Washington State Health Care Authority

STATE OF WASHINGTON
HEALTH CARE AUTHORITY

REQUEST FOR INFORMATION (RFI)

RFI NO. 2024HCA16

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

SCOPE TITLE: Dental Plans

RFI RELEASE DATE: January 6, 2025

SUBMISSION DUE DATE: January 30, 2025, by 2 PM Pacific Time, Olympia, Washington, USA

RFI RESPONSE: Please limit your entire RFI response to 30 pages or less. At HCA's discretion, you may also be asked to participate in an ad-hoc conference call with HCA personnel.

Only e-mailed submissions will be accepted.

1. RFI GOALS AND OBJECTIVES

This Request for Information (RFI) seeks information from dental insurers that currently have, or can obtain, a Washington State Office of the Insurance Commissioner (OIC) license that can share valuable experience related to the questions in Exhibit A.

1.1. RFI GOAL

HCA is currently gathering information that will assist HCA in its plan design and purchasing strategy in obtaining fully-insured dental plans and changes to the design of a self-insured dental plan. The information may be used in consideration of a possible future procurement of fully-insured dental plans for more than 775,000 members between the Public Employees Benefits Board (PEBB) and the School Employees Benefits Board (SEBB).

1.2. BACKGROUND

HCA's current member population includes roughly 320,000 PEBB actives, 335,000 SEBB actives, 118,000 PEBB retirees and 3,000 Consolidated Omnibus Budget Reconciliation Act (COBRA)/self-pay members.

By law, two risk pools have been used in the PEBB Program for most of the program's history (since the mid-1990s): RCW 41.05.022, which includes active employees and non-Medicare retirees, and RCW 41.05.080, which includes only members enrolled in Medicare Part A and Medicare Part B. There is a separate SEBB risk pool required under RCW 41.05.022, which includes only active K-12 employees; all K-12 retirees move to PEBB upon retirement. The Washington State Legislature is considering combining the non-Medicare and SEBB risk pools in Senate Bill 5086.

HCA is interested in the dental insurer community's knowledge and expertise regarding the benefit structure, implementation, and operation of dental plans.

2. CONTENT OF RESPONSES

This section outlines the elements requested in the response to this RFI. The timeline in Section 3.2 includes time for additional questions to address any information not covered in the subsequent sections.

2.1 RFI RESPONSES

HCA is seeking information from dental insurers who have the capabilities to provide dental plans to the members outlined above.

Qualified entities are requested to respond to the questions outlined in Exhibit A.

Please use the above assumptions and background as a framework in your responses. This common framework will greatly facilitate interpretation of the RFI results.

3. ADMINISTRATIVE TERMS AND CONDITIONS

3.1 RFI COORDINATOR

The RFI Coordinator is the sole point of contact in HCA for this RFI. Please submit responses to the RFI Coordinator at the email below.

Name	Mayra Ledesma
E-Mail Address	HCAProcurements@hca.wa.gov

Please be sure to include the RFI Number **2024HCA16** in the subject line of any emails.

3.2 ESTIMATED RFI SCHEDULE

Release RFI	January 6, 2025
Vendor RFI Questions Due	January 13, 2025 due by 2:00 PM PT
HCA Answers Posted*	January 22, 2025
Vendor Exhibit A Response due to HCA	January 30, 2025 due by 2:00 PM PT
HCA Ad-Hoc Conference Call Confirmation Email Notice sent to Selected Vendor(s)*	February 12, 2025
Vendor Ad-Hoc Conference Call Confirmation to HCA	February 14, 2025 due by 2 PM PT
Ad-Hoc Conference Calls	February 18, 2025 – February 21, 2025

* Dates are anticipated and subject to change without an official amendment.

HCA reserves the right to change the RFI schedule at any time.

3.3 VENDOR RFI QUESTION PERIOD

Vendors are provided with an opportunity to ask questions during the vendor question period which starts on the date of the RFI posting and concludes on the Vendor RFI Questions due date specified in Section 3.2 (ESTIMATED RFI SCHEDULE).

A. Questions regarding the RFI will only be accepted in writing, sent by email to the RFI Coordinator. The Vendor must use the following email subject line when submitting questions: “RFI #2024HCA16 Question(s) – [Vendor Name]” to ensure timely receipt.

B. HCA anticipates it will post answers to the questions in WEBS as an RFI amendment on the HCA Answers Posted date specified in Section 3.2 (ESTIMATED RFI SCHEDULE).

C. HCA is under no obligation to respond to any questions received after the Vendor RFI Questions due date but may do so at its discretion.

