REVISED 4/17/2013

STATE OF WASHINGTON
WASHINGTON STATE HEALTH CARE AUTHORITY
REQUEST FOR APPLICATION (RFA) NO. 2013-003

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

PROJECT TITLE: HPW STRATEGY 2 FINANCIAL ALIGNMENT DEMONSTRATION

PROPOSAL DUE DATE: May 15, 2013, no later than 3:00pm PACIFIC TIME

EXPECTED PERIOD OF CONTRACT: The initial term of this contract will be for a three (3) year demonstration period.

APPLYING FOR RFA AND COUNTIES: Only those Bidders that applied for the CMS MOC can apply for this State specific RFA. This RFA can be used to apply for: (a) a project that covers just one coverage area (King or Snohomish County) or *(b) for projects in each of the coverage areas.

There are differences in the target populations and infrastructure of the two counties, so the Bidder will have to be clear how each project will be designed to be unique to the specific county.

MULTIPLE AWARD: It is HCA's intention to award no more than two (2) plans per county. HCA reserves the right to award contracts for just one coverage area when applicant applies to do both coverage areas.

MINIMUM REQUIREMENT: HCA intends to implement the demonstration only with those plans that are eligible to accept passive enrollment. HCA will not include in the demonstration any interested organizations that are ineligible for passive enrollment as of the start of the demonstration. As such, HCA will not approve applications for organizations that are identified as "consistently low performing" in the Medicare Plan Finder release of plans' star ratings information (including LPI designation) in Fall 2012, or that otherwise become ineligible for passive enrollment prior to the demonstration start date.

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

Activity	Deadline	Time
RFA Release Date	April 10, 2013	
Bidders Conference (Phase 1 Question Due)	April 19, 2013	1:00PM PST
Bidder Questions Due (Phase 2 Questions Due)	April 22, 2013	3:00PM PST
Response to Bidder Conference and Bidder questions	April 29, 2013	
Proposal Due	May 15, 2013	3:00PM PST
Evaluation Period (approximate time frame)	May 16-30, 2013	
Projected Announcement of Apparently Successful Bidder	June 5, 2013	
Debriefing Request Deadline	June 6-10, 2013	

Conduct Debrief	June 12, 2013	
Protest Period	June 13-20, 2013	
Health Plan selection submitted to CMS in preparation for Readiness Review	End of June	
CMS and External Contractor prepare Readiness Review with final state selected health plans (sending desk review letters to selected plans)	July 2013	
Joint Readiness Review	September – October, 2013	
Contract Execution	November 2013	

TABLE OF CONTENTS

1 DEFINITIONS 6

2 INTRODUCTION 10

2.1 BACKGROUND AND PURPOSE 10
2.2 INTEGRATED SERVICE DELIVERY VISION GUIDING DEMONSTATION DESIGN 13
2.3 PROJECT GOVERNANCE 15
2.4 CMS/STATE CONTRACT MANANGEMENT 16
2.5 BENEFICIARY PARTICIPATION 16
2.6 CONTRACT TERM ..... 17~~16~~
2.7 AMERICAN WITH DISABILITIES ACT 17

3 GENERAL INFORMATION FOR BIDDERS 17

3.1 RFA COORDINATOR 17
3.2 COMMUNICATIONS ..... 18~~17~~
3.3 PROCUREMENT SCHEDULE 18
3.4 (M) DELIVERY OF PROPOSALS 19
3.5 BIDDER CONFERENCE 19
3.6 BIDDERS QUESTIONS AND ANSWERS ..... 20~~19~~
3.7 CERTIFICATIONS AND ASSURANCES 20

4 GENERAL PROVISIONS 21

4.1 COSTS OF PROPOSAL PREPARATION 21
4.2 ALTERNATIVE PROPOSALS 21
4.3 OWNERSHIP OF PROPOSALS 21
4.4 RECIPIENT OF INSUFFICIENT COMPETITIVE PROPOSALS/REPSONSE 21
4.5 NON-RESPONSIVE PROPOSALS/WAIVER OF MINOR IRREGULARITIES 21
4.6 AMENDMENT TO THE RFA 22
4.7 NO OBLIGATION TO BUY 22
4.8 MANDATORY RESPONSE OVERVIEW 22
4.9 (M) PROPRIETARY INFORMATION/PUBLIC DISCLOSURE 23
4.10 ACCEPTANCE PERIOD 24
4.11 AUTHORITY TO BIND HCA 24
4.12 CONTRACT TERMS 24
4.13 FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) (IF APPLICABLE) 25
4.14 CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) APPROVAL (IF APPLICABLE) 26
4.15 AMERICAN RECOVERY AND REINVESTMENT ACT (ARRA) 26
4.16 INCORPORATION OF RFA AND PROPOSAL IN CONTRACT 26
4.17 MOST FAVORABLE TERMS 26
4.18 WITHDRAWAL OF PROPOSALS 26
4.19 PROPOSAL CLARIFICATIONS 27
4.20 NON-ENDORSEMENT 27
4.21 WAIVERS 27
4.22 MULTIPLE AWARD 27
4.23 WORKER'S COMPENSATION COVERAGE 27
4.24 MINORITY AND WOMEN OWNED AND VETERAN OWNED BUSINESS ENTERPRISES 27
4.25 RIGHT TO WITHDRAW AWARD 28

5 PROPOSAL CONTENT AND SUBMISSION 29

5.1 (M) SUBMISSION OF PROPOSAL 29
5.2 (M) PROPOSAL FORMAT 29
5.3 (M) LETTER OF SUBMITTAL 31
5.4 (M) APPLYING FOR COUNTIES 31
5.5 (M)CONTRACT READINESS REVIEW AND SITE VISIT 31

6 STANDARD PROJECT REQUIREMENTS 32

6.1 (M) ATTESTATIONS OF COMPLIANCE 32
6.2 (M) COORDINATION WITH STATE AND LOCAL SPONSORING/AUTHORIZING AGENCIES AND PROGRAM 32
6.3 (M) ENROLLE COMMUNICATIONS 33
6.4 (M) GRIEVANCE AND APPEAL PROCESS 33
6.5 (M) CONSOLIDATED REPORTING PROCESS 34
6.7 (M) STATE, COUNTY AND MMI PLAN DATA SHARING 35

7 APPLICANT QUALIFICATIONS 37

7.1 (M) INTRODUCTION STATEMENT OF QUALIFICATION 37
7.2 (M) MMI PLAN ACCOUNT EXECUTIVE 37
7.3 (M) IN-DEPTH KNOWLEDGE OF THE DUAL ELIGIBLE POPULATION 39
7.4 (M) OUTEACH STRATEGY FOR PERSON DIFFICULT TO ENGAGE AND RETAIN 41
7.5 (M) OVERCOMING ACCESS TO CARE BARRIERS 42
7.6 (M) INDIVIDULAIZED PERSON-CENTER INTERDISCIPLINARY CARE TEAM 44
7.7 (M) PERSON AND FAMILY CENTER CARE PHILOSOPHY AND STRATEGY 45
7.8 (M) "HIGH-TOUCH" INTERACTIVITY PHILOSOPHY AND STRATEGY 46
7.9 (M) BEHAVIORAL HEALTH RECOVERY PHILOSOPHY AND STRATEGY 47
7.10 (M) CULTURAL COMPETENCY PHILOSOPHY AND STRATEGY 49
7.11 (M) BUILDING KNOWLEDGE AND EXPERTISE ACROSS THE FULL SPECTRUM OF SERVICE CATEGORY 50
7.12 (M) COORDINATION WITH LOCAL HEALTH, SOCIAL SERVICE, EMERGENCY AND RESPONSE AND OTHER SAFETY NET SYSTEMS 52
7.13 (M) APPOINTMENT STANDARDS FOR PERSONS WITH SPECIAL HEALTHCARE NEEDS 53
7.14 USE OF HEALTH INFORMATION TECHNOLOGY 56
7.15 (M) CREDENTIALING AND QUALIFICATION VERIFICATION OF NETWORK PROVIDERS AND FACILITIES 58

8 DEMONSTRATION OF QUALIFICATIONS USING CASE STUDIES 59

8.1 (MS) CASE STUDY 1 59
8.2 (MS) CASE STUDY 2 60
8.3 (MS) CASE STUDY 3 61
8.4 (MS) CASE STUDY 4 62

9 ALIGNMENT WITH STATE PURCHASING STRATEGIES 63

9.1 (M) MMI PLAN'S ROLE AS A CONTRIBUTING MEMBER OF THE LOCAL AND REGIONAL DELIVERY SYSTEM 63
9.2 (M) EXPANSION POTENTIAL OF DEMONSTRATION MODEL 64

10 SCREENING, EVALUATION AND AWARD 65

10.1 INITITAL SCREENING OF BIDDER 65
10.2 EVALUTATION OF PROPOSAL 65
10.3 SELECTION PROCESS 65
10.4 DEBRIEFING OF UNSUCCESSFUL BIDDERS 66

11 RESOLUTION OF PROTESTS 67

11.1 PROTESTS 67
11.2 PROCUREMENT RECORDS DISCLOSURE 67
11.3 GROUNDS FOR PROTEST 67
11.4 PROTEST FORM AND CONTENT 68
11.5 SUBMITTING A PROTEST 68

12 EXHIBIT A – LETTER OF SUBMITTAL 70

13 EXHIBIT – B MODEL CONTRACT 71

14 EXHIBIT C - WRITTEN PROPOSAL SCORING TOOL 72

15 EXHIBIT D - CERTIFICATIONS AND ASSURANCES 73

16 APPENDIX A – HEALTHPLAN WASHINGTON STRATEGY 2 FINANCIAL ALIGNMENT DEMONOSTRATION GRAPHIC 74

17 APPENDIX B – CMS JOINT RATE-SETTING PROCESS UNDER THE CAPITATED FINANCIAL ALIGNMENT INITIATIVE 75

18 APPENDIX C – ATTESTATION OF COMPLIANCE 76

19 APPENDIX D – PARTIAL LIST OF RESPONSIBILITIES AND DUTIES THAT REQUIRE MANDATORY STATE/LOCAL/MMI PLAN INTERACTION. 77

20 APPENDIX E - PARTIAL PROFILES OF THE DUAL ELIGIBLE POPULATIONS IN KING COUNTY AND SNOHOMISH COUNTIES, 2010. 78

1 DEFINITIONS

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

1.1 **"Addendum" or "Amendment"** shall mean written clarification or revision to this RFA issued by the RFA Coordinator.

1.2 **"Agency"** shall mean the Health Care Authority as the agency of the State of Washington issuing this RFA.

1.3 **"Apparently Successful Bidder(s)"** shall mean the Bidder(s) selected as the entity to perform the anticipated services, subject to completion of contract negotiations and execution of a written contract.

1.4 **"Bidder" and/or "Applicant"** shall mean the individual, company, or firm submitting a Proposal in order to attain a contract with the Agency.

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

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

1.7 **"Contractor"** shall mean that firm, provider, organization, individual or other entity performing services under this contract. It shall include any subcontractor retained by the prime contractor as permitted under the terms of this agreement.

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

1.9 **"DES"** shall mean the Department of Enterprise Services.

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

1.11 "Full Benefit Dual Eligible Beneficiary" or "Dual Eligible Beneficiary" means a Medicare managed care recipient who is also eligible for Medicaid, and for whom the State has a responsibility for payment of Cost Sharing Obligations under the Washington State Plan. For purposes of this Agreement, Dual Eligible Enrollees are limited to the following categories of recipients:

1.11.1 "QMB Plus" -- QMBs who also meet the financial criteria for full Medicaid coverage. QMB Plus individuals are entitled to QMB Medical Benefits, plus all benefits available under the Washington State Plan for fully eligible Medicaid recipients.

1.11.2 "SLMB Plus" – SLMBs who also meet the financial criteria for full Medicaid Coverage. SLMB Plus individuals are entitled to payment of Medicare Part B premiums, plus all benefits available under the Washington State Plan for fully eligible Medicaid recipients.

1.12 "HCA" means the State of Washington Health Care Authority.

1.13 "HCA Contract Administrator" shall mean that HCA employee designated to receive legal notices, and to administer, amend, or terminate this Contract.

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

1.15 "Individualized Care Plan" means an integrated, individualized, person-centered care plan jointly created and managed by the beneficiary, his or her selected support system, his or her health plan care management team, and his or her interdisciplinary team of care providers. The plan incorporates a holistic, preventative, and recovery focus and is based on a comprehensive assessment of clinical and non-clinical needs and addresses identified gaps in care and barriers to care.

1.16 "Interdisciplinary Care Team" means a consistent grouping of people from relevant clinical and non-clinical disciplines, inclusive of the enrollee and individuals of his or her choice, whose interactions are guided by specific team functions and processes to achieve team-defined favorable outcomes for the enrollee.

