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***This is not an advertisement.***

***Miami-Dade County, Florida***

***RFP No.***

**SCOPE OF SERVICES**

**2.1 Background**

The County's existing Plan includes two (2) Point-of-Service (POS) (i.e., redesign and non-redesign) options, and four (4) Health Maintenance Organization (HMO) options (i.e., 2 Open Access High (i.e., redesign and non-redesign), Select (i.e., narrow network-redesign) and Low (i.e., non-redesign). Plan design options and corresponding benefits are available for review at Miami-Dade County's Benefits Webpage. Please refer to the following link: <http://www.miamidade.gov/humanresources/benefits.asp> for this information. The County's newly introduced Select HMO option, which has a limited network, became effective on January 1, 2015. The Low HMO and non-redesign plan options may be eliminated in the future. Notwithstanding, the County reserves the right to continue offering the Low HMO and non-redesign plan options to employees covered under certain bargaining units based on their respective unit's agreement. Modifications to the County's benefit levels are subject to collective bargaining agreements. Additionally, there are currently three plan design options **only** offered to Medicare-eligible (ages 65+) retirees, as follow: 1) Low HMO option with pharmacy, 2) High HMO with pharmacy, and 3) High HMO option with no pharmacy coverage.

The County employs approximately 26,000 individuals in South Florida, although the Plan covers 46,000 lives. Jackson Health System (JHS) has participated in the County's Plan since the inception of the current agreement, with the exception of Plan Year 2011. However, effective with the January 1, 2015 Plan Year, JHS commenced providing Plan benefit options to its employees and retirees which fall outside of the scope of this Solicitation, and is therefore not expected to participate in the future Plan, with the exception of approximately one hundred (100) JHS employees who remain eligible for participation under collective bargaining agreements.

The County's comprehensive Employee Benefits Program is designed to retain current employees and recruit potential new employees. The majority of County employees are covered by a collective bargaining agreement, as there are eleven (11) labor organizations representing County employees consisting of:

Labor Organizations:

AFSCME 121 Water and Sewer Employees

IAFF 1403 Fire Fighter Employees

TWU Local 291 Transit Employees

PBA Rank & File

**\*AFSCME 3292 Solid Waste Employees**

**\*AFSCME 1542 Aviation Employees**

**\*AFSCME 199 General Employees**

**\*GSAF Supervisory**

**\*GSAF Professional**

PBA Law Enforcement Supervisory

\*Unions which have adopted plan re-design.

**Note:** The International Association of Firefighters Local 1403 ("IAFF"), offers a Union-sponsor plan to its members. Employees who are members of IAFF will be offered the opportunity to participate in the County's

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Plan, or the Union-sponsored plan, if eligible. To identify participants in the Union-sponsored health plan, please refer to the census data provided in **Attachments 1 and 1a, titled "Census."**

The County reserves the right to, at any time during the term of any agreement resulting from this Solicitation; allow either the JHS and/or IAFF group to participate in the County's Plan. Both JHS and IAFF group will continue to participate in the County's existing dental and vision plans.

The County anticipates continuing with the existing contribution strategy, per employee, as the current Self-Funded Group Healthcare Benefits Plan. The County contribution levels are subject to change, primarily based on collective bargaining agreements, and at the County's sole discretion.

**2.2 Objective/Overall Goal of the County**

The County is interested in receiving comparative value-added Plan design options which may include, but not be limited to, reductions in employee out-of-pocket expenses, greater accessibility to network providers and a comparative formulary inclusive of the minimum therapeutic categories and copay tiers included in the current Plan design, along with specific plan options that address the County's actively employed and retired populations. Proposers are expected to match, to the utmost extent possible, the County's current Plan design, in addition to offering up to two (2) alternative redesigned plan options. Proposers' offer shall include plan designs that offer current POS and HMO Plan options. Notwithstanding, the County reserves the right, at its sole discretion, to alter the current Plan design going forward. The County is not currently interested in Stop-Loss coverage or Pharmacy Benefit Management carve-out services.

To further consider a broad array of innovative solutions, the County may be interested in a stand-alone and sustainable Wellness Program on an unbundled basis. As such, the County may award a separate contract for wellness and remove such services from the group healthcare (refer to Section 4.0). The County's Wellness Mission is to create a holistic, accessible and fun program that encourages, supports and nurtures healthy eating, work life balance, and an active lifestyle. Please refer to Section 2.7 for further information regarding the Program.

