% / 640 points
Experience (Section 3.6)	10% / 160 points
Cost Proposal / Rates (Section 3.8)	25% / 400 points
Total	1600 points
Bonus Questions / Points (Exhibit E, Section 6)	110 points

HCA reserves the right to award the contract(s) to the Bidder(s) whose Proposal is deemed to be in the best interest of HCA and the state of Washington.

4.2.2. Except in regards to Section 4.2.3, HIPAA Compliance Scoring, noted below, evaluators will assign scores to each Scored (S) requirement on a scale of zero (0) to ten (10) where the end and midpoints are defined as follows:

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

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

4.2.3. HIPAA Compliance Specific Scoring

Exhibit E, Evaluation Questions, Section 5.16 HIPAA Compliance, Question 5.16.2 will be scored on the following scale:

Score	Description	Discussion
0	No Value	Response is missing, totally inadequate or shows Bidder did not comply with HIPAA Rules
1	Poor	The Response has not fully established the capability to perform the HIPAA requirements, or only marginally shown compliance.
3	Below Average	The Response only minimally shows compliance with the HIPAA requirements.
5	Average	The Response shows an acceptable understanding or experience with the HIPAA requirements. Sufficient detail to be considered "as meeting the minimum requirements."
7	Good	The Response is thorough and complete and demonstrates firm understanding of concepts and requirements.
10	Excellent	The Response has provided a detailed and thorough response to the HIPAA requirements, and clearly demonstrates a high-level of experience or understanding of the HIPAA requirements.

4.3. NETWORK SCORING (PASS/FAIL)

Along with the Bidder's network submissions, Bidders must submit the following with the RFP Proposals in order for the networks to be considered a "pass":

4.3.1. Bidders must submit the following templates and files provided in Exhibit D, Provider Network Submission: GeoNetwork report (GeoDental.rpt), used to generate the responses; Provider Network Submission Excel workbook of the Bidder's network; and Page Calculation Excel workbook. Bidder must also submit a written explanation of irregularities in either the data or network analysis output. Bidder must have an adequate dental network capacity with signed contracts (see Section 4.3.2) that covers all counties in regions they are bidding on. A "Passing" score means the Bidder has 7% network capacity for adults and 18% network capacity for children within a given service area for all providers. Bidder must include the number of eligible Clients that each provider within their network can be expected to serve. The Bidder's network must

provide reasonable access to all Enrollees without unnecessary travel time or wait times for appointments.

4.3.2. Signature pages of all network contracts in accordance with Section 3.3 and 4.3.1.

4.3.3. An attestation verifying (a) attempts to contract with 100% of tribes, IHS facilities, and UIHPs delivering dental services in Washington 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; and (b) meeting contractually required distance standards set out above (3.3.2) and in Attachment 1, Sample PAHP Apple Health Dental Services Contract. Please include the number and a detailed description of the effort made to contract with the tribes, IHS facilities, and UIHPs delivering dental services in and out of Washington State.

4.4. FINAL SCORE AND APPARENTLY SUCCESSFUL BIDDER(S) (ASB)

The RFP Coordinator will compute the Bidders' final score by totaling the Evaluation Question Scores from all evaluators and then averaging.

4.5. SUBSTANTIALLY EQUIVALENT SCORES

Substantially equivalent scores are scores separated by two percent or less in total points. If multiple Proposals receive a Substantially Equivalent Score, HCA may leave the matter as scored, or select as the Apparently Successful Bidder(s) the Proposal(s) that are deemed by HCA, in its sole discretion, to be in HCA's best interest relative to the overall purpose and objective as stated in Sections 1.1, 1.2, and 1.3 of this Procurement.

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

4.6. NOTIFICATION TO BIDDERS

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

4.7. DEBRIEFING OF UNSUCCESFUL BIDDERS

Any Bidder who has submitted a Proposal and been notified it was not selected for a contract award may request a debriefing. The request for a debriefing conference must be received by the RFP Coordinator no later than 5:00 p.m., local time, in Olympia, Washington, within three business days

after the Unsuccessful Bidder Notification is e-mailed to the Bidder. The debriefing will be held within three business days of the request, or as schedules allow.

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

4.7.1. Evaluation and scoring of the firm's Proposal;

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

4.7.3. Review of Bidder's final score in comparison with other final scores without identifying the other firms.

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

4.8. PROTEST PROCEDURE

A bid protest may be made only by Bidders who submitted a response to this RFP and who have participated in a debriefing conference. Upon completing the debriefing conference, the Bidder is allowed five (5) business days to file a protest of the RFP with the RFP Coordinator. Protests must be received by the RFP Coordinator no later than 4:30 p.m., local time, in Olympia, Washington on the fifth (5th) business day following the debriefing. Protests may be submitted by e-mail or by mail.

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

Bidders protesting the RFP must post a bond or cashier's check in the amount of five hundred thousand dollars ($500,000.00). The bond will be used to cover the costs associated with a protest (for example, cost of processing the protest and any costs associated with the delay to the project that would result from a protest). Any remaining funds will be returned to the protestor Bidder. If the protest is successful, the entire $500,000.00 will be returned. Bidders who submit a protest will receive instructions from the RFP Coordinator regarding submitting the bond.

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

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

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

4.8.1.2. Errors in computing the score; or

4.8.1.3. Non-compliance with procedures described in the RFP.

HCA will not consider any protest that does not address one or more of the items listed in Section 4.8.1. In addition, HCA will not consider the portion of any protest that contains allegations other than those listed in Section 4.8.1. For example, HCA will reject as without merit the portion of a protest that addresses issues such as an evaluator's professional judgment on the quality of a Proposal or HCA's assessment of its own needs or requirements.