1.17 "Mandatory" or "(M)" shall mean the Bidder must comply with the requirement, and the Response will be evaluated on a pass/fail basis.

1.18 "Mandatory Scored" or "(MS)" shall mean the Bidder must comply with the requirement, and the Response will be scored.

1.19 "Normal Business Hours" shall mean normal State business hours are Monday through Friday from 8:00 a.m. to 5:00 p.m. except State Holidays.

1.20 "Proposal" shall mean a written offer to perform a contract to provide goods or services to the State in response to an RFA or other acquisition process.

1.21 "Proposal Due Date/Time" shall mean Proposals and Letters of Intent to Propose are due on the date and at the time specified in the schedule. Any Proposal or Letter of Intent to Propose received at any time after the stated date and time (e.g. 3:01p.m.) will be considered late and will not be evaluated.

1.22 "Purchaser" shall mean the State of Washington Health Care Authority; any division, section, office, unit or other entity of Purchaser; or any of the officers or other officials lawfully representing Purchaser.

1.23 "Personal Services" shall mean professional or technical expertise provided by a consultant to accomplish a specific study, project, task, or other work statement.

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

1.25 "RCW" shall mean Revised Code of Washington**.**

1.26 "RFA" shall mean a Formal procurement document in which a service or need is identified but no specific method to achieve it has been chosen. The purpose of an RFA is to permit the consultant community to suggest various approaches to meet the need at a given price.

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

1.28 "Subcontractor" shall mean one not in the employment of Vendor, who

is performing all or part of the business activities under this RFA under a separate contract with Vendor. The term “Subcontractor” means Subcontractor(s) of any tier.

1.29 “Contractor Account Manager” shall mean a representative of Vendor who is assigned as the primary contact person whom the HCA Contract Manager shall work with for the duration of the awarded Contract and as further defined in the section titled Contractor Account Manager.

2 INTRODUCTION

This state-specific Request for Applications is being conducting in conjunction with the Medicare 2014 Capitated Financial Alignment Application for Washington State. In order to participate as a MMI Plan in the HealthPath Washington Strategy 2 Financial Alignment Demonstration, an applicant must be selected through both the Medicare and the State application processes, pass a readiness review, and be eligible for passive enrollment at the time the 3-Way contract is signed.

2.1 Background and Purpose

The State of Washington is planning to implement the HealthPath Washington Strategy 2 Financial Alignment Demonstration (Demonstration) under a Federal-State partnership with the Centers for Medicare & Medicaid Services (CMS). The Demonstration will use a full-risk managed care model of health delivery that coordinates Medicare and Medicaid medical services, behavioral health services, long-term services and supports, and community resources to better serve the needs of the whole person in a manner that is more seamless to the beneficiary. The Demonstration will test an innovative payment and service delivery approach to alleviate the fragmentation and improve coordination of services for enrollees, enhance quality of care and reduce costs for both the State and the Federal government.

The Demonstration will be available to adults and children of King County and Snohomish County who are eligible for both Medicare and Medicaid, and for whom the State has a responsibility for payment of Cost sharing Obligations under the Washington State Plan (See Definition of Full Benefit Dual Eligible Beneficiary). Beneficiaries may not be concurrently enrolled in the Demonstration and a Medicare Advantage Plan, the Program of All-inclusive Care for the Elderly (PACE), or a Medicare Hospice Program. Beneficiaries may participate in and are eligible for enrollment in the Demonstration if they voluntarily disenroll from their existing programs. Beneficiaries who are on the Medicaid Fee-for-Service delivery system and the Medicare Fee-for-Service delivery system and are receiving Medicare ESRD benefits may also voluntarily enroll in the Demonstration.

~~The Demonstration will be available to adults and children of King County and Snohomish County who are eligible for both Medicare and Medicaid, and for whom the State has a responsibility for payment of Cost sharing Obligations under the Washington State Plan (See Definition of Full Benefit Dual Eligible Beneficiary). Beneficiaries enrolled in the Program of All-inclusive Care for the Elderly (PACE), or receiving Medicare hospice are not eligible for concurrent participation in the Demonstration. Such~~

~~beneficiaries may participate in and are eligible for enrollment in the Demonstration if they voluntarily disenrollment from their existing programs.~~

~~It is the intent of Washington to phase-in dual eligible beneficiaries who are receiving developmental disabilities 1915c Home and Community Based Waiver services. The State is working with CMS to determine the point in the three-year demonstration period when these dual eligible beneficiaries will be passively enrolled. At the time these beneficiaries are enrolled, the MMI Plans will be responsible for a services specified as MMI Plan covered services. This phase-in approach will enable the State and the MMI Plans to coordinate an implementation plan that will ensure a smooth transition based on a full understanding of this population and the services and supports they may be eligible to receive through the Demonstration.~~

At a future date, subject to additional discussions with CMS and other interested parties, Washington may also include beneficiaries who are receiving developmental disabilities 1915c Home and Community-based Waiver Services. If they are included, the MMI programs will be responsible for services specified in the negotiated 3-way contract.

Under this proposed Federal-State partnership, the State of Washington and CMS will enter into 3-Way contracts with each selected Medicare-Medicaid Integrated Plan (MMI Plan or MMIP) to conduct a specific Demonstration project (Project) designed for the King County coverage area or the Snohomish County coverage area. Each county-specific Project will be tailored to the unique features of the eligible population of the county coverage area and will provide a comprehensive plan benefit package to meet the needs of that population.

CMS and the State will jointly select and monitor the MMI Plans. Prior to implementation, MMI Plans will also be subject to a joint Readiness Review conducted by CMS and the State. The number of Projects and selected plans in each county-specific coverage area will be determined by the State based on the projected number of eligible beneficiaries in each coverage area and other factors important to assure the Projects fulfill the intended purpose to test new delivery system designs. The Demonstration will begin on April 1, 2014 and continue through December 31, 2017, unless terminated pursuant to terms of the CMS/State Memorandum of Understanding (MOU) and or the 3-Way contract.

The State plans to conduct enrollment into the MMI Plans using a passive enrollment process except in the case of American Indian/Alaskan Native beneficiaries or beneficiaries who are enrolled in a PACE program or a

Medicare Hospice program. Prior to the effective date of their enrollment, beneficiaries will receive a 60 day notification that includes information on how to opt-out of the Demonstration prior to the effective date. The information will also describe the beneficiary's ability to make a voluntary choice at any time to enroll or dis-enroll from the Demonstration or to switch to another Demonstration MMI Plan in the coverage area if one is available.

~~The State plans to conduct enrollment into the MMI Plans using a passive enrollment process except in the case of American Indian/Alaskan Native beneficiaries or beneficiaries currently participating in a PACE program, or receiving hospice through an existing program. Prior to the effective date of their enrollment, beneficiaries will receive a 60 day and a 30 day notification that includes information on how to opt-out of the Demonstration prior to the effective date. The information will also describe the beneficiary's ability to make a voluntary choice at any time to enroll or dis-enroll from the Demonstration or to switch to another Demonstration MMI Plan in the coverage area if one is available.~~

Under the Demonstration, each MMI Plan will be required to provide, either directly or through subcontracts, a comprehensive benefit package of Medicare and Medicaid covered services, as well as additional items and services, under a capitated model of financing. The MMI Plan will ensure that beneficiaries have access to an adequate network of medical, mental health, chemical dependency and long-term services and supports providers. CMS and the State will participate in ensuring the adequacy of the network by validating and monitoring the network.

Key objectives of the Demonstration are to improve the beneficiary access to care, deliver person-centered care, promote independence in the community, improve quality, eliminate cost shifting between Medicare, Medicaid and State-funded programs, and achieve cost savings through improvements in care and coordination. CMS and the State expect this model of integrated care and financing to improve quality of care, reduce health disparities, meet both health and functional needs, and improve transitions among care settings. Meeting beneficiary needs, including the ability to self-direct care, be involved in one's care, and live independently in the community, are central goals of the Demonstration. The State expects MMI Plan and provider implementation of person-centered care, independent living and recovery philosophies, wellness principles, and cultural competence to contribute to achieving these goals.

The Demonstration will test the effect of an integrated care and payment model on serving both community and institutional populations. In order to accomplish these objectives, comprehensive contract requirements will specify access, quality, network, financial solvency, and oversight standards. Contract management will focus on performance measurement and continuous quality improvement. Except as otherwise specified in the MOU, MMI Plans will be required to comply with all applicable existing Medicare and Medicaid laws, rules, and regulations as well as program specific and evaluation requirements as further specified in the 3-Way contract.

CMS and the State plan to allow for certain flexibilities that will further the goal of providing a seamless experience for enrollees, utilizing a simplified and unified set of rules, as detailed in the 3-Way contract. Flexibilities will be coupled with specific beneficiary safeguards. MMI Plans will receive a capitated payment established using payment parameters described in Appendix B and will have full accountability for managing the capitated payment to best meet the needs of enrollees who are determined to need a plan of intervention through Individualized Care Plans developed by enrollees, their caregivers, and their individualized Interdisciplinary Care Teams using a person-centered planning process and high-touch interactivity. CMS and the State expect MMI Plans to achieve savings through better integrated and coordinated care. Subject to CMS and State oversight, MMI Plans will have the ability to innovate around care delivery and to provide a range of community-based services as alternatives to or as a means to avoid high-cost services if indicated by the enrollees' wishes, needs, and Individualized Care Plan.

2.2 Integrated Service Delivery Vision Guiding Demonstation Design

Recognizing the Demonstration is a beginning in a larger State journey to develop innovative new approaches to integrated service delivery, the following design expectations and key features have been outlined by HCA/DSHS Executive Leadership to provide outcomes that this and subsequent activities can use to guide the development of demonstration designs and selection of partner health plans. These items provide the foundation for the evaluation of applicants' responses to this Request for Application.

1. Seamless integration of primary care, acute care, behavioral health care, prescription drugs, long term services and supports, preventive services, and community-based human services and social supports.

2. Innovative model of service delivery that demonstrates principles of high touch interaction between the enrollee and the MMI Plan, self-

direction, consumer choice, and wellness and recovery and demonstrates the use of evidence-based protocols and promising practices shown to improve quality of care.

3. Single financing model that aligns financing streams and financial incentives.

4. Single entity with combined authority and accountability for the whole person and the delivery of needed services, at the time and in the setting that services are needed.

5. Collaborative joint governance that brings together MMI Plan, CMS, State and Local Health and Human Service leadership to form a strong partnership that draws from the diversity of strengths and expertise in the community and shares a commitment to develop new, innovative ways to improve coordination of services across health care, human services, and public health systems.

6. Culturally appropriate care coordination and care management delivered by Interdisciplinary Care Teams that draw upon the expertise of professionals and other qualified workers across the disciplines of medical, behavioral health, prevention, long term services and supports, social services, and community health worker/peer support to assess the health care and human service needs of the whole person and to plan person-centered integrated interventions.

7. Diverse network of service providers with the capacity and flexibility to meet the full range of the specific and diverse needs of the enrolled population, to provide choice for beneficiaries, and to be responsive to changing needs over time.

8. Strong consumer protections designed to assure clients have the information they need to make an informed choice about participation and provide access to dedicated processes to support clients and help them to navigate the system when they feel their needs are not being met.

9. Collaborative outreach and engagement through a partnership of the MMI Plan and local community resources to proactively reach individuals, get them into care, and re-engage them in care if they fall out of care.

10. Information and data sharing systems that assure accurate and timely exchange of information necessary to effectively integrate care delivery for individuals and to enable systems to facilitate collection and analysis of impacts and outcomes of the

Demonstration and to drive quality improvement and undertake corrective action as necessary.

11. Proactive and coordinated transition planning from multiple settings to help individuals successfully transition back to the community from short-term inpatient and from long term institutional settings, including medical, mental health, substance abuse, and correctional settings (examples vary locally but may include hospitals, SNFs, jails, mental health crisis diversion programs, post-hospital recuperation programs for homeless people, detox programs, etc.).

2.3 Project Governance

Under the terms of the 3-Way contract, the MMI Plan is the recognized single accountable entity responsible for the quality of care delivered to enrollees and for the financial performance of the respective Project, At the same time, the MMI Plan and the public agencies sponsoring the HealthPath Washington Strategy 2 Financial Alignment Demonstration must share responsibility for fulfilling the Demonstration's purpose to test innovative features of a new managed care model of health delivery and to continuously learn and improve throughout the three-year demonstration period. CMS, the Health Care Authority, the Department of Social and Health Services, Snohomish County, King County, and the City of Seattle, as the sponsoring public agencies for the Demonstration in the King County and Snohomish County coverage areas, are committed to actively participating with the selected MMI Plans in the governance of the Projects to achieve the intended goals. An active joint governance approach will be a major avenue to overcoming challenges experienced in previous pilot projects targeted to chronic care management and integration of services for Medicaid beneficiaries, including those that are dual eligible.