**Note:** The County reserves the right, at its sole discretion, to determine whether the Wellness Program will be provided through group healthcare or as a stand-alone.

The purpose of this Solicitation is to verify competitiveness and evaluate alternatives to the County's current Plan design and fees. Moreover, the County seeks full transparency on the proposed healthcare Plan's quality and pricing schematic. The County is not interested in proposals that only offer one of the above Plan design options.

**2.3 Qualification Requirements**

**A. Minimum Qualifications Requirements**

The Proposer shall:

1. Be licensed by the State of Florida, to transact the appropriate insurance, and/or administrative products and services, for which the proposal is being submitted for, as of the proposal due date.
2. Have a minimum "A- Rating" from A.M. Best Company, and no less than a "Classification of VII" or higher, as of the firm's most recent rating. If Proposer does not have a financial rating from A.M. Best, the

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most recent independently audited financial statements for the past two (2) years, or the SEC's Annual Report 10-K Reports shall be submitted to the County for determination of Proposer's financial stability.

**Note:** The above requirements are a continuing requisite throughout the contract award and term of the agreement.

**B. Preferred Qualifications**

The Proposer should:

1. Have been licensed to transact the appropriate insurance and/or administrative products for a minimum of five (5) years in the State of Florida. This preferred qualification is also applicable to the selected Proposer's sub-consultants, as applicable.
2. Have a minimum of five (5) years of experience in the State of Florida administering claims and providing similar services to those listed in this Solicitation, for a governmental group of 10,000 employees or greater. This preferred qualification is also applicable to the selected Proposer's sub-consultants.
3. Have sufficient provider networks, quality practitioners, and highly-rated facilities in areas in which County employees and retirees reside (primarily in South Florida). Retirees and out-of-area dependents shall have sufficient access to providers and should be covered based on the same plan designs as in-area participants. The network for the proposed benefit plan should include a local and national network of providers while maximizing discounts to the Plan. The minimum access standard should be one (1) provider/facility within 5 miles, or two (2) providers/facility within 10 miles. This preference is not applicable to the Wellness Program.

**2.4 General Information**

1. **Attachments 2, 2a and 2b titled, Health Plan Premium Equivalent Rates**, outline the 1) Monthly/Bi-weekly Active Employee Rates, 2) Monthly Pre-Medicare Retiree Rates, 3) Monthly Medicare Eligible Retiree Rates, 4) other plan rates and, 5) COBRA benefit rates for 2015. Employees' contributions are offered on a pre-tax basis, except for those employees with dependents who do not qualify as a tax dependent under the Internal Revenue Service (IRS) provisions. The County reserves the right to change its contribution strategy at any time. Notwithstanding, the selected Proposer's fees and rates for the Plan shall remain in effect regardless of the County's contribution strategy.
2. Effective January 1, 2014, any full-time County employee who has completed 60 days of employment is eligible for coverage, or as determined by the County. Any part-time employee who consistently works at least 60 hours bi-weekly and has completed 60 continuous days of employment is eligible for coverage. If an election is made, coverage is effective the first day of the month following completion of the eligibility period without any actively-at-work exclusion.

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Dependent eligibility is defined as follows:

<b>Eligible Dependents</b>	
Spouse*	Subscriber's legal spouse
Domestic Partner (DP)*	Subscriber's Domestic Partner in accordance with County Ordinance 08-61.
Child	Subscriber's Biological child, legally adopted child or child placed in the home for the purpose of adoption in accordance with applicable state and federal laws.
Child with a Disability	Subscriber's Dependent child incapable of sustaining employment because of a mental or physical disability may continue coverage beyond the limiting age, if enrolled for medical prior to age 26 (or 25 for dental). Proof of disability must be submitted to the Plan on an ongoing basis.
Step Child	Subscriber's spouse's child, for as long as Subscriber remains legally married to the child's parent.
Foster Child	A child that has been placed in Subscriber's home by the Department of Children and Families Foster Care Program or the foster care program of a licensed private agency. Foster children may be eligible until their age of maturity.
Legal Guardianship	A child (ward of Subscriber) for whom Subscriber has legal guardianship in accordance with an Order of Guardianship pursuant to applicable state and federal laws. Subscriber's ward may be eligible until their age of maturity.
Grand Child	A newborn dependent of Subscriber's covered child; coverage may remain in effect for up to 18 months of age as long as the newborn's parent remains covered. After 18 months, the grand child must have met the criteria of permanent legal ward of the Subscriber.
Over-Age Dependent**	Subscriber's unmarried dependent children and dependent children of Domestic Partner from age 26 to age 30 (end of calendar year) are eligible for coverage. Overage dependent must be without dependents, live in Florida or attend school in another state, and have no other health insurance.