3.4 RESPONSE REQUIREMENTS

A. Written Response - Required

Please limit your response to 30 pages or less. Responses must be provided in an electronic format, such as Adobe Acrobat or Microsoft Word. This will assist in HCA's review process. You only need to provide a single copy of your response. Responses may be provided in more than one file and submitted in more than one email. HCA requires that all responses be submitted via email to the RFI Coordinator in Section 3.1.

Please note that HCA will not accept zipped or compressed files in connection with this RFI. HCA will not open any such file. If individual files to a response are too large, please send multiple emails instead of compressing files.

B. Response Font, Margins, and Paper Size

The response must be clear and conform to the following requirements:

i. Use the font identified below:
   a. Arial (not Arial Narrow) at a font size of 11 points.
   b. A font size of less than 10 points may be used for mathematical formulas or equations, figures, tables, or diagram captions and when using a Symbol font to insert Greek letters or special characters.

ii. Margins, in all directions, must be at least one (1) inch. No vendor-supplied information may appear in the margins.

iii. Paper size must be no larger than standard letter paper size (8 ½" by 11").

These requirements apply to all sections of response, including supplementary documentation.

C. Page Formatting

Since many reviewers will be reviewing proposals electronically, vendors are strongly encouraged to use only a standard, single-column format for the text. Avoid using a two-column format since it can cause difficulties when reviewing the document electronically.

While line spacing (single-spaced, double-spaced, etc.) is at the discretion of the vendor, established page limits must be followed.

D. Ad-Hoc Conference Calls (at HCA's discretion)

HCA may choose to request a conference call with one or more vendor(s) to ask clarifying questions or seek additional information. HCA will work with the vendor(s) to schedule the call(s). If selected for a conference call, you will be emailed by the RFI Coordinator with the conference call dates and times.

E. Cost of Response

Respondents will not be reimbursed for any costs associated with preparing or presenting any response to this RFI.

F. Response Property of HCA

All materials submitted in response to this RFI become the property of HCA. HCA has the right to use any of the ideas presented in any response to the RFI.

G. Public Records and Proprietary Information

Any information contained in the response that is proprietary or confidential must be clearly designated as such. The page and the particular exception(s) from disclosure must be identified. Each page claimed to be exempt from disclosure must be clearly identified by the word "confidential" printed on the **lower right-hand corner** of the page. Marking the entire response as confidential will be neither accepted nor honored and may result in disclosure of the entire response.

To the extent consistent with Chapter 42.56 RCW, the Public Records Act, HCA will maintain confidentiality of your information marked confidential or proprietary. If a request is made to view your proprietary information, HCA will notify you of the request and of the date that the records will be released to the requester unless you obtain a court order enjoining that disclosure. If you fail to obtain the court order enjoining disclosure, HCA will release the requested information on the date specified in its notice to you.

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

3.5 REVISIONS TO THE RFI

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

HCA reserves the right to cancel or reissue this RFI at any time, without obligation or liability.

3.6 NO OBLIGATION TO BUY OR ISSUE SOLICITATION

HCA will not contract with any vendor as a result of this RFI. While HCA may use responses to this RFI to draft a competitive solicitation for the subject of these services, issuing this RFI does not compel HCA to do so.

Responding to this RFI will not be a requirement of future solicitations. Responses and information provided in response to this RFI will not be considered when evaluating bidders responding to any future solicitation.

If HCA does a solicitation, HCA will post it on WEBS.

3.7 SECURITY AND PRIVACY REQUIREMENTS

Any solution HCA procures and implements will need to comply with applicable state, federal, and industry regulations, such as the following:

1. HIPAA Privacy, Security and Breach Notifications
2. WA State OCIO Security Standard, OCIO 141.10
3. 42 CFR Part 2
4. RCW 70.02
5. HCA Privacy and Security Policies, such as HCA 1-02 and HCA 6-16
6. NIST 800-53 Rev 4
7. Industry certifications

Further information about any of the above can be provided at vendor request.

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4. EXHIBIT A – RFI QUESTIONS

1. Benefit Structure:

a. How do you define in-network and out-of-network benefits?

b. How much flexibility is there in applying the plan maximum to different services? For example, do you currently, or can you, offer a plan in which preventive services do not apply to the plan maximum?

c. Do you currently, or can you, offer a plan in which a member can earn a decrease in their copay amount for the following year if the member consistently uses preventive services?

   i. Are there limits on the level of incentive that can be achieved by a member?
   ii. Which services do you see as being eligible for decreased cost shares?

d. Do you currently, or can you, offer a benefit model where the copays are fixed by service and there is no total annual coverage maximum for the plan? What are the details of this plan and how many clients offer this plan currently?

e. What is the percentage of your large group plans that are defined benefit plans where there is an annual benefit maximum versus true insurance plans?