Working on both an individual Project and combined Demonstration basis, the Project Governance Teams will be a forum for open communication, shared expertise, and collective decision-making in an environment that acknowledges the "demonstration" nature of the Demonstration, thereby fostering continuous review of the Demonstration and each Project's performance and timely action to resolve identified problems and undertake timely action on identified opportunities to improve services for enrollees.

Additionally, the team forum will provide a focal point for guiding the evolving model of integrated health care delivery into a design that is replicable in other counties of the State and a design that informs other states seeking to develop similar integrated delivery systems.

Each Project Governance Team will be composed of designated senior management representatives from each organization who can act on behalf of their respective organization to assure the Project is accomplishing the intended outcomes, as well as to identify and address any unintended consequences should they arise.

The team will meet on at least a quarterly basis to evaluate information received from the CMS/State Project Management Team, a State/County Demonstration Implementation Team, and the HealthPath Washington Advisory Team.

2.4 CMS/State Contract Manangement

CMS and HCA will designate a Contract Management Team authorized and empowered to represent CMS and the State about all aspects of the 3-Way contracts. Preliminary information about the Contract Management Team is presented in Exhibit B ~~C~~ and more information will be provided in the MOU and the 3-Way contracts,

The CMS/State Contract Management Team will utilize onsite monitoring visits, reports as required by the 3-Way contract, external quality review activities and other performance information to evaluate the MMI Plan's compliance with the terms of the 3-Way contract, including evaluation of the quality, appropriateness, and timeliness of services performed by the MMI Plan and its provider network.

The CMS/State Contract Management Team ongoing contract oversight findings will serve as an important source of information and guidance to the Project Governance Teams about the progress of the Demonstration and necessary design adjustments throughout the duration of the 3-Way contract.

2.5 Beneficiary Participation

Throughout this Request the applicant is asked to describe the organization's qualifications to provide a health plan that has at its heart a person-centered approach to serving its enrollees that is universally engrained in its culture, vision, policies and practices. As part of the 3-Way contract, CMS and the State will require the selected MMI Plan to present specific methods that it will employ to obtain beneficiary and community input on issues of program management and enrollee care through a range of approaches that reflect the diversity of the MMI Plan enrollee population, and participation of individuals with disabilities. The agreed upon approaches will include methods to enable direct beneficiary input to the activities of the MMI Plan's own governance body and to the Project Governance Team described in this Section.

2.6 Contract Term

The initial term of this contract will be for a three (3) year demonstration period. If at a later time CMS/State agree to extend the demonstration, CMS/State may decide to extend the current Demonstration contracts for a defined period (e.g. up to 3-years). Any decision to expand the Demonstration (possibly extended to additional coverage areas or a multi-county coverage area) would involve a new vendor selection process.

2.7 American with Disabilities Act

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

3 GENERAL INFORMATION FOR BIDDERS

3.1 RFA Coordinator

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

Jenna Mannigan, RFA Coordinator
Email: contracts@hca.wa.gov

Overnight or hand delivery of Proposal:

Jenna Mannigan, RFA Coordinator
2013-003 – HPW STRATEGY 2 FINANCIAL ALIGNMENT DEMONSTRATION
3819 Pacific Avenue S.E., Suite A
Lacey, WA 98503

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

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

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

3.2 Communications

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

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

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

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

3.3 Procurement Schedule

All Bidders must adhere to the following schedule of activities. Bidders mailing Proposals should allow normal mail delivery time to ensure timely receipt of their Proposals by the RFA Coordinator listed in this RFA. Notwithstanding the provisions of RCW 1.12.070, late Proposals will not be accepted, nor will time extensions be granted.

RFA PROCUREMENT SCHEDULE

Activity	Deadline	Time
RFA Release Date	April 10, 2013	
Bidders Conference (Phase 1 Question Due)	April 19, 2013	1:00PM PST
Bidder Questions Due (Phase 2 Questions Due)	April 22, 2013	3:00PM PST
Response to Bidder Conference and applicant questions	April 29, 2013	
Proposal Due	May 15, 2013	3:00PM PST
Evaluation Period (approximate time frame)	May 16-30, 2013	
Projected Announcement of Apparently Successful Bidder	June 5, 2013	
Debriefing Request Deadline	June 6-10, 2013	
Conduct Debrief	June 12, 2013	
Protest Period	June 13-20, 2013	
Health Plan selection submitted to CMS in preparation for Readiness Review	End of June	
CMS and External Contractor prepare	July 2013	

Readiness Review with final state selected health plans (sending desk review letters to selected plans)		
Joint Readiness Review	September – October, 2013	
Contract Execution	November 2013	

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

3.4 (M) Delivery of Proposals

The Proposal must be received by the RFA Coordinator at the address specified in Section 3.1 no later than the **date and time** specified in the RFA Procurement Schedule. Bidders mailing Proposals should allow normal mail delivery time to ensure timely receipt of their Proposals by the RFA Coordinator. Bidders assume the risk for the method of delivery chosen. Bidders are encouraged to submit their responses at least one day early to insure against unforeseen delivery issues such as weather or traffic problems. HCA assumes no responsibility for delays caused by the U.S. Postal Service, or other delivery systems regarding any documents relating to this RFA. Time extensions will not be granted. Documents received after the specified deadline will be deemed as non-responsive and will not be accepted, reviewed, or evaluated. **Emailed Proposals will not be accepted and will be disqualified**.

All Proposals and any accompanying documentation become the property of the HCA and will not be returned.

3.5 Bidder Conference

A Bidders Conference (Conference) will be held on April 19, 2013 beginning at 1:00PM PST, at the HCA Olympia Bldg. located at 626 8th AVE SE, Olympia, WA 98504 in the 1st Flr Sue Crystal Room. Attendance at the Bidders Conference is not mandatory, but all interested bidders are encouraged to attend in order to facilitate better preparation of their proposals.

The Bidders Conference presentation will be summarized by HCA. No later than April 29, 2013 a high-level written summary of the Bidders Conference and all questions and answers known at that time will be posted to the HCA website: http://www.hca.wa.gov/rfp.html.

In order to assure adequate seating and other accommodations at the Bidders Conference, please submit a Conference Registration Form (see attached) to contracts@hca.wa.gov no later than 3:00 pm PST on April 16, 2013.

3.6 Bidders Questions and Answers

1. Bidders are provided two (2) scheduled opportunities to ask questions. See 3.3, Procurement Schedule, for submittal dates/times for written questions and Section 3.5 for the date/time/location of the Bidders Conference.

2. HCA is only obligated to answer questions received in writing by the dates/times stated in the Procurement Schedule. As reasonably possible and appropriate, questions will be answered at the Bidders Conference.

3. It is the responsibility of the potential bidders to carefully read, understand, and follow the instructions contained in this RFA document and all amendments to the RFA.

4. All questions regarding this RFA must be in writing (e-mail) and addressed to the RFA Coordinator. HCA will only answer questions received no later than date and time specified in RFA Procurement Schedule. Questions received after the date and time stated in the schedule will not be accepted.

5. Questions will not be individually answered prior to the date scheduled for HCA responses. Those questions and the response will become part of the official questions and answers (RFA Amendment).

3.7 Certifications and Assurances

The Applicant must attach a copy of the Certifications and Assurances Exhibit D signed by a person authorized to bind the Applicant to a contract.

4 GENERAL PROVISIONS

4.1 Costs of Proposal Preparation

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

4.2 Alternative Proposals

Each Bidder may submit only one Proposal. Unless specifically required in the RFA if you include alternatives within your Proposals, or send multiple Proposals, HCA will reject all of your Proposals.

4.3 Ownership of Proposals

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

4.4 Recipient of Insufficient Competitive Proposals/Repsonse

If HCA receives only one (1) responsive Proposal as a result of this RFA, HCA reserves the right to select the Contractor which best meets HCA's needs. That Contractor will be selected by HCA management. The Contractor selected need not be the sole Bidder.

4.5 Non-Responsive Proposals/Waiver of Minor Irregularities

HCA will not be liable for any errors or omissions in Bidder's Proposal. Bidders will not be allowed to alter Proposal documents after the RFA Responses due date identified in the RFA Procurement Schedule.

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

HCA reserves the right to waive minor administrative irregularities contained in any Proposal. Including, but are not limited to:

- Do not affect responsiveness;
- Are merely a matter of form or format;

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

4.6 Amendment to the RFA

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

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

It is incumbent upon each potential Bidder to carefully examine these requirements, terms and conditions. Should any potential Bidder find discrepancies, omissions or ambiguities in this RFA, the Bidder shall at once request, in writing, an interpretation from HCA's RFA Coordinator. Any inquiries, suggestions or requests concerning interpretation, clarification or additional information shall be made, in writing, (including email transmissions) to HCA's RFA Coordinator, as specified in Section 3.1.

4.7 No Obligation to Buy

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

4.8 Mandatory Response Overview

Bidder must complete a response to each mandatory section. Proposals may be disqualified for not completing Proposal sections. Each Mandatory item is noted with an (M) and scored on a Pass/Fail basis. Each Mandatory Scored item is noted with a (MS) and scored based on how Bidder response meets compliance with requirement.

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

4.9 (M) Proprietary Information/Public Disclosure

HCA is subject to the Public Records Act (chapter 42.56 RCW). Bidder's Response can be disclosed through the process set forth in this section. Portions of Bidder's Response may be protected from disclosure through the process set forth in this section.

- Bidder cannot restrict its entire Response or entire sections of the Response from disclosure.
- Bidder cannot restrict its pricing from disclosure

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

If Bidder wants to protect any Proprietary Information that is included in its Response from disclosure, the information must be clearly identified by Bidder as Proprietary Information. Each page claimed to be exempt from disclosure must be clearly identified by the word "Proprietary" printed on the lower right hand corner of the page. Bidder must identify sections or pages claimed as Proprietary in its Letter of Submittal (Section 5.3 Letter of Submittal).

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

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

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

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

4.10 Acceptance Period

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

4.11 Authority to Bind HCA

The HCA Director and the Director's designees are the only persons who may legally commit HCA to the expenditures of funds under contracts or amendments to the contract resulting from this RFA. The Contractor shall not incur, and HCA shall not pay, any costs incurred before a contract or any subsequent amendment is fully executed.

4.12 Contract Terms

The Apparently Successful Bidder(s) will be expected to sign a contract with terms that are substantially the same as the contract included in this RFA as Exhibit ~~C~~B, Model Contract. The contract will also incorporate this RFA and the successful proposal.

The sample contract may be subject to change dependent on negotiations with the Center for Medicare and Medicaid (CMS).

All Apparently Successful Bidders, after executing a Contract with HCA, will be subject to an CMS/HCA joint onsite Contract readiness review to ensure the their ability to perform under the Contract before receiving Enrollees under the Contract. In CMS/HCA's sole judgment, CMS/HCA may either terminate the Contract or require the Contractor to complete corrective action if the results of the readiness review are not satisfactory. If CMS/HCA requires corrective action, CMS/HCA may at its sole discretion, either withhold or allow enrollment while corrective action is in-process.

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

4.13 Federal Funding Accountability and Transparency Act (FFATA) (if applicable)

The resulting contract may be supported by federal funds that require compliance with the Federal Funding Accountability and Transparency Act (FFATA or the Transparency Act). The purpose of the Transparency Act is to make information available online so the public can see how federal funds are spent.

To comply with the act and be eligible to enter into this contract, your organization must have a Data Universal Numbering System (DUNS®) number. A DUNS® number provides a method to verify data about your organization. If you do not already have one, you may receive a DUNS® number free of charge by contacting Dun and Bradstreet at www.dnb.com

You will be required to complete a Federal Funding Accountability and Transparency Act (FFATA) Data Collection Form (**sample attached**) which must be returned with your signed contract. If this form is not completed and returned, your contract will not be executed until it has been received by the agency.

Required Information about your organization and this contract will be made available on USASpending.gov by the Washington State Health Care Authority as required by P.L. 109-282. As a tool to provide the information, HCA encourages registration with the Central Contractor Registry (CCR) because less data entry and re-entry is required by both HCA and your organization. You may register with CCR on-line at https://www.uscontractorregistration.com/

4.14 Centers for Medicare and Medicaid Services (CMS) Approval (if Applicable)

Any contract awarded as a result of this RFA may require the approval of CMS. Should CMS fail to approve the contract resulting from this RFA, the resulting Contract may be terminated in accordance with the "Savings" clause of the Contract.

4.15 American Recovery and Reinvestment Act (ARRA)

This contract will be paid for with federal stimulus funds. The federal government requires the state to report the number of jobs created and/or retained by stimulus-funded projects. If you are awarded a contract or grant a result of this solicitation, you may recruit by any means you prefer, but you (and your sub-contractors, if any) must list and report any jobs retained or created with the WorkSource system (affiliated with the Employment Security Department). WorkSource also will assist by referring you with pre-screened candidates to the contractor, but the contractor retains all hiring discretion.