**Coverage Limiting Age for Dependent Children** - Your dependent child's coverage ends on:

**Medical** - December 31 of the calendar year the child turns 26. May be continued to age 30, see extended coverage note below.

**Dental & Vision** - December 31 of the calendar year child turns 25 (26 for vision). There is no extension for dental and vision coverage unless the adult child is disabled.

**\*Subscriber's spouse or Domestic Partner (DP)** is not an eligible dependent for coverage if also a County employee. Eligible employees are not permitted to cover each other on their group medical/dental plans. Ex-spouses may not be enrolled for group benefits under any circumstance, even if a divorce decree, settlement agreement or other document requires an employee to provide coverage for an ex-spouse.

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**\*\* Adult Children (FSS 627.6562) – Eligibility for Extended Medical Coverage**

Medical coverage may be continued beyond December 31 of the year the adult child turns 26 until the end of the calendar year (December 31) the child turns age 30. Only medical coverage is available to this group. Once your dependent child reaches age 26, Subscriber is required to submit an **Affidavit of Eligibility** every year, with no exceptions, to continue such medical coverage for Over-Age Dependent. Failure to provide the documentation will result in coverage ineligibility for coverage.

3. The Census, as provided for in **Attachments 1 and 1a**, also identifies all active employees, to include IAFF and JHS participants that have elected stand-alone dental and/or vision Plan options.
4. Employees under the age of 65, who retire from County service, may continue POS, HMO or Select Limited HMO Plan membership for themselves and their dependents until age 65 with remittance of the required premium to the County. Currently, the dependents of deceased retirees or retirees attaining Medicare eligibility may continue coverage through the retiree group plan option by remitting the appropriate premiums to the County. The County reserves the right to make modifications such as offering COBRA as an alternative.
5. Retired employees who have attained age 65 may choose a plan for Medicare eligible retirees, offered by the County or a “Medicare-like” Advantage Plan offered by the selected Proposer with required premium remittance. The “Medicare-like” Advantage Plan premium (if any) will be collected directly by the selected Proposer.
6. Retiring employees shall be provided a one-time opportunity, at the time of retirement (no later than 30 days from the retirement date), to change their medical insurance plan election in order to allow participation in the option which best meets their retirement needs. The selected Proposer shall allow a separate annual enrollment change period for retirees, if requested by the County.
7. All retirees under and over the age of 65 shall have access to national networks at least equivalent to the networks offered to active employees. The selected Proposer shall provide current plan participants continued coverage on a no-loss, no-gain basis (meaning no employee should lose nor gain a benefit due to a change in the selected Proposer).
8. All underwriting requirements shall conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), where applicable. Please refer to the HIPAA Business Associate Agreement included in the County’s Form of Agreement herein as **Appendix C**. The selected Proposer is required to execute this agreement as part of any award issued as a result of this Solicitation.
  - (a) New employees and their eligible dependents are eligible for coverage without proof of insurability and are not subject to pre-existing condition exclusions.
  - (b) Employees who do not enroll within their initial benefits eligibility period, and do not satisfy a HIPAA special enrollment qualifying event, may not enroll until the following annual open enrollment period with a January 1 effective date.