f. What kind of focused approaches do you have to encourage annual visits or other preventive services among the following populations?

   i. Active

   ii. Retiree

   iii. Children

g. What are your deductibles, if any, for adults and children? Please include the age at which a member moves from the “child” to the “adult” tier.

h. Do you currently, or can you, offer plan designs that offer enrollees an opportunity to pay cost differences between covered and deluxe items when available? For example, if a plan covers a certain type of material for a retainer or denture, and there is a higher grade of material or a new 3D printer technology that can produce the item, do you have a plan design allowing the patient to pay for the difference in the charges for the standard item compared to the deluxe, as opposed to having to pay for the deluxe item in full as a “non-covered” item?

i. What benefit models and structures would you recommend for programs as large as the PEBB and SEBB populations?

j. Describe your experience with administering a benefit design that more closely resembles standard medical insurance designs, meaning a deductible, cost share, out of pocket maximum structure instead of a defined benefit structure.

   i. What challenges would you foresee in administering such a benefit design?

2. **Clinical:**

    a. How are you using your power as an insurance company to drive upstream prevention and intervention when the model of dentistry is sustained by surgical interventions?

    b. How do you support accessibility for enrollees with disabilities?

    c. How do you address enrollees with congenital disabilities?

        i. Specifically, do you currently, or could you, cover dentally necessary treatment of congenital abnormalities (e.g. ectodermal dysplasia)?

        ii. Does or could that coverage include services and procedures for any missing or abnormal body part dentally necessary to achieve normal body function, including teeth?

    d. What is your policy around prevention and early intervention? For example: silver diamine fluoride?

    e. Does the plan consider any comorbidities (example – diabetes, pregnancy, Substance Use Disorder) that impact oral health and provide additional benefit or coverage?

    f. Do you use Artificial Intelligence (AI) for any clinical applications (e.g., reading X-rays, diagnostics, or to inform treatment plans)?

    g. What telehealth options do you offer or support?

    h. Please describe your organization's experience and knowledge with clinical reviews for authorization of dental services.

        i. Describe how you provide clinical review of cases including what type of system is used, if any.

        ii. Describe the staffing matrix and credentials of the clinical authorization review section.

        iii. Describe what types of clinical review standards are used during the case review process.

        iv. Describe if and how AI is used in this process.

3. **Quality Assurance and Program Integrity:**

    a. Please describe your organization's quality assurance program, including but not limited to experience and knowledge in successfully administering a quality assurance plan, your plan for ongoing quality improvement and what reports were used to direct this success.

b. Please describe your organization's experience and knowledge with performing utilization reviews to assure program integrity and fiscal stability are maintained and that quality of care is provided to your clients.

    i. Describe what your regular reporting of service utilization looks like and how this information is used to enhance your dental offerings.

    ii. What type of activity do you perform to prevent or identify misappropriation of dental expenditures?

    iii. What type of program integrity standards do you adhere to?

c. Please describe your organization's experience and knowledge with receiving, processing and finalizing prior authorization (PA) requests.

    i. Describe your abilities to process authorizations on a timely basis, start to finish.

        i. Describe your standard timeline of processing authorizations across your contracts (example X% within Y days)

    ii. Describe how an all-electronic submissions PA program works, including submission of backup documentation. If your system does not allow attachments, explain how back up documentation is managed.

    iii. Describe how you handle denials of authorizations, including the appeals process and expedited hearings.

4. Data:

a. What capabilities do you have to disaggregate data to identify and address health disparities between populations? For example, can you disaggregate data based upon race, ethnicity, rural status, and primary language?

b. While oral health quality metrics are less developed than medical counterparts, much progress is being made in the oral health measures available. Which, if any, of the Dental Quality Alliance metrics do you currently utilize to understand what is happening in your population of enrollees? For reference: DQA Dental Quality Measures | American Dental Association,

    i. If you do collect data on any of these metrics, how do you utilize it and what have you learned? How have you changed your benefit as a result?

    ii. If you do not collect data on any of these metrics, how do you know you are promoting oral health and managing disease for your enrollees? What metrics do you use?

c. Do you use any data or metrics to develop accountability applications? If yes, please provide an example.

d. Do you use any data or metrics to develop and support quality improvement? If yes, please provide an example.