For more information, contact the Employment Security Department's ARRA Business Unit at 877-453-5906 (toll-free), 360-438-4849 or ARRA@esd.wa.gov.

4.16 Incorporation of RFA and Proposal in Contract

This RFA and the Bidder's response, including all promises, warranties, commitments, and representations made in the successful Proposal, shall be binding and incorporated by reference in HCA's contract with the Bidder.

4.17 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 that the Bidder could offer. At its discretion, HCA reserves the right to request best and final offers from the RFA finalists. Bidder must be prepared to accept this RFA for incorporation into a contract resulting from this RFA. The contract may incorporate some or the Bidder's entire Proposal. It is understood that the Proposal will become a part of the official file on this matter without obligation to HCA.

4.18 Withdrawal of Proposals

Bidders may withdraw a Proposal that has been submitted at any time up to the Proposal due date and time in Section 3.3. A written request signed by an authorized representative of the Bidder must be submitted to the RFA Coordinator by email (see Section 3.3). After withdrawing a

previously submitted Proposal, the Bidder may submit another Proposal at any time up to the Proposal due date and time as listed in Section 3.3.

4.19 Proposal Clarifications

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

4.20 Non-Endorsement

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

4.21 Waivers

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

4.22 Multiple Award

HCA intends to award a limited number of contracts per coverage area based on the results from this RFA and the amount of eligible beneficiaries within each coverage area.

4.23 Worker's Compensation Coverage

The Vendor will, at all times, comply with all applicable workers' compensation, occupational disease and occupational health and safety laws, statutes and regulations to the full extent applicable. Neither the State of Washington nor HCA will be held responsible in any way, for claims filed by the Vendor or their employees for service(s) performed under the terms of this contract awarded from this RFA.

4.24 Minority and Women Owned and Veteran Owned Business Enterprises

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

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

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

4.25 Right to Withdraw Award

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

5 PROPOSAL CONTENT AND SUBMISSION

5.1 (M) Submission of Proposal

Bidders are required to submit their Proposal in both CD and hard copy format. Bidders must submit one (1) hard copy with **original** signatures and fourteen (14) identical **copies** of their Proposal. Submit one (1) electronic copy of all required information on a CD-RW/CD-ROM in Microsoft Office 2003 or later. Ensure the diskette is labeled with the date, RFA title, RFA number, and Bidder's name and packaged with the original copy of the Proposal.

The Proposal must be received by the RFA Coordinator at the address specified no later than the date and time specified in RFA Procurement Schedule. Late Proposals will not be accepted and shall automatically be disqualified from further consideration. The method of delivery shall be at your discretion and it shall be at your sole risk to assure delivery at the designated office. Faxed or emailed Proposals will not be accepted and will be disqualified.

For your Proposal to be considered complete you must respond to **all requirements** of this RFA. Bidders must provide a Proposal to all sections of the RFA. Bidder's failure to comply with any part of HCA's RFA may result in the Bidder's Proposal being disqualified for being non-responsive to HCA request.

5.2 (M) Proposal Format

The Proposal should be prepared simply and economically, providing straightforward concise description of Bidder's ability to meet the requirements of this RFA.

Proposals must be prepared using 12-size font Arial or Times Roman and printed on single-side 8.5" x 11" inch paper using separators for the major sections of the Proposal with each copy bound either by binder clips or in 3-ring binders. **Do not use spiral binding**. See each major section for page limitations. Page limitations must including all narrative description and supporting documents not otherwise directly requested in RFA.

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

The major sections of the RFA shall include:

- Section 6 - Standard Project Requirements
- Section 7 – Applicant Qualifications
- Section 8 – Demonstration of Qualifications Using Care Studies
- Section 9 – Alignment with State Purchasing Strategies
- Letter of Submittal (Exhibit A)
- Certification and Assurances (Exhibit D)

Proposals must provide information in the same order as presented in this document with the same headings. This will not only be helpful to the evaluators of the Proposal, but should assist the proposer in preparing the response.

All pages must be consecutively numbered. The firm name and the page number may be located at the top or bottom as the Bidder prefers, but the location must be consistent throughout.

Title and number your response to each item in the same order it appears in the RFA by restating the question number and text of the requirement in sequence and writing the response immediately after the requirement statement. **Failure of the Bidder to respond to any mandatory requirements may cause the entire Proposal to be eliminated from further consideration**.

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

For mandatory requirements (M) or mandatory scored requirements (MS), the Bidder must always indicate explicitly whether or not the Bidder's proposed solution meets the requirement. A response of "not applicable" is considered non-responsive. Do not respond by referring to other sections of your Proposal. Do not refer to websites or other sources in your RFA. The evaluators will only evaluate materials provided in the Proposal that are responsive to the requirements.

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

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

Brevity and clarity in your Proposal is essential. Be succinct, concrete, and use quantified descriptions whenever possible. It is the bidder's responsibility to ensure all of the pages are included in all of the copies and all pages are numbered. Reviewers will not have access to pages that were included in the original, but not in their copies.

5.3 (M) Letter of Submittal

The Letter of Submittal will be submitted using Exhibit ~~C~~A, Letter of Submittal. Bidders must complete all sections of Exhibit ~~C~~A, Letter of Submittal. Signing the Letter of Submittal, Exhibit ~~C~~ A indicates the Bidder accepts the terms and conditions of the RFA. Failure to address all of the elements identified in Exhibit A may result in disqualification.

Carefully read Exhibit ~~C~~A, Letter of Submittal as there are additional pages that you must attach to Exhibit ~~C~~A, depending on your responses to the questions.

5.4 (M) Applying for Counties

This RFA can be used to apply for: (a) a project that covers just one coverage area (King or Snohomish County) or *(b) for projects in each of the coverage areas. Bidder must identify what counties they are apply for.

There are differences in the target populations and infrastructure of the two counties, so the Bidder will have to be clear how each project will be designed to be unique to the specific county.

*Note - the state reserves right to award contracts for just one coverage area when applicant applies to do both coverage areas.

5.5 (M)Contract Readiness Review and Site Visit

After executing the contract resulting from this Procurement, but prior to the contractors providing any services to enrollees, CMS and HCA will review the contractors' readiness to begin providing services. The review will be to determine whether the contractors are carrying-out their implementation plans as submitted in response to this procurement. During time, HCA reserves the right to ask questions related to their managed care operations. If HCA determines that any contractor will not be ready to begin services on April 1, 2014, it may, at its sole discretion, withhold enrollment and require corrective action or terminate the Contract.

6 STANDARD PROJECT REQUIREMENTS

6.1 (M) Attestations of Compliance

The applicant must complete Appendix C attesting to the organization's agreement to comply with the terms of the Model Contract presented in ~~Exhibit C~~Appendix C, subject to any modifications established in the MOU and 3-Way contract.

6.2 (M) Coordination with State and Local Sponsoring/Authorizing Agencies and Program

The Demonstration is sponsored by multiple governmental agencies and programs responsible for administering publicly-funded services for Medicaid beneficiaries and persons eligible for state-funded health and social services. Existing federal, state and local laws, administrative rules, and agency policies control the scope of authority of the sponsoring agencies and their ability to transfer financial accountability and delegate program administrative and operational functions to the MMI Plan. This includes laws, rules and policies that specify the authorities responsible for determining financial and functional eligibility for services, authorizing access to program covered benefits, and assuring compliance with requirements of CMS for the Medicaid State Plan program, the Medicaid Behavioral Health 1915(b) Waiver program, and the Medicaid 1915(c) Waiver programs.

Conducting the Demonstration will require the sponsoring agencies, program authorities and the MMI Plan contractor to coordinate activities, exchange information, and effectively transition enrollees across responsibilities. In specific cases a public agency or program must retain responsibility for financial and functional eligibility determinations and other duties and not delegate or transfer the responsibilities and duties to the MMI Plan. In these cases, it will be imperative that the MMI Plan work closely with the public agency or program to assure the allocation and performance of duties and responsibilities are consistent with the specific requirements established for each State and local program while providing the enrollee a seamless experience. The nature and degree of required coordination will vary by sponsoring program based on the federal, state, and local requirements of that program. Therefore, it will be essential that each sponsoring program and the Demonstration contractor define mandatory points of interaction and required information that must be exchanged and establish appropriate written protocols and written agreements accordingly.

Appendix D provides a partial list of responsibilities and duties that require mandatory State/Local/MMI Plan interaction.

The applicant response must agree to complete mandatory interactions and information exchange with applicable state and local sponsoring agencies based on terms contained in the final 3-Way contract and written protocols and agreements negotiated between the parties.

6.3 (M) Enrolle Communications

CMS and the State will jointly establish a set of unified marketing requirements and review processes that integrate Medicare and Medicaid marketing materials to the extent possible and assure materials are accessible and understandable to beneficiaries, including those with disabilities, low literacy levels, and limited English proficiency. CMS and the State will prospectively review outreach and marketing materials subject to a single set of rules established in the MOU and the 3-Way contract. Part D marketing and outreach requirements will apply as they currently do to Medicare Advantage organizations and Prescription Drug Plan sponsors.

Enrollee and prospective enrollee materials, in all forms, shall require prior approval by CMS and the State unless CMS and the State agree that one or the other entity is authorized to review and approve such documents on behalf of CMS and the State. CMS and the State will also work to develop pre-approved documents that may be used, under certain circumstances, without additional CMS or State approval. All materials shall be integrated and include, but not be limited to: outreach and education materials; enrollment and disenrollment materials; benefit coverage information; and operational letters for enrollment, disenrollment, claims or service denials, complaints, internal appeals, external appeals, and provider terminations. Such uniform/integrated materials will be required to be accessible and understandable to the beneficiaries that will be enrolled in the MMI Plans, and their caregivers. This includes individuals with disabilities, including, but not limited to, those with cognitive and functional limitations, and those with limited English proficiency, in accordance with current Federal guidelines for Medicare and Medicaid. Where Medicare and Medicaid standards differ, the standard providing the greatest access to individuals with disabilities or limited English proficiency will apply.

The response must acknowledge that the applicant is aware that additional work will occur to establish unified marketing requirements and review processes and rules that will be specified in the MOU and 3-Way contract.

6.4 (M) Grievance and Appeal Process

CMS and the State will jointly establish a unified process that integrates relevant Medicare and Medicaid grievance and appeals processes to the

extent possible and assures beneficiaries do not experience a decrease in safety or increase in complexity in comparison to current processes. Protocols will be developed to assure coordinated access to the appeals mechanism. CMS and the State will establish a single set of rules for grievances and appeals established in the MOU and the 3-Way contract.

All MMI Plan Grievances and Internal Appeals procedures shall be subject to the review and prior approval of CMS and the State. Medicare Part D appeals and grievances will continue to be managed under existing Part D rules, and Medicaid non-Part D pharmacy appeals will be managed by Washington Medicaid. CMS and Washington Medicaid will work to continue to coordinate grievances and appeals for all services.

The response must acknowledge that the applicant is aware that additional work will occur to establish a unified grievance and review process and rules that will be specified in the MOU and 3-Way contract.

6.5 (M) Consolidated Reporting Process

CMS and the State will define and specify in the MOU and the 3-Way contract a Consolidated Reporting Process for MMI Plans that ensures the provision of the necessary data on diagnosis, Healthcare Effectiveness Data and Information Set (HEDIS) and other quality measures, enrollee satisfaction and evidence-based measures, and other information as may be beneficial in order to monitor each MMI Plan's performance. MMI Plans will be required to meet the encounter reporting requirements that are established for the Demonstration.

MMI Plans will be required to report measures that examine access and availability, care coordination/transitions, health and well-being, physical and behavioral health, patient/caregiver experience, screening and prevention, and quality of life. This includes a requirement to report Medicare HEDIS, Health Outcome Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, as well as measures related to long term supports and services. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS plus any additional Medicaid measures identified by the State. All existing Part D metrics will be collected as well. The State will supplement quality reporting requirements with additional State-specific measures. The State will also be required to report on long term supports and services as delineated in approved waivers and will coordinate the quality requirements as feasible.

A combined set of core metrics will be referenced in the MOU and the 3-Way contract. In addition, technical specifications will be provided in annual technical guidance to the MMI Plans. CMS and the State will utilize the reported measures in the combined set of core metrics for

various purposes, including implementation and ongoing monitoring, assessing plan performance and outcomes, and to allow quality to be evaluated and compared with other plans in the model. A subset of the performance measures will also be used for calculating the quality withhold payment; these will be established in the MOU. Additional detail regarding the core quality metrics and other reporting requirements will be specified through technical guidance to the MMI Plans.

The response must acknowledge that the applicant is aware that additional work will occur to establish a set of core measures and a consolidated reporting process that will be specified in the MOU and 3-Way contract.