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- (c) All employees and dependents enrolled as of December 31, 2015 are eligible for coverage with no actively at work exclusion.
9. The following rules apply for adding dependents:
- (a) New Dependents - A dependent of an insured may be added to the Plan by submitting an application within 45 days (60 days for newborns) of acquiring the dependent status. The employee must enroll the dependent within 45 days after the marriage, registration of Domestic Partnership or birth/adoption of a child (60 days for newborns). Coverage for a new spouse or Domestic Partner is effective the first day of the month following receipt of the application. Coverage for a newborn and children placed for adoption or adopted is effective as of the date of birth, or the earlier of 1) placement for adoption, or 2) adoption date. The change in rate, if applicable, is effective the first day of the month following the birth or the earlier of 1) placement for adoption or, 2) adoption date.
  - (b) If eligible employees have declined coverage for themselves or their dependents because of other insurance coverage and the other coverage ends, they may request enrollment within 45 days after the other coverage ends.
  - (c) Change of Family Status - A dependent may be added to, or deleted from, the Plan at any time during the year, under HIPAA special enrollment, or pursuant to IRS Section 125 provisions. Proof of the change in family status must be submitted at the time of request for change. Please refer to item 8(a) above for information on adding a new dependent. Payroll changes to add a newborn are processed in accordance with Florida Statute 641.31(9). If the Change in Status (CIS) Form is received by the County within the first 31 days from birth, the rate is waived for the first 31 days. If the CIS Form is received after the first 31 days, but within 60 days of the birth, the new rate will be charged retroactive to the date of birth. The same applies when adding an adopted child or child placed for adoption. The rate is waived if the CIS Form is received by the County within the first 31 days from the earlier of: a) adoption, or b) placement for adoption. If the CIS Form is received after the first 31 days, but within 45 days of the event, the new rate will be charged retroactive to the earlier of: a) adoption or b) placement for adoption. Payroll changes to delete a dependent, other than those events specified in this paragraph, become effective the first day of the pay period following receipt by the County.
10. Employee membership terminates on the last day of the pay period for which applicable payroll deductions are made after the date the employee ceases active work for any reason other than an approved leave of absence or retirement.
11. The selected Proposer shall:
- (a) Adhere to generally accepted standards (as suggested by the National Committee for Quality Assurance "NCQA") for the consideration and credentialing of physicians in its networks.
  - (b) Notify the County of any change in its financial ratings by A.M. Best, or any other industry rating service by which it is subject to rating. Notification of such change shall be

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provided to the County's Project Manager, through their preferred method of delivery, no later than three (3) business days after the selected Proposer has been apprised of such change.

- (c) Perform a GeoAccess analysis on an annual basis and make reasonable efforts to contract with additional physicians', hospital providers and urgent care centers where minimum access standards are not met. The minimum access standards are one (1) provider/facility within 5 miles, or two (2) providers/facilities within 10 miles.
- (d) Retain all fiduciary responsibilities, including, but not limited to responsibility for all internal and external appeals and determination of what constitutes a "medical necessity."

**2.5 Enrollment/Communications Provisions**

The selected Proposer shall:

- 1. Provide promotional enrollment materials at a minimum of thirty (30) days prior to the start of the County's annual open enrollment period, anticipated to be late October/early November for each upcoming Plan Year. Enrollment materials shall be provided in printed format, in an adequate amount (for approximately 10,000 employees), at the County's discretion. The County may also require the selected Proposer to provide enrollment materials in alternate formats (i.e., Braille, large print and/or audio compact disk.) An electronic version of enrollment materials, as well as a customized benefits website shall be made available to all eligible employees/retirees during initial enrollment and to new enrollees. Materials include, but are not limited to, the Summary Plan Design (SPD) of Benefits and Coverage and other materials, as deemed necessary by the County. Printing and production of material costs are the sole responsibility of the selected Proposer.
- 2. Draft materials including, but not limited to, the SPD, at least thirty (30) days prior to the Plan Year effective date, January 1st. The selected Proposer shall print and mail the SPD directly to Members' homes, at no additional cost to the County, with additional supplies available, as required by the County.
- 3. Utilize authorized County-specific forms and materials, as deemed necessary by the County.
- 4. Mail identification (ID) card to each enrolled Member within 5 business days from the date of receipt of each eligibility tape, excluding weekends and holidays. On-demand temporary ID printing capability shall be available at the selected Proposer's website, wherein Members can easily print temporary ID cards, when any of the following events occur:
  - a) Change in coverage option;
  - b) Change in coverage tier; and/or
  - c) A replacement/duplicate card is requested.
- 5. Ensure that the Plan can identify Members/Subscribers by both social security number **and** employee ID number, as required by the County. The selected Proposer shall ensure that all social security numbers are maintained for all Members/Subscriber enrolled in the Plan, and as such, shall bear the responsibility of protecting the privacy and legal rights of all Members/Subscribers.