5. Administration:

a. Please describe your organization's claim processing knowledge and experience in processing claim payments for a dental program.

   i. Describe how your claim processing works.

   ii. Describe your abilities to transmit claims/encounter data electronically to clients.

   iii. Do you use AI in claims adjudication? If so, how?

   iv. Is any aspect of claims adjudication performed outside the United States?

   v. What are the qualifications and training of your claims staff?

b. How do you handle claims appeals?

   i. What are the qualifications and training of your appeals staff?

   ii. Is any aspect of handling appeals performed outside the United States?

c. Describe what kinds of reports you produce, how you use them in providing oversight to assist with program management, integrity, improvement and fiscal soundness.

d. Please describe your organization's experience and knowledge with administering a complaint, appeal and hearings program for a dental benefit.

   i. Describe your complaint, grievance, continuation of services and appeals process, including the levels of review. At what time in the process would clients be aware of and involved in a case?

   ii. What is the role of the call center/customer service in the handling of complaints, grievances and appeals?

   iii. What is your process for tracking and trending complaints and appeals to monitor plan design and performance?

e. Regarding dental claims and adding ICD11 and diagnostic codes: Are you currently prepared to be compliant with this? If not, what is your implementation timeline?

f. Where are enrollment and claims data stored/located?

g. Please describe your organization's experience and knowledge in running a customer service/call center.
   i. Describe your customer service program and process, including hours of operation, staff training including cultural orientation, and responsiveness data (response time, first call resolution goals, etc.).
   ii. Do you outsource your call center functions? If so, where to and how do you monitor this contract to assure compliance with your expectations?
   iii. Describe your interpretive services available to enrollees when calling the center.

iv. Where are your customer service activities performed?

h. Do you use AI in any part of your customer service operations, for example the call center or chat?

i. For whom do you currently provide dental third-party administration (TPA) services, and how many members do you serve? Do those include any public sector clients?

j. Do you use subcontractors for provision of administrative services? If so, please describe.

k. When your organization thinks about health outcomes and health equity, what strategies does it employ to understand, influence, and improve disparities and outcomes?

l. Please describe your organization's experience and knowledge in administering a dental benefit for a public sector population.

i. Describe innovative programs that improve access and care to the covered population.

ii. Describe activities/programs that have successfully coordinated and integrated dental and primary care to ensure continuity of care and services.

6. Provider Network:

a. Describe your provider network.

i. Do you contract directly with your provider network, or do you contract for the use of a provider network maintained by a third party? If the latter, please identify the network.

ii. Does your network include tiers of providers? If so, please describe the difference(s) between the tiers and the size of the tiers.

iii. What is the intention or goal of tiering providers?

b. For each of your provider networks, please describe service areas and provider turnover rates in your service areas.

c. If you offer more than one provider network, discuss each network offered and the key features/differences of each.

d. How do you establish and adjust rates to be paid to providers?

i. How often do you adjust the rates paid to providers?

ii. What is your review process for determining provider rates?

iii. What ability do your provider contracts give you and the provider to make changes to the rates?

iv. What provider payment models do you use? Please provide information on your use of incentives, value-based purchasing arrangements, including bonus and shared savings arrangements, as well as financial rewards for providers who meet, exceed, or improve their performance on specified quality measure targets.

e. What standards do you (or the third party that manages the network) use to determine the adequacy of your provider network(s)? Please include details such as time/distance standards and whether the standards differ for urban and rural.

f. Please describe your organization's experience and knowledge with obtaining and maintaining an adequate dental network to meet your customer needs.

g. Do you or can you offer an online or print (or both) directory of in-network providers?

    i. If so, how is that provider directory maintained? How often is it updated?

h. Do you track or identify providers who offer telehealth and mobile or home/care facility dental and/or hygienist services?
    i. Do you track or identify other special categories of services? For example, 3D printing technology.

i. What percentage of providers in your network are accepting Medicaid patients?

j. What provider types do you credential and consider in-network (for example, hygienists, dentists, dental therapists)?

k. Do you provide coverage for onsite care for patients in facilities or mobile or portable dentistry?

l. Do you provide any special support for providers in rural or underserved areas? Do you provide mobile services to rural areas or have any targeted rural access strategies? If so, please describe.

m. Do you track and publish ethnicity of your providers, languages spoken by your providers, or any other demographic characteristics of your providers? If so, please describe.

n. Are there areas of Washington that are more challenging to cover in your experience? Please describe the nature of those challenges.

o. Do you or can you offer coverage nationally?

    i. If not, do you offer coverage in Washington, Idaho, and Oregon? Please provide a list of counties in these states in which you provide coverage.

p. Please provide a high-level overview on provider audits and review policies for established providers as well as providers who are onboarding.

6. Financial:

a. Please provide an outline of your cost control measures and practices.

b. Can you please provide your utilization and unit cost trends from 2019 – 2024 by dental class?

7. Other:

a. Is your dental company licensed in Washington now or can you be licensed in Washington at a later date?
b. What wellness program tools do you or can you offer and make available to participants?