6.~~5~~6 (M) Medicaid-Only Provider Network Adequacy

As outlined in CMS guidance dated January 9, 2013, for the Capitated Financial Alignment Demonstration, CMS' minimum standard for demonstrating network adequacy is to use Medicare standards for medical services and prescription drugs. For Medicaid-only behavioral health and long-term care supports and services (LTSS), MMI Plans will use state Medicaid network adequacy standards. For services that are covered under both Medicaid and Medicare, such as home health, the appropriate (and more beneficiary-friendly) network adequacy standard will be determined via the CMS-state MOU development process and included in the 3-Way contract.

The State plans to require MMI Plans to comply with the Medicaid-only provider network distance standards, section ~~6.9~~7.9 of the proposed model contract Exhibit ~~C~~B, during the initial MMI Plan selection process. Applicants will work directly with the State during the plan selection process to satisfy state-specific network adequacy requirements for LTSS and behavioral health for which the Medicaid standard has been agreed to by CMS and the state in the MOU.

The response must acknowledge that the applicant is aware that additional work will occur to establish a set of Medicaid-only network distance standards and other standards that will be specified in the MOU.

6.~~6~~7 (M) State, County and MMI Plan Data Sharing

Currently, Federal, State and county programs responsible for the purchasing and delivery of health-related services, social services, emergency response services, crisis intervention services, and other safety net services have insufficient data exchange arrangements to develop comprehensive understanding of the nature and scope of

services being accessed by individuals with multiple complex chronic conditions combined with insufficient resources to meet basic living needs. Without this comprehensive understanding the ability of programs to coordinate across services and develop effective interventions to address the needs of the whole person is severely limited. The HealthPath Washington Health Strategy 2 Financial Alignment Demonstration offers an opportunity for CMS, the State, the participating counties, and participating MMI Plans to develop innovative data exchange strategies to build comprehensive understandings of the whole-person needs and service utilization patterns of the enrolled populations and to then forge innovative approaches to coordinating services across the broader delivery system.

The State will participate in necessary efforts to move forward with the development of enhanced data sharing arrangements to facilitate care coordination and to monitor utilization of consumer services funded by the Demonstration and the counties. The first necessary order of business will be to put in place properly executed Business Associate Agreements between individual MMI Plans, State agencies, CMS and County officials representing the Project coverage areas. Such agreements will contain appropriate privacy, confidentiality, and other data protection provisions necessary to provide consumer protection and comply with Federal and State requirements.

The applicant response must agree to develop data sharing agreements with State and County agencies participating in the county-specific Demonstration to implement terms that will be specified in the 3-Way contract.

7 APPLICANT QUALIFICATIONS

7.1 (M) Introduction Statement of Qualification

This Section provides the applicant the opportunity to describe the organization's qualifications related to specific features of the Demonstration felt to be essential to achieving the Demonstration's goals and expectations. For each Qualification, the applicant is to provide a complete response within the defined page limit for that Qualification including graphics, organization charts, position descriptions, etc. The response may reference supporting information contained in other responses within Section 7.

In some cases a request for supporting documentation is delineated. In these cases, the requested supporting documentation will not be counted against the specified page limit for that individual Qualification. No other supporting documents, narrative, or other information will be considered and should not be submitted as part of the applicant's response.

The State is participating in a joint review of the Model of Care component of the Medicare 2014 Capitated Financial Alignment applications. In preparing the organization's responses for items contained in this Section, the applicant should consider describing applicable relationships or linkages that exist between the Model of Care approach and structure presented in the Medicare Application and the stated qualifications in Section 7.

7.2 (M) MMI Plan Account Executive

The MMI Plan will participate with CMS, the State, and the County in developing and testing a new Washington model to align Medicare and Medicaid financing while preserving or enhancing the quality of care furnished to participating beneficiaries. It is important the leadership of the MMI Plan recognizes the important role the Demonstration outcomes will play in guiding the direction major Washington publicly-funded health purchasing agencies will undertake in the future and the influence the chosen direction will have on the larger Washington health care market. Additionally, the MMI Plan leadership must understand the visibility the Demonstration will have nationally within Congress and CMS, at the State level within the State Legislature and the Governor's Office, and at the local level within the respective County and City Councils and Executive Offices. Understanding the goals of the Demonstration and recognizing the political implications of its eventual successes and shortcomings must be on the radar screen of the MMI Plan leadership throughout the demonstration period.

HCA expects the applicant to designate an Account Executive for the awarded Project who has experience in managing large full-capitation managed care accounts, a strong depth of expertise, and sufficient tenure and status within the applicant organization to assure the innovations designed into the Project are adequately supported at the organization's executive levels locally and centrally in the corporation. The designated Account Executive must be accessible to CMS and the State in order to rapidly respond to problems and issues of importance to the performance of the Project and must be physically present for regular onsite meetings of the Project Governance Team, the CMS/State Contract Management Team, and for presentations to the Legislature, Governor's Office, County Executives, and at other meetings and events. If the Account Executive is not located in Washington, the contractor must provide a local account manager to coordinate routine account business, maintain an active presence in activities of the local health system, and ensure ongoing communication with the Account Executive.

7.2.1 (MS) Specification to be Addressed

The applicant is to submit a response in sufficient detail and specificity to identify the person that will be designated as the Account Executive, his or her related qualifications and experience, his or her position within the organizational structure, and intended work arrangements to assure the necessary local presence is achieved (primary work location, schedule, account management backup, etc.). The response should include how the organization's account executive will support the ongoing communication and improvement process to ensure quality care tailored to the needs of the MMI Plan enrollees.

7.2.2 Optional Documentation

Organization chart and position description.

7.2.3 Evaluation Insight

This requirement will be evaluated on the basis of the bidder's commitment of executive level resources to assure an effective partnership is fostered with the sponsoring public agencies to govern the performance of the Demonstration and to assure corporate decisions are well informed, responsive to identified problems, and result in the support necessary to achieve the intended goals of the Demonstration.

7.2.4 (M) Applicant Response

Bidders response shall not exceed 5 pages

7.3 (M) In-Depth Knowledge of the Dual Eligible Population

IMPORTANT NOTE: THIS QUALIFICATION REQUIRES A SPECIFIC DESCRIPTION FOR KING COUNTY AND A SPECIFIC DESCRIPTION FOR SNOHOMISH COUNTY BASED ON THE CHARACTERISTICS OF THE DUAL ELIGIBLE BENEFICIARIES RESIDING IN EACH COUNTY.

An upfront in-depth understanding of the demographic and cultural makeup and chronic disease burden of the dual eligible populations of the King County coverage area and/or the Snohomish County coverage area is critical to establishing a county-specific starting Project structure that will enable rapid implementation of innovative features of an integrated system and assure steady progress toward the intended outcomes within the three-year demonstration period. The dual eligible population in each of the coverage areas presents a highly diverse group of enrollees in terms of age, race, ethnicity, and language diversity, percentage of highly transient individuals, health status, complexity of co-morbid health conditions, and the prevalence of behavioral health, functional status, and housing issues.

It will not be sufficient for the applicant to rely on population demographics, service utilization statistics, and other information aggregated at a national, regional, or state level given the highly diverse nature of the specific residents in each of the coverage areas.

Appendix E provides State-prepared summary profiles of the dual eligible populations in King County and Snohomish Counties. These profiles only contain a historical point-in-time subset of information about the make-up of the populations and service utilization costs and are not to be relied upon as the complete set of information available to the applicant through the public domain or as a complete source of information in preparing a response to this qualification.

7.3.1 (MS) Specification to be Addressed

The applicant's response must be limited to the county coverage area(s) the MMI Plan is proposed to serve. The response must demonstrate a working knowledge of the dual eligible population characteristics that will substantively influence the MMI Plan's ability to effectively perform care management and coordination, improve engagement by enrollees in managing their personal health status, and improve access to needed health care services and community-based social supports. The applicant must present a concise overview of the range of diversity in the dual eligible population of each coverage area the applicant intendeds to serve, including at a minimum:

- Age distribution
- Gender distribution
- Cultural diversity (race, ethnicity, language, etc.)
- Service utilization patterns
- Disease profiles
- Geographic distribution and density (preferably by zip code)
- Housing status
-

The response should include a list of the data sources used to develop the overview and to validate the accuracy of the information presented.

7.3.2 Evaluation Insight

The applicant's response will be evaluated for completeness and accuracy in comparison to commonly used statistics from the available public domain specific to the county general population and county dual eligible population.

7.3.3 (M) Applicant Response

Bidder's response shall not exceed 5 pages.

7.4 (M) Outeach Strategy for Person Difficult to Engage and Retain

A significant challenge to the success of the Demonstration will be locating and engaging eligible beneficiaries and maintaining engagement by enrolled beneficiaries whose physical conditions, behavioral health conditions, cultural characteristics and social conditions cause them to be particularly difficult to locate, to engage in a structured care management arrangement, and to follow through with transitional and extended treatment regimens. Among the factors contributing to this difficulty is a substantial number of persons, often with behavioral health issues and limitations in abilities to perform daily living activities and mobility, who may fall in and out of homelessness, be in and out of jails, lack a regular mailing address or do not check for mail, do not have telephones, and who are occupied with more immediate challenges of meeting basic needs for food and shelter.

Engaging and retaining these individuals in the Demonstration and facilitating their effective participation in needed services and supports pose major challenge for the MMI Plan, requiring a well designed and implemented strategy of outreach and ongoing engagement.

7.4.1 (MS) Specifications to be Addressed

The applicant's response must document the organization's responsiveness to the challenges posed by difficult to engage beneficiaries. The response should describe a strategy designed to utilize proactive and creative means, including collaborations with local outreach programs that have relevant expertise and trust with the populations, to locate and reach out to eligible beneficiaries that do not respond to initial enrollment efforts and to enrolled beneficiaries at high risk due to treatment noncompliance and to employ methods and resources proven to be effective in overcoming poor engagement.

7.4.2 Evaluation Insight

The applicant's response will be evaluated based on an assessment of the feasibility that the described outreach and

engagement strategy for hard-to-engage persons will result in a high rate of successful initial contacts with potential enrollees, a high rate of actual enrollments, a high rate of ongoing contact, and improved adherence with transitional and extended treatment regimens.

7.4.3 (M) Applicant Response

Bidder's response shall not exceed 5 pages.

7.5 (M) Overcoming Access to Care Barriers

The demographic and socio-economic diversity of the Demonstration population, combined with the multiple complex health-related conditions experienced, results in substantial disparities in access to necessary, high quality health care services and social supports for certain subgroups. Understanding the make-up of the dual eligible population and major subgroups within the population, identifying where disparities exist, determining the root causes of the disparities, and developing methods to overcome the disparities is essential to achieving the goal of providing the right care to each enrollee at the right time and in the right manner.

In dealing with access to care barriers, it is important to be responsive to the many different domains of access in which barriers arise including physical accessibility, access to information, access to community supports that help people stay in their homes, access to care providers and teams, etc.

7.5.1 (MS) Specifications to be Addressed

Using the population description(s) presented by the applicant in 7.3 and the multiple domains of access, the applicant's response should provide a detailed description of the processes the organization will use to identify and address access to care barriers and disparities. As a component of the response, the applicant should provide an initial analysis of the population and discuss a set of specific individuals and subgroups of the population that the organization will initially focus on due to a high potential for those persons to experience barriers to access. In addition the response should provide a timeline and include additional disparity outreach groups that will be addressed in the future.

7.5.2 Evaluation Insight

The applicant's response will be evaluated on the organization's demonstrated understanding of thefactors that create barriers in access to care, the strategies and approaches that will be implemented to reduce barriers for all enrollees, and the feasibility that the organization's described process for monitoring and

resolving disparities will effectively monitor improvements for those enrollees identified for initial focus.

7.5.3 (M) Applicant Response

Bidder's response shall not to exceed 5 pages.

7.6 (M) Individulaized Person-Center Interdisciplinary Care Team

To be effective in providing a comprehensive array of services that are integrated, seamless, and provide a whole-person perspective, the MMI Plan's chosen approach must have the flexibility and staff/resource diversity to enable the Interdisciplinary Care Team (ICT) to be responsive to the enrollee's right to direct his or her care and to be tailored to best respond to the unique characteristics of the enrollee.

As necessary, this will require adjustments to existing or prior approaches designed primarily around a primary care medical home model, care teams with a limited medical focus, etc. to provide sufficient flexibility to accommodate the expanded array of covered benefits in the Demonstration and an enrollee population in which there is a high prevalence of behavioral health needs and long term service and support needs, complex co-morbid health conditions, and increased potential for utilization of high cost services.

7.6.1 (MS) Specifications to be Addressed

The applicant is to provide a detailed response that demonstrates, through the design of an approach to care and related guiding policies and procedures, the organization's commitment to providing care management and care coordination that proactively engages the enrollee and when the enrollee choose his or her support system, in health care decisions, decisions about the composition, leadership, and role of the interdisciplinary care team, and decisions about who attends care team meetings. The response should address the degree to which the care approach provides flexibility for the structure of the interdisciplinary care team to be tailored to the enrollee's predominant care needs across the array of service categories integrated into the Demonstration.