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6. Distribute all communication materials to the various County locations no later than two (2) weeks prior to the start of the County's open enrollment period. The County shall approve in writing all booklets and any/all other employee communications prior to its printing. Additionally, the County retains the right to prohibit distribution of any materials that make false or misleading statements, reference any plan other than the selected Proposer's plan, or any other materials or "giveaways", at the County's sole discretion, which the County deems to be inappropriate.
7. Review its plan-specific information to be included in the County's Employee Benefits Handbook for accuracy. Provide necessary updates to the County no later than September 1<sup>st</sup>, for each upcoming Plan Year. The County will finalize and publish the Benefits Handbook. The County shall retain final approval authority over all communication material.
8. Consent to the use of the County's existing Enrollment Form and/or on-line enrollment process. The Enrollment and Change in Status Forms can be found at the County's benefits website. The County uses web enrollment for the annual open enrollment and anticipates its continued use for ongoing enrollments.
9. Have access to County employees on County premises, as determined by the County.
10. Provide sufficient personnel to attend all initiating enrollment period meetings with the County's Project Manager and subsequent open enrollment period meetings (estimated to be approximately 30 representatives), on a schedule set by the County. The selected Proposer's personnel (i.e., Account Executive/Manager/Representative, etc.) shall attend periodic meetings throughout the Plan Year, scheduled by the County, with reasonable notice given.
11. Consent to receiving eligibility data, in an electronic format, in the file layout used by the County.
12. Update eligibility data within one (1) business day from the receipt of such data. The selected Proposer shall notify the County of any issues arising within one (1) business day from the time of the data upload.
13. Provide a single point of contact for the purpose of facilitating eligibility and enrollment information, and coordinating any internal distribution of such information, as well as facilitating any necessary transfer of data to third party administrators.

**2.6 Benefit Provisions**

The selected Proposer shall:

1. Ensure that the Plan complies with federal guidelines for Cafeteria Plans pursuant to I RS Code Section 125, the Patient Protection and Affordable Care Act (PPACA), the Age Discrimination in Employment Act (ADEA), American Disabilities Act (ADA), Medicare Secondary Payer, HIPAA, and COBRA, as well as any other applicable federal requirements and all Florida mandated benefits.

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2. Offer full service provider contracts with Jackson Health Systems (JHS). JHS, as a provider, is subject to the Plan design approved by the County and standard credentialing methods. The selected Proposer shall allow Members to use all health care services (i.e., primary, secondary and tertiary services) offered by JHS. Provider contract between JHS and the selected Proposer should: a) become effective no later than December 1, 2015, b) remain in force for the duration of the selected Proposer's contract with the County, and any renewals or extensions thereof, and c) not contain any provision restricting or limiting a Member's use of these providers in any way that is not imposed on other physician or hospital provider within the selected Proposer's network. The selected Proposer shall be prepared to offer proof of an existing contract or a properly executed letter of intent with JHS; or demonstrate to the County's satisfaction, at its sole discretion, the inability to contract with JHS was out of the selected Proposer's direct control or not its decision.
3. Notify the County on a timely basis, of any issues/discussions surrounding its network of physicians and hospitals which would have an impact on County employees and retirees.
4. Provide the criteria for approval of organ transplants in the Plan. This criterion shall be defined and incorporated by reference into any agreement issued as a result of this Solicitation, including the criteria for approval and the definition of Experimental Procedures that will not be covered by the Plan. The selected Proposer shall provide all explanations in layperson's terms.
5. Provide the criteria for approval of the Gastric Bypass Benefit Program at JHS and one additional hospital facility that is currently certified as a Bariatric Surgery Center of Excellence, as defined by the American College of Surgeons (ACS), or the American Board of Metabolic and Bariatric Surgeons (ASMBS). This criterion shall be defined and incorporated by reference into any agreement issued as a result of this Solicitation, including the criteria for approval and the definition of Experimental Procedures that will not be covered by the Plan. The selected Proposer shall also provide all explanations in layperson's terms.
6. Provide the criteria and process for determining a "medical necessity" under the Benefit Plan. This criteria and process shall be defined and incorporated by reference into any agreement issued as a result of this Solicitation.
7. Accept pregnant employees/dependents', who are beyond the first trimester, continuance with their current attending OB/GYN, through the time of delivery. Such coverage shall be considered at the in-network level of benefits.
8. Provide an in-network level of care and benefits to a designated employee, and/or retiree, in special catastrophic cases, as determined by the County, even if the provider utilized is not part of the selected Proposer's network.
9. Allow for any deductible satisfied, and credited by the selected Proposer for covered medical expenses in the last three months of a calendar year (every plan year) to be carried over to satisfy the participant's next year's deductible.
10. Offer the POS, HMOs and Select Limited Network Plans on an open access basis (no Gatekeeper).