Upon receipt of a protest, HCA will undertake a protest review. The HCA Director, or an HCA employee delegated by the HCA Director who was not involved in the RFP, will consider the record and all available facts. If the HCA Director delegates the protest review to an HCA employee, the Director nonetheless reserves the right to make the final agency decision on the protest.

If possible, a final HCA decision will be issued within ten business days of receipt of the protest. If HCA determines, in its sole discretion, it requires additional time to review the protest, the protesting party (and any other parties that HCA deems appropriate) will be notified of the delay and the revised timeline for completion of the review.

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

4.8.2. The final determination of the protest will:

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

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

4.8.2.3. Find merit in the protest and provide options which may include:

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

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

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

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

5. RFP EXHIBITS AND ATTACHMENTS

Exhibits:

Exhibit A Letter of Submittal (attached as separate document)

Exhibit B Minimum Qualifications Certification (attached as separate document)

Exhibit C Certifications and Assurances

Exhibit D Provider Network Submission (available via SFT site)

Exhibit E Evaluation Questions (attached as a separate document)

Exhibit F Dental Data Book (available via SFT site)

Exhibit G Data Share Agreement (attached as a separate document)

Exhibit H Diverse Business Inclusion Plan

Attachments (attached as separate documents):

Attachment 1	Sample PAHP Apple Health Dental Services Contract including General Terms and Conditions (GT&Cs)
Attachment 2	Benefit Package Spreadsheet
Attachment 3	Regional Service Areas
Attachment 4	OCIO Security Standard 141.10
Attachment 5	Information Services Board (ISB) Identity Management User Authentication Standards
Attachment 6	OCS Security Design Review Checklist
Attachment 7	ABCD Program Description
Attachment 8	Oral Health Connections Pilot Project Description
Attachment 9	Federal Register for IHS Service Delivery Areas

EXHIBIT A
Letter of Submittal

Please refer to Exhibit A, Letter of Submittal, attached as a separate document.

Exhibit B
Certification of Minimum Qualifications

Please refer to Exhibit B, Certification of Minimum Qualifications, attached as a separate document.

EXHIBIT C
CERTIFICATIONS AND ASSURANCES

I/we make the following certifications and assurances as a required element of the Proposal 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 Proposal 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 Proposal.
3. The attached Proposal is a firm offer for a period of 120 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 120-day period.
4. In preparing this Proposal, 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 Proposal 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 Proposal. All Proposals become the property of HCA, and I/we claim no proprietary right to the ideas, writings, items, or samples, unless so stated in this Proposal.
6. Unless otherwise required by law, the prices and/or cost data which have been submitted have not been knowingly disclosed by the Bidder and will not knowingly be disclosed by him/her prior to opening, directly or indirectly, to any other Bidder or to any competitor.
7. I/we agree that submission of the attached Proposal 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 Bidder to induce any other person or firm to submit or not to submit a Proposal 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 Bidder and the lead staff person to perform the services contemplated by this RFP.
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 2.14, Contract and General Terms and Conditions.) If Contract exceptions are being submitted, I/we have attached them to this form.

On behalf of the Bidder submitting this Proposal, 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 Proposal.

_____

Signature of Bidder

_____

Title Date

EXHIBIT D
Provider Network Submission

Please refer to Exhibit D, Provider Network Submission, attached separately on SFT site. Bidders who submit a Letter of Intent to Propose (Section 2.4) with a signed Data Share Agreement (Exhibit G) will receive access to the SFT site from RFP Coordinator.

EXHIBIT E
Evaluation Questions

Please refer to Exhibit E, Evaluation Questions, attached as a separate document.

EXHIBIT F
Dental Data Book

Please refer to Exhibit F, Dental Data Book, attached separately on the SFT site. Bidders who submit a Letter of Intent to Propose (Section 2.4) with a signed Data Share Agreement (Exhibit G) will receive access to the SFT site from RFP Coordinator.

EXHIBIT G
Data Share Agreement

Please refer to Exhibit G, Data Share Agreement, attached as a separate document.

Exhibit H
DIVERSE BUSINESS INCLUSION PLAN

Do you anticipate using, or is your firm, a State Certified Minority Business? Y/N

Do you anticipate using, or is your firm, a State Certified Women's Business? Y/N

Do you anticipate using, or is your firm, a State Certified Veteran Business? Y/N

Do you anticipate using, or is your firm, a Washington State Small Business? Y/N

If you answered No to all of the questions above, please explain:

_____

Please list the approximate percentage of work to be accomplished by each group:

Minority __%

Women __%

Veteran __%

Small Business __%

Please identify the person in your organization to manage your Diverse Inclusion Plan responsibility.

Name: _____

Phone: _____

E-Mail: _____

Attachment 1
Draft Sample PAHP Apple Health Dental Service Contract

Attached as a separate document.

Attachment 2
Benefit Package

Attached as a separate document.

Attachment 3
Regional Service Areas

Attached as a separate document.

Attachment 4
OCIO Security Standard 141.10

Attached as a separate document.

Attachment 5
Information Services Board (ISB) Identity Management User Authentication Standards

Attached as a separate document.

Attachment 6
OCS Design Review Checklist

Attached as a separate document.

Attachment 7
ABCD Program Description

Attached as a separate document.

Attachment 8
Oral Health Connections Pilot Project Description

Attached as a separate document.

Attachment 9
Federal Register for IHS Service Delivery Areas

Attached as a separate document.