In particular the response should clearly describe the role mental health professionals, geriatricians, and other health care professionals beyond the primary care physician may play in the leadership of the interdisciplinary care team. The response should also address the role other behavioral health, long-term services and supports, peer supports, community health workers, public health workers, social service agency staff, and enrollee-employed Individual Providers may play in relation to care coordination, care management, self-management support, and the interdisciplinary care team. This should include the applicant's plan for connecting beneficiaries to community-based supports and programs that support people to live as independently as possible.

7.6.2 Evaluation Insight

The applicant's response will be evaluated on the capacity of the organization's care approach to be tailored to the individual enrollee circumstances, including his or her goals, preferences and predominant health conditions.

7.6.3 (M) Applicant Response

Bidder's response shall not exceed 5 pages.

7.7 (M) Person and Family Center Care Philosophy and Strategy

Delivering care with a person- and family-centered focus is core to the Demonstration design for all dual eligible enrollees. Regardless of the age, health status, functional status, or cognitive status of the individual, the underlying principles of person- and family-centered care hold true. As examples, drawing from publications from n organizations representing different subgroups of the dual eligible population, a common theme of purpose and value is described for person-centered care:

The AARP Public Policy Institute refers to Person- and Family-centered care (PFCC) as[1]:

> "An orientation to the delivery of health care and supportive services that considers a person's needs goals, preferences, cultural traditions, family situation, and values. It includes the person and the family at the center of the care team, along with health and social service professionals and direct care workers. It also evaluates the person's experience of care. Services and supports are delivered from the perspective of the individual receiving the care, and, when appropriate, his or her family.
>
> The PFCC approach respects and meaningfully involves the person's family caregivers, as specified by the individual, in the planning and delivery of supportive services. It also recognizes and addresses family needs and preferences, and integrates family caregivers as partners in care."
>
> [[1] Minor adjustments were made to the AARP text to broaden the focus to address the broader nature of the Demonstration target population.]
>
> The US Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) states:
>
> "Person-centered care is about understanding the strengths and abilities, as well as the needs and challenges, of each individual and

understanding that individual's personal recovery vision—and then helping him or her to get the services and supports needed to make those hopes and dreams a reality. In contrast, traditional care has tended to focus more on symptoms and "deficits" and not on the whole person and the quality of their life."

7.7.1 (MS) Specifications to be Addressed

The applicant's response must document the organization's established philosophy and policy regarding "Person- and Family-Centered Care" in sufficient detail to enable the State to evaluate the organization's approach and commitment to providing person- and family-centered care to enrollees of the Demonstration. In addition, the response must provide a sufficiently detailed organization strategy for actualizing its philosophy through the implementation of its Model of Care, provider network development, outcome-based performance measurement processes, and other elements of its Demonstration design.

7.7.2 Evaluation Insight

The applicant's response will be evaluated in relation to the content of the above AARP and SAMHSA descriptions and the State's assessment of the degree to which the organization's stated strategy will achieve meaningful delivery of person-and family-centered care to person's choosing to participate in the Demonstration.

7.7.3 (M) Bidder's Response

Bidder's response shall not exceed 5 pages.

7.8 (M) "High-Touch" Interactivity Philosophy and Strategy

Just as person- and family-centered care is an essential part of the ICT philosophy and strategy, "high-touch" interactivity between the enrollee, the assigned care coordinator and/or care manager, members of the interdisciplinary care team, and other involved service providers plays an important role. Face-to-face contact has been identified as one of the common elements of successful integrated care management programs for individuals with complex health and social needs (extracted from Cheryl Schraeder et al, "Intervention Components" In *Comprehensive Care Coordination for Chronically Ill Adults*, First Edition. Edited by Cheryl Schrader and Paul Shelton. 2011 John Wiley & Sons).

The State is seeking a MMI Plan with a care management and coordination approach and proactive strategy that uses person-to-person interactions to build essential trust relationships, effectively communicate needs, expectations, and care instructions, observe

subtle changes in and environmental contributors to health status, provide education and socialization, and foster the enrollee's desire and ability to self-direction care.

Of particular importance is an awareness of existing trust relationships and effective methods of communication the beneficiary has established within the local delivery system and the role "high-touch" interactivity plays. With this knowledge the MMI Plan will be positioned to incorporate these existing relationships into MMI Plan care management and coordination in ways that support the organization's person-centered care philosophy and strategy.

7.8.1 (MS) Specifications to be Addressed

The applicant's response must document the organization's established philosophy and strategy regarding the use of "high-touch" interactivity within the MMI Plan's Model of Care. The response must provide a sufficiently detailed organization strategy for actualizing its philosophy through the implementation of its Demonstration Model of Care, provider network development, outcome-based performance measurement processes, and other elements of its Demonstration infrastructure.

7.8.2 Evaluation Insight

The applicant's response will be evaluate the feasibility that the organization's stated strategy will achieve meaningful interactions between the enrollee, the members of his or her team providing care coordination and care management support, and the members of the care delivery team.

7.8.3 (M) Bidder's Response

Bidder's response shall not exceed 5 pages.

7.9 (M) Behavioral Health Recovery Philosophy and Strategy

The US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration's (SMHSA), working definition of recovery from mental health disorders and substance abuse is:

> "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. "

SAMHSA has also delineated four major dimensions that support a life in recovery and a set of guiding principles of recovery:

- ***Health***: overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;
- ***Home:*** a stable and safe place to live;
- ***Purpose:*** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- ***Community***: relationships and social networks that provide support, friendship, love, and hope.

SAMHSA's Guiding Principles of Recovery

- Recovery emerges from hope.
- Recovery is person-driven.
- Recovery occurs via many pathways.
- Recovery is holistic.
- Recovery is supported by peers and allies.
- Recovery is supported through relationship and social networks
- Recovery is culturally-based and influenced.
- Recovery is supported by addressing trauma.
- Recovery involves individual, family, and community strengths and responsibility.
- Recovery is based on respect.

7.9.1 (MS) Specifications to be Addressed

The applicant's response must document the organization's philosophy and policy regarding implementation of a recovery oriented approach to care and the degree to which the organization utilizes the mental health and chemical dependency recovery models, including the role Peer Supports may play. The response must provide sufficient detail regarding mental health and chemical dependency program philosophy and strategies to enable the State to understand the organization strategy for actualizing its recovery orientation through the implementation of its Demonstration Model of Care, provider network development, outcome-based performance measurement processes, and other elements of its Demonstration infrastructure.

7.9.2 Evaluation Insight

The applicant's response will be evaluated in relation to the SAMHSA description and the State's assessment of the degree to which the organization's stated strategy will achieve a recovery oriented system of care that includes meaningful involvement of individuals with mental health and chemical dependency needs in managing their own care.

7.9.3 (M) Bidder's Response

Bidder's response shall not exceed 5 pages.

7.10 (M) Cultural Competency Philosophy and Strategy

NOTE TO APPLICANTS: THIS QUALIFICATION REQUIRES A RESPONSE THAT PRESENTS A SPECIFIC APPROACH FOR KING COUNTY AND A SPECIFIC APPROACH FOR SNOHOMISH COUNTY BASED ON THE CHARACTERISTICS OF THE DUAL ELIGIBLE BENEFICIARIES RESIDING IN EACH COUNTY.

The US Department of Health and Human Services, Office of Minority Health, provides the following overview of Cultural Competency:

What Is Cultural Competency?

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989).

And why is it important?

Cultural competency is one the main ingredients in closing the disparities gap in health care. It's the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it. Quite simply, health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

Culture and language may influence:

- Health, healing, and wellness belief systems;
- How illness, disease, and their causes are perceived; both by the patient/consumer;
- The behaviors of patients/consumers who are seeking health care and their attitudes toward health care providers;
- The delivery of services by the provider who looks at the world through his or her own limited set of values, which can compromise access for patients from other cultures.

The increasing population growth of racial and ethnic communities and linguistic groups, and increase in diverse communities, each with its own cultural traits and health profiles, presents a challenge

to the health care delivery service industry in this country. The provider and the patient each bring their individual learned patterns of language and culture to the health care experience which must be transcended to achieve equal access and quality health care.

7.10.1 (MS) Specifications to be Addressed

The applicant's response must be limited to the county coverage area(s) the MMI Plan is proposed to serve. The response must document the organization's established philosophy and policy regarding "Cultural Competency" in sufficient detail to enable the State to evaluate the organization's approach and commitment to providing culturally competent care to enrollees of the Demonstration. In addition, the response must provide a detailed organization strategy for actualizing its philosophy through the implementation of its Model of Care, provider network development, outcome-based performance measurement processes, and other elements of its Demonstration infrastructure.

7.10.2 Evaluation Insight

The applicant's response will be evaluated in relation to the HHS Office of Minority Health description and the State's assessment of the degree to which the organization's stated strategy will achieve the delivery of culturally competent care coordination, care management, direct service delivery, customer service and other functions performed by organization staff and contractors.

7.10.3 (M) Bidder's Response

Bidder's response shall not exceed 5 pages.

7.11 (M) Building Knowledge and Expertise Across the Full Spectrum of Service Category

All involved parties must work together to share specialized experience and expertise to the comprehensive integrated system that demonstrates a new model of service delivery that moves financial and service quality accountability from separate programs providing medical, mental health, chemical dependency, and long-term services and supports to a single accountable MMI Plan responsible for providing a comprehensive array of services..

State and local public agencies are currently performing health screenings, needs assessments, care planning, care coordination, care management, provider network development, community resource referrals, etc. for dual eligible beneficiaries eligible for their respective programs and services. Similarly, these programs have established provider networks delivering

medical, behavioral health, and long-term services and supports directly to the beneficiaries. These public agencies and the direct service providers possess a wealth of expertise and experience that is available to the MMI Plan to draw upon through effective partnerships, contracting arrangements, and information exchange protocols.

The State believes opportunities exist at multiple levels of the MMI Plan structure to exchange knowledge with State and local agencies and services providers that will increase quality of care for enrollees, contribute to the success of the MMI Plan in effectively implementing its strategies described in other qualification narratives, and advance the Demonstration's outcomes.

7.11.1 (MS) Specifications to be Addressed

The applicant is to provide a detailed response that demonstrates the organization's strategy to:

a) Draw upon the wealth of experience and expertise within the organization, state and local programs, and service providers to build a comprehensive knowledge base across the spectrum of medical, behavioral health, long-term services and supports, and community-based social services and supports and
b) Form partnerships with the publicly-funded programs to implement operations models with the capacity and competency to integrate a comprehensive service delivery system oriented to serving the needs of the whole-person.

In particular, the response should address the organization's strategy to involve representatives of state and local agencies responsible for publicly-funded health care, public health, and community services interventions and all elements of the provider network in the organization's care management and care coordination processes as a mechanism to share expertise and build the comprehensive knowledge base. The response should include description of how the applicant would partner with housing providers including supportive housing for formerly homeless, senior housing, housing for people with disabilities, assisted living, retirement communities, etc. to arrange for housing and to assure the provision of appropriate health-related services in those facilities as appropriate to support beneficiaries continued ability to maintain stable housing and live independently.

7.11.2 (MS) Supporting Documentation

- Diagrams, flow charts or other visual depictions of existing or planned working relationships between the MMI Plan and state and local agencies.
- Representation on committees, boards, task forces that directly relate to local health care and social services for the dual eligible population.

7.11.3 Evaluation Insight

The applicant's response will be evaluated in terms of the approach the organization proposes to take to effectively draw upon the breadth of resources available to inform and perform effective care management, care coordination, and service delivery that encompasses the full array of available services and the new model of service delivery being tested.

7.11.4 (M) Bidder's Response

Bidder's response shall not exceed 5 pages.

7.12 (M) Coordination with Local Health, Social Service, Emergency and Response and Other Safety Net Systems

A substantial portion of the enrollee population will present complex needs associated with a combination of medical and behavioral health conditions, functional impairments, living conditions, transportation issues, justice system involvement, and other factors resulting in decreased health status and high utilization of costly services. Many of these enrollees experience frequent encounters with service systems that are currently outside the scope of the anticipated Demonstration benefit package but are recognized as key to successfully improving the health status of the enrollees and implementing a value-based publicly-funded health system.

Key to maximizing progress in addressing the needs of the enrollee as a whole-person is an understanding of the full array of services currently being accessed by the dual eligible population, the interconnectivity between the service systems delivering the services, problems of over-use/underuse/misuse and cost-shifting, and opportunities to increase coordination in ways that improve access to appropriate, timely care and cost-effectiveness.