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11. Provide full transparency on the pharmacy rebates earned based on the County's prescription drug utilization. The selected Proposer shall provide credit the County for such rebates on a quarterly basis. All earned rebates shall be credited to the County even if any the contract resulting from this Solicitation, is terminated. The County reserves the right to audit the pharmacy management services inclusive of the rebate benefit, on an annual basis.
12. Notify the County within sixty (60) days of changes in the preferred drug list prior to the change, with explanation of how it will directly affect the County's Members. The selected Proposer shall include the number of Members affected and what other drug options the Members will have going forward. Additions are permitted at any time during the Plan Year. Deletions other than those resulting from Federal Drug Administration (FDA) requirements are only permissible one time per Plan Year.
13. Comply with the County's preference in receiving full transparency from the selected Proposer on provider discounts and billed charges.
14. Provide the County with full transparency on the Plan's healthcare quality and pricing schematic, upon request by the County. Such transparency's intent is to allow the County to make decisions based on patterns and behaviors that drive costs and impact outcomes on premium prices, and coverage levels. The selected Proposer shall serve as the County's strategic partner in forecasting possible reduction of risk and costs on common procedures to meet the needs of a changing economy. The County reserves the right to audit the Plan for this information, on an annual basis.
15. Have a technology-enabled solution to support reduction in cost of care through an accountable care delivery system. Such system's intent is to support new value-based care by allowing providers, key accountable executives as designated by the County Mayor, and their staff's, access to critical clinical and financial information. The intent is also to enable timely, value-based health care decisions that accomplish better health outcomes, costs and improved patient/physician satisfaction, shifting focus from volume to value.

**2.7 Wellness Program**

The Proposer shall:

1. Provide enhanced wellness initiatives, benefits, rewards and funding. The selected Proposer shall cooperate with the County and the County's Healthcare Plan provider in readily providing a comprehensive wellness program for employees and covered dependents. In addition, the selected Proposer shall readily and regularly provide various wellness activities including, but not limited to, disease management, health risk assessments, fitness workshops, wellness coaching, health fairs/health screenings, educational workshops, healthy behavior challenges and rewards and flu vaccines. In considering the provision of a wellness program and surrounding services, the selected Proposer's shall provide ASO fees' that include a wellness program and ASO fees' without a wellness program, based on annualized enrollment. The selected Proposer shall strategize and partner with the County in designing a wellness program tailored to the County's needs.

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2. Perform all administrative functions for the wellness program including monitoring and tracking participant membership, producing all employee communication materials relating to the wellness program, and tracking monthly program updates and results for participants.
3. Assume responsibility for all aspects of compliance with HIPAA, Genetic Information Nondiscrimination Act (GINA), Americans with Disabilities Act (ADA), Age Discrimination in Employment Act (ADEA), COBRA and any other applicable laws and regulations.

**Note:** Should the County pursue a stand-alone Wellness Program, selected Proposer will not be responsible for providing a Wellness Program. Selected Proposer will be expected to work with third party provider for the betterment and evolution of the County's wellness initiative.