NOTE: More detail about the Demonstration Plan Benefit Package will be included in the formal release of all PBP-related requirements as a component of the *Medicare 2014 Capitated Financial Alignment Application for Washington State.*

7.12.1 (MS) Specifications to be Addressed

The applicant is to provide a detailed response that demonstrates the organization's understanding of the multi-faceted array of health, social service, criminal justice, emergency response and other safety net systems in the geographic area to be served that, in addition to the Demonstration MMI Plan, are integral components of the target population's overall health experience. The response must also present the applicant's strategy for proactively working with the local public programs responsible for these delivery systems to advance the degree of coordination and cooperation necessary to improve integration and to reduce the likelihood of duplicative or conflicting care management for a given individual. In particular, strategies related to data information exchange, coordinating access, care planning, and transitions between systems and settings, and structured coordinated performance monitoring and quality improvement should be described in detail.

7.12.2 OPTIONAL Accompanying Documentation

Proposed interagency agreements, letters of cooperation, or other evidence of coordination between the MMI Plan and key local programs serving the target population.

7.12.3 Evaluation Insight

The applicant's response will be evaluated in terms of the described depth of understanding of and the extent of existing or planned relationships with the array of programs serving the targeted population within the Demonstration coverage area and the degree to which the organization's stated strategy will result in the exchange of information and the establishment of working relationships that provide the necessary foundation for improved integration.

7.12.4 (M) Bidder's Response

Bidder's response shall not to exceed 5 pages.

7.12.4.1 Psychiatric hospitalization

7.12.4.2 Detoxification services.

7.13 (M) Appointment Standards for Persons with Special Healthcare Needs

Timely access to services holds special importance to the plan enrollees who are determined to have special health care needs due to the intensity and complexity of their chronic and co-morbid conditions. The following

focal appointment standards as proposed in the model contract demonstrate the need for MMI Plan customer service processes to address the access needs of enrollees presented by the expanded scope of health conditions and provider categories in the Demonstration:

1. Transitional healthcare:
    a. The Contractor shall ensure that a care coordinator works with the hospital or other facility discharge planner to ensure that an enrollee being discharged from inpatient care has a follow-up medical appointment within seven days of release from the facility. If the enrollee requests it, or there is a probability of the enrollee not attending the appointment, the care coordinator shall accompany the enrollee to the appointment, and shall work with the enrollee to ensure that all prescriptions and follow up instructions are followed by the enrollee and that any additional appointments are scheduled and attended. The care coordinator shall also ensure that a clinical assessment is provided and a care plan developed after discharge from one of these facilities.
    b. The Contractor shall also ensure follow up activities described above are provided for enrollees who are discharged from inpatient or institutional care for mental health disorders or discharged from a substance use disorder treatment program, if ordered by the enrollee's primary care provider or as part of the discharge plan. The care coordinator shall also ensure that a clinical assessment is provided and a care plan developed after discharge from one of these facilities.

2. Urgent and Emergent healthcare:
    a. Urgent, symptomatic office visits shall be available from the enrollee's PCP or another provider within forty-eight (48) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening.
    b. Emergency medical care shall be available twenty-four (24) hours per day, seven (7) days per week.
    c. Enrollees may access the following urgent and emergent medically necessary mental health services prior to the completion of an intake evaluation:
        1. Crisis Services;
        2. Freestanding Evaluation and Treatment;
        3. Stabilization;
        4. Rehabilitation Case Management:
        5. Psychiatric Hospitalization.

3. Behavioral Health:

a. An appointment for the initial mental health intake assessment by a Mental Health Professional shall be offered within ten (10) working days of the request for mental health services. A request for mental health services can be made by telephone, referral, clinic walk-in, or in writing.
b. Contracted private practice mental health providers must offer an appointment as soon as reasonably possible given individual wait times. If provider cannot meet the allotted 10 working day wait period, the provider shall refer the enrollee back to the Contractor for additional care management.
c. After initial assessment has been completed, routine mental health services must be offered to occur within 14 calendar days of a determination to initiate mental health services. The time from request for mental health services to first routine appointment must not exceed 28 days unless the Contract documents a reason for the delay.
d. Comprehensive chemical dependency assessment and treatment services shall be provided no later than 14 days after the services have been requested by the enrollee. If the enrollee cannot be placed in treatment within 14 days, interim services must be made available to the enrollee.

4. Long Term Services and Supports:
The contractor shall make a referral to DSHS or its designee within five (5) days upon identification through the care coordination process or by the enrollee that the enrollee has unmet long term service and support needs.

NOTE: The above set of appointment standards are Washington's proposed standards to be considered in the development of the MOU and 3-Way contract.

7.13.1 (MS) Specifications to be Addressed

Using the above appointment standards as a guideline, the applicant's response must describe the organization's comprehensive customer service approach to insuring that enrollees with intensive and complex chronic conditions and co-morbidities have timely access to necessary screenings and assessments to identify the need for service and timely access to urgent and emergent services and timely access to services of an immediate nature.

7.13.2 Evaluation Insight

The applicant's response will be evaluated in terms of the comprehensiveness of the described approach in addressing appropriate screening, assessment, referral, and service delivery

timelines across the categories of medical services, mental health services, chemical dependency services, long-term services and supports, and community social services. In particular, the described approach will be evaluated on the degree of differentiation made between general appointment standards for all enrollees and specialized appointment standards designed specifically to account for the needs of enrollees with special health care needs.

7.13.3 (M) Bidder's Response

Bidder's response shall not exceed 5 pages.

7.14 Use of Health Information Technology

In discussing essential elements of care coordination for populations with complex needs, the Agency for Healthcare Research and Quality (AHRQ) provides the following information:

> "Last, but perhaps most important, effective care coordination can be accomplished only through regular monitoring of the patient's health status, needs, and services, and through frequent communication and the free exchange of information. It often requires multiple modes of communication (in person, by phone, or in writing) and increasingly depends on the effective use of electronic tools (for example, remote physiologic monitoring, electronic data acquisition and reminders, networked electronic health records (EHRs), patient education modules, and informed decision making tools). While the frequency of communication depends on a variety of factors, it must occur at several levels: (1) between health care professionals and patients and their families to ensure they understand the care plan and their responsibility for self-care, and any help, such as respite care, that is available; (2) within teams of health and social service professionals; and (3) across the entire care spectrum, particularly when individuals transfer between care settings (for example, hospital, rehabilitation facility, nursing home, or community residence). If care is to be coordinated effectively, all communication must be timely, and it must include the information that each team member must know in order to provide care that is congruent with a patient's preferences without subjecting the team to information overload. Another key element involves monitoring and support for patient adherence to therapy and other elements of self-care."

Though not requirements, the following are examples of desirable uses of health information technology to support effective care management and coordination as follows:

1. Use HIT to identify and support management of high risk beneficiaries in care management.
2. Use conferencing tools to support case conferences/team based care, including audio, video and/or web deployed solutions when security protocols and precautions are in place to protect Protected Health Information (PHI).
3. Use a system to track and share beneficiary information and care needs across providers, to monitor processes of care and outcomes, and to initiate changes in care, as necessary, to address beneficiary need and preferences.
4. Use web-based HIT registries and referral tracking systems.
5. Use HIT to promote administrative simplification such as supporting the use of common care registries across the client populations served by network providers.
6. Track service utilization and quality indicators and provide timely and actionable information to the Care Coordinator regarding under, over or mis-utilization patterns.
7. Develop a system with hospitals, nursing homes and residential/rehabilitation facilities to provide the health home prompt notification of a beneficiary's admission and/or discharge from an emergency room, inpatient, or residential/rehabilitation setting.
8. Develop methods to communicate real-time use of emergency room, inpatient hospitalizations, missed prescription refills and the need for evidence-based preventive care to the Care Coordinator.

7.14.1 (MS) Specifications to be Addressed

The applicant response must describe the organization's strategies for using health information technology to foster effective care coordination. The response must provide sufficient detail to provide insight into specific ways health information technology is or will be used by the organization, what will be accomplished through the described uses, how extensively the technology will be disseminated throughout the contract provider network, and how it contributes to improving integration of care and meaningful engagement of the enrollees and providers in realizing the right service, at the right time, and in the right manner.

7.14.2 Evaluation Insight

The applicant's response will be evaluated in terms of the depth of insight provided to reviewers regarding the organization's vision for the use of health information technology to enhance communications among and between the beneficiary and his or her care team, provide a whole-person perspective of the beneficiary to care team members, increase the timeliness and accuracy of

information, inform and educate the beneficiary and care team members, etc.

7.14.3 (M) Bidder's Response

Bidder's response shall not exceed 5 pages.

7.15 (M) Credentialing and Qualification Verification of Network Providers and Facilities

Incorporating an expanded array of behavioral health and long-term services and supports providers into the MMI Plan contracted provider network requires additional processes to verify provider qualifications to perform services covered by the comprehensive benefit package. Because many of these providers have not been included in traditional medical health plan credentialing processes and programs, there may not be well-organized systems and resources to draw from in establishing credentialing standards and verifying qualifications of several provider categories that will become part of the comprehensive MMI Plan provider network.

7.15.1 (MS) Specifications to be Addressed

The applicant response must describe the categories of providers that will be subject to credentialing and/or qualifications verification and the processes the organization will use to define standards and verify qualifications for these categories. The response must address the provider categories that are not covered under the credentialing processes described in the applicant's *Medicare 2014 Capitated Financial Alignment Application*.

7.15.2 Evaluation Insight

The applicant's response will be evaluated in terms of the credentialing process' potential for assuring the full contracted provider network make-up is properly licensed and qualified to deliver the respective services covered in their provider contracts.

7.15.3 (M) Bidder's Response

Bidder's response shall not to exceed 5 pages.

8 DEMONSTRATION OF QUALIFICATIONS USING CASE STUDIES

The four (4) case studies presented in this section, though fictional, are representative of the dual eligible populations within the two coverage areas of the Demonstration. The purpose of these case studies is to enable the applicant to demonstrate how the array of qualifications described throughout this state-specific Request for Applications and the Medicare 2014 Capitated Financial Alignment Application will translate into quality care for each of the portrayed persons and thereby demonstrate how the MMI Plan design contributes to demonstrating a new model of service delivery consistent with the goals of the Demonstration.

The cases are designed to portray persons with combinations of personal characteristics, health conditions, socio-economic status, living arrangements, and other features that present challenges for the MMI plan in developing an integrated system of services and supports addressing the needs of the whole person. These cases enable the applicant to demonstrate an understanding of the complexity of the individuals and the impact of the multiple issues on their overall health.

Additionally the applicant has the opportunity to describe how the organization's array of available staff (employed and contracted), services, systems, network of providers, referral networks, etc. are brought together with the individual to function as a team and how the organization's philosophies, strategies, and policies are moved to reality through the team's activities and interactions.

The applicant is encouraged to explain in the response the "who, what, and how" in sufficient detail to understand the persons that are involved, the roles they perform, and processes used. This level of detail as it pertains to the Interdisciplinary Care Team and development and content of the Individualized Care Plan is of special interest but is not meant to be the sole focus of the response.

8.1 (MS) Case Study 1

Han is a 55-year-old, Chinese immigrant. She came to Seattle from Hong Kong in 1957. She has limited English proficiency and is unemployed. She has worked intermittent entry level jobs in the past but has not worked in over 10 years. She has a current diagnosis of PTSD and previous diagnoses include major depression with psychosis. Han also has significant physical health conditions including cardio-vascular problems, Type 2 diabetes, and excess weight. She has had 9 ED visits in the last two years, mostly regarding her heart condition. In addition, last year she made 51 phone calls to the mental health crisis line. She makes frequent

complaints that her psychiatric medications are not working while practitioners note concerns regarding the consistency of her taking her medications.

Han has received extensive services from 5 different mental health centers over the last 10 years and had 6 different home addresses over the last decade. She has lived in mental health residential facilities and in independent living situations throughout the past 10 years. Han is currently living in subsidized housing in the county. Keeping her house in order when she is depressed is a re-occurring challenge for her, her neighbors and landlords. Han has a primary care physician whom she visits inconsistently due to transportation barriers and difficulty navigating the bus system. She has two children who were removed from her home by Children's Administration who are now in their 20s. She periodically expresses a desire to re-connect with them. There are no other known family or ongoing community supports.

8.1.1 (M) Bidder's Response

Bidder's response shall not exceed 5 pages.

8.2 (MS) Case Study 2

Bobby is a 45 year old African-American, single male with a current primary mental health diagnosis of schizophrenia. Since his initial diagnosis at age 22, Bobby has been prescribed a wide range of traditional and atypical antipsychotics and mood stabilizers which frequently require re-adjustment to manage his symptoms. Even when fully medication adherent, Bobby still experiences symptoms—he is still tormented by voices, fearful of strangers and experiences sleep disturbances. Bobby's treatment history includes four involuntary hospitalizations.

Bobby has been living alone in supportive housing for the past 3 years. He no longer has contact with his parents or siblings because they do not understand why he just does not stay on his medications or take enough medications to be "normal." He has been evicted multiple times due to being disruptive to neighbors (because he stands in corner at night and screams due to the voices) and for doing property damage. Based on delusions regarding fiberglass insulation and wiring, Bobby usually removes both from the interior walls of his residence. He also has fear of being naked and accordingly seldom bathes or showers.

Bobby receives intermittent case management services from a local community mental health agency (CMHA). Bobby is difficult to engage, occasionally disappears for weeks at a time and frequently misses his prescriber and medication monitoring appointments.

Bobby does not have a primary care physician. He is fearful of community medical clinics and does not willingly go to them. Community clinics complain about him when he is in the waiting room due to body odor, mumbling to himself and scaring other patients. Due to heavy tobacco use and untreated bronchitis, Bobby has developed COPD. Bobby has had multiple ER visits due to symptoms of his mental illness and COPD. Typically he is brought to the ER by law enforcement, his case manager or a crisis worker.

Approximately four months ago, he stopped taking his psychiatric medications. As a result, he was kicked out of his housing and is now homeless. He has been bouncing from shelters and homeless encampments and is now using alcohol and drugs again. He has spent a total of 42 days in jail with 5 bookings for crimes related to homelessness and substance abuse. Due to his lack of stable housing and deteriorating mental status, Robert's diabetes is now out of control and he has been making frequent visits to the emergency room.

8.2.1 (M) Bidder's Response

Bidder's response shall not exceed 5 pages.

8.3 (MS) Case Study 3

Polly is Hispanic, divorced, age 67, 5'1" tall and 260 lbs. Polly was first diagnosed with depression at age 17. She was a victim of domestic violence during her first and second marriages and was diagnosed with PTSD at age 38. Additional diagnoses include obesity, arthritis, anxiety disorder and diabetes. She also has COPD from a long history of smoking. Six months ago, Polly developed an incision infection following knee replacement surgery and spent six weeks in a skilled nursing facility. Polly has two adult children living with her; her 40 year old son recently released from prison and her 38 year old daughter, who is developmentally disabled. Polly has recently been accessing routine medical care through the Emergency Room at a local community hospital rather than through a primary care physician. Several local physicians have discontinued care for her due to history of missed appointments.

8.3.1 (M) Bidder's Response

Bidder's response shall not exceed 5 pages.

8.4 (MS) Case Study 4

Michael is a 74 year old Caucasian male who lives alone in a small trailer park in a rural part of the County. He is eligible for a COPES in-home personal care worker for 70 hours of care a month. The worker is authorized to assist with medication management; bathing; locomotion outside of home; transfers; housework; essential shopping and meal preparation. It is difficult to find a care provider to serve him, and his current worker just quit. He has no informal supports to help him until a new provider can be located. Several of the contracted home care agencies choose not to serve him because he has a history of accusing workers of stealing small items from his home, though he typically finds the missing items later with some help. He is not reliable in answering the door when the worker is scheduled to come, as he sleeps at odd hours and can be angry and disagreeable when the worker wakes him up by knocking loudly on the front door.

The medical history available is limited and the client rarely agrees to see a Doctor. History includes: disabling work-related back injury 10 years ago; poorly controlled chronic back, neck and hip pain; osteoarthritis; glaucoma; hospitalization 6 months ago for pneumonia and heart failure. Prescriptions include Digoxin, VIcodin, Diclofenac, and Betopic eye drops. His medication compliance is poor.

He owns his trailer, which is in need of repair for a leaking roof an unsafe 5 step entry to his front door and a lack of heating system. He uses a portable electric heater as his sole heating source, and is currently behind on paying his electric bill. He has a land line phone, but is hard of hearing, so does not answer it. Michael has had several falls both inside and outside of his home in the last few months. He had no apparent injuries, and refused to go to the Dr. The client has been offered residential placement options, but is unwilling to leave his home at this time. He wants in-home care and help with his financial and home repair needs.

8.4.1 (M) Bidder's Response

Bidder's response shall not exceed 5 pages.

9 ALIGNMENT WITH STATE PURCHASING STRATEGIES

9.1 (M) MMI Plan's Role as a Contributing Member of the Local and Regional Delivery System

Medicare and Medicaid purchased health care is a major component of Washington's health care market and heavily relies on the local and regional health care delivery systems across the state to provide the vehicle for dual eligible beneficiaries to access quality, value-based services and supports. In developing new models of health care delivery for publicly funded health care programs, the State intends to make meaningful contributions to the ability of local and regional health delivery systems to be the effective vehicles of service delivery. The State is interested in selecting MMI Plans that demonstrate a commitment to further develop infrastructures that move outside MMI Plan central offices into the communities where enrollees and their care teams reside and to contribute as a valued member of the local health and human services delivery system in ways that improve health care quality on a system level.

The State envisions the Demonstration to become a model from which the State can measure future progress in supporting local and regional health delivery systems state-wide through this approach.

9.1.1 (MS) Required Elements to be Addressed

The applicant is to submit a response that describes the organization's support for enhancing its role as a contributing member within the local and regional health delivery system serving the county coverage area. The response should include specific details about how the organization will interact with members of the delivery system and community health and human services agencies to identify and implement meaningful ways the Demonstration can contribute, including expanding the shared knowledge base of all members about the essential features focused on a whole-person approach to care, use of evidence-based health care, person- and family-centered care, effective use of health information systems to exchange complete, accurate, and timely data necessary to support effective care, etc.

9.1.2 Evaluation Insight

The applicant's response will be evaluated based on the insight provided about envisioned opportunities specific to the Demonstration and the described approach to be used to interact with the members of the local and regional delivery systems to explore opportunities to improve quality and access to care and other vital resources needed to support the dual eligible population.

Specific attention will be paid to the applicant's described approach to integrating itself into the local and regional health delivery system to support ongoing efforts to improve the health status of the population and the effective and efficient delivery of value-based services and supports by local agencies and individual and group providers.

9.1.3 (M) Bidder's Response

Bidder's response shall not exceed 5 pages.

9.2 (M) Expansion Potential of Demonstration Model

As the Demonstration Projects are rolled-out in King County and Snohomish County for the initial three-year period, it is important for the State to remain focused on the goal of developing a new model of integrated health care delivery that will serve to inform CMS and other states and that has the potential to be extended to other counties in the State without losing the integrity and effectiveness of the model. In order to keep this goal in the forefront, the State will maintain an ongoing dialogue with the selected Project MMI Plans to assure the Demonstration model could support broad geographic application.

NOTE: This three-year demonstration is only planned to include King County and Snohomish County. Any further expansion would require further Federal approval.

9.2.1 (MS) Required Elements to be Addressed

The applicant is to provide a response that presents the organization's perspective on the expansion value of its proposed MMI Plan design for other geographic areas of the state and to inform other state's integrated health delivery system development efforts. In addition, the response should propose a method to monitor the Demonstration MMI Plan as it develops over the course of the Demonstration period to assure it retains its capacity to be used on a broader geographic basis, should expansion occur in the future.

9.2.2 Evaluation Insight

The applicant's response will be evaluated based on the insight provided regarding a process to assure the Demonstration model design has potential future applicability in other counties of Washington.

9.2.3 M) Bidder's Response

Bidder's response shall not exceed 5 pages.

10 SCREENING, EVALUATION AND AWARD

10.1 Initital Screening of Bidder

A three-step Screening process will be used to determine bidder eligibility to submit a proposal and determine whether a complete proposal has been received and the bidder is eligible to submit a proposal. Eligibility to submit a proposal does not mean that HCA has determined the bidder or proposal satisfies mandatory performance or functionality requirements.

1. The HCA Contracts Officer will review the Letter of Intent to determine whether the bidder has provided the information required and sufficient documentation that they meet or exceed the minimum qualifications to be eligible to submit a proposal.

2. Review of the entire proposal by the Contracts Officer to ensure that the submittal is complete and in compliance with RFP procedural requirements such as number/type of copies, format, responses to each section, etc. This is also a Pass/Fail review and not part of a proposal's actual evaluation, numerical score or ranking. HCA is not required to contact a bidder for additional information if a proposal appears incomplete, unclear, or non-compliant with RFP requirements.

3. Review of Bidders Attestations of Compliance Check list

10.2 Evalutation of Proposal

After the proposals are screened for eligibility, proposals that are eligible will be evaluated and ranked as follows:

A. A single evaluation team will be formed to evaluate the written proposals. The team will be comprised of individuals with technical, management, and/or financial backgrounds. The evaluation team will consider how well each submittal responds to the individual RFA exhibits and meets the needs of HCA. The evaluation team will assign a Written Proposal Score and Ranking to each proposal. See Exhibit C for the written proposal scoring tool. It is important that the proposal be concise, clear and complete, so the evaluation team understands all aspects of the proposal.

B. HCA intends to award a limited number of contracts per coverage area based on the results from this RFA and the amount of eligible beneficiaries within each coverage area.

10.3 Selection Process

Award will be based on the initial screening process, bidders weighted combined score and how well, in the sole judgment of HCA, the bidder will serve the needs of HCA.

This RFA process will not determine final factor of award for a 3-Way contract. All of the specifications and terms in the RFP are based on the most current information available to the state at the time of publication and are subject to change and dependent on final approval and execution of a Memorandum of Understanding between the State of Washington and CMS. Specifications and terms will be finalized during the Memorandum of Understanding process and completion of the 3-Way contract between CMS, the State of Washington and MMI Plans.

Bidders, whose proposals have not been selected, will be so notified via email.

10.4 Debriefing of Unsuccessful Bidders

Bidders who submitted a proposal and were not selected will be given the opportunity for a debriefing conference. The RFA Coordinator must receive the request for a debriefing conference within three (3) Business Days after the notification of unsuccessful Bidder email is sent. The debriefing shall be held within three (3) Business Days of the request.

Discussion will be limited to a critique of the requesting Bidder's proposal. 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.

11 RESOLUTION OF PROTESTS

11.1 Protests

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

HCA shall not accept any protest before the announcement of the Apparently Successful Bidder. This procedure is available to Bidders who submitted a response to this RFA document and who have participated in a debriefing conference. HCA must receive a protest within five (5) business days of the debriefing

11.2 Procurement Records Disclosure

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

a) The requested documents will either be sent to or made available to the requesting Bidder, except for any portions of the documents that have been identified as Proprietary Information. HCA will follow the process set forth in Section 4.9 Proprietary Information/Public Disclosure before disclosing any portions of Proposals that have been identified as Proprietary Information.

b) If more time is needed, HCA will inform the requestor of the date the requested documents will be available.

11.3 Grounds for Protest

A protest may be made based on these grounds only:

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

Protests not based on these grounds will not be considered. Protests will be rejected as without merit if they address issues such as: 1) An

evaluator's professional judgment on the quality of a proposal, or 2) HCA's assessment of its own needs or requirements.

11.4 Protest Form and Content

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

- The name of the protesting Bidder, mailing address and phone number, and the name of the individual responsible for submission of the Protest;
- The RFA number and title;
- A detailed and complete statement of the specific action(s) by HCA under protest;
- The grounds for the Protest;
- Description of the relief or corrective action requested.

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

11.5 Submitting a Protest

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

All protests shall be emailed to Susan DeBlasio, HCA Contract Administrator as follows:

Email: susan.deblasio@hca.wa.gov
The subject Line must contain the RFX Title and RFX number. Example: RFA#12-123, Save the Children]

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

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

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

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

If the reviewer determines that the protest is without merit, HCA will enter into a contract with the Apparently Successful Bidder. If the protest is determined to have merit, one of the alternatives noted in the preceding paragraph will be taken.

If HCA determines that the protest is without merit, HCA will enter into a contract with the apparently successful bidder. If the protest is determined to have merit, one of the alternatives noted in the preceding paragraph will be taken.

12 EXHIBIT A – LETTER OF SUBMITTAL

See attached document.

13 EXHIBIT – B MODEL CONTRACT

See attached document.

14 EXHIBIT C - WRITTEN PROPOSAL SCORING TOOL

See attached document.

15 EXHIBIT D - CERTIFICATIONS AND ASSURANCES

See attached document.

16 APPENDIX A – HEALTHPLAN WASHINGTON STRATEGY 2 FINANCIAL ALIGNMENT DEMONOSTRATION GRAPHIC

See attached document.

17 APPENDIX B – CMS JOINT RATE-SETTING PROCESS UNDER THE CAPITATED FINANCIAL ALIGNMENT INITIATIVE

See attached document.

18 APPENDIX C – ATTESTATION OF COMPLIANCE

See attached document.

19 APPENDIX D – PARTIAL LIST OF RESPONSIBILITIES AND DUTIES THAT REQUIRE MANDATORY STATE/LOCAL/MMI PLAN INTERACTION.

See attached document.

20 APPENDIX E - PARTIAL PROFILES OF THE DUAL ELIGIBLE POPULATIONS IN KING COUNTY AND SNOHOMISH COUNTIES, 2010.

See attached document.