**2.8 Data and Reporting Provisions**

The selected Proposer shall:

1. Provide the following reports (which shall include the information as stated below):
  - (a) **Monthly Claims Activity Reports**  
Monthly report of billed and paid claims due to the County by the 15<sup>th</sup> of the following month, segregated by bargaining unit, active employees, Medicare and Non-Medicare eligible retirees, and further categorized with dependents and COBRA beneficiaries identified separately (active and retirees).
  - (b) **Annual Utilization Data Reports**  
Annual report due to the County within 90 days of the close of the Plan Year, showing inpatient utilization by hospital, outpatient utilization and physician by type of service.
  - (c) **Annual Care Management/Disease Management Reports**  
Annual report due to the County within 90 days of the close of the Plan Year, showing utilization by Benefit Program (High Risk Stratification, Disease Specific, Quality Management).
  - (d) **Annual Prescription Drug Management Reports**  
Annual report due to the County within 90 days of the close of the Plan Year, providing cost indicators including brand and generic drug utilization, Formulary and non-Formulary utilization with separate specialty drug cost indicators.
  - (e) **Quarterly Data Feeds**  
Quarterly data feeds due to the County or its assigned consultant within 90 days of the close of the quarter, showing quarterly data feeds including all medical and pharmacy claims and covered membership.
  - (f) **Quarterly Quality and Performance Management Dashboards**  
Quarterly dashboards displaying cost and clinical quality measures used to ensure physician and group contract metrics are being met

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(g) **On-Demand Reports**

On-demand trends over time on advanced analytics to identify drivers of Plan quality, cost and utilization.

On-demand reports segregated by bargaining unit, active employees, Medicare and Non-Medicare eligible retirees, and COBRA further categorized with dependents and beneficiaries identified separately (active and retirees).

(h) **Quarterly Reports**

Quarterly reports due to the County 90 days from the close of the quarter, showing return on investment for the Wellness Program (if part of the contract) and disease management program, any cost containment programs and Pharmacy rebate reconciliation.

2. Provide web-based access to eligibility, census data and individual claim information to the onsite customer service representatives for the County.
3. Maintain utilization statistics based on the resultant desired County Plan structure.
4. Provide the County (and its designated consultant, if any) with on-line access to the selected Proposer's reporting system in order to retrieve standard and ad hoc claims and utilization reports.

The County is ultimately interested in accessing/receiving all information through web-based reporting. The selected Proposer shall provide a timeline to the County, for the implementation of such web-based reporting, within 90-days of contract effective date.

**2.9 Administrative and Related Services**

The selected Proposer shall:

1. Consent to the County's self-billing process as all benefit plans shall be administered on a self-billing fee/premium rate remittance basis.
2. Consent to bi-weekly bank wire-transfers of fee/premium payments, which will be remitted for the prior pay period. The selected Proposer shall grant a 30 day grace period for active and paid leave status employees.
3. Establish a benefit plan account ("Account") with a Qualified Public Depository bank agreed upon between the County and the selected Proposer. The account shall be in the name of the County for the exclusive use of the County's plan. An initial imprest balance will be maintained in the Account. Should it become necessary to increase the imprest amount, the County will agree to do so based on satisfactory evidence, at the County's sole discretion, from the selected Proposer of insufficient funds. The Account shall be funded weekly by the County based on electronic reports provided by the selected Proposer of issued checks. The County will issue payments via wire transfer. Any interest earned in the Account shall be accrued to the County and any banking fees will be charged to the Account.

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4. Establish an account ("Disbursement Account") with a Qualified Public Depository bank for the purpose of disbursements. The Disbursement Account shall be in the name of the selected Proposer. The selected Proposer, on behalf of the County, shall issue payments from the Disbursement Account for Medical Plan benefits and Medical Plan-related expenses in the amount selected Proposer determines to be proper under the Medical Program and/or under and future agreement resulting from the Solicitation. The selected Proposer shall provide to the County a monthly reconciliation of the Disbursement Account.
5. Implement the County's Group Health Care Benefit Program in a timely manner for a January 1, 2016 plan effective date, with enrollment scheduled for October/November of 2015.
6. Pursue Coordination of Benefits (COB) before payment of claims. The selected Proposer shall administer potential subrogation on a "pay, then pursue" basis. Subrogation action shall not be pursued against the County for Workers' Compensation claims that have been denied by the County. Selected Proposer shall annually identify all fees, percentage and to whom these fees are paid that are associated with such services as COB, Subrogation, Bill Negotiations, etc.
7. Coordinate directly with Medicare, on behalf of retirees, in processing plan claims for Medicare eligible retirees.
8. Administer appropriate procedures to carefully monitor and report the status of over-age unmarried dependent children and dependent children of Domestic Partner (26 years and over) to ensure satisfactory proof of eligibility is obtained and that coverage complies with Federal and State regulations, including COBRA status. Dependent children and dependent children of Domestic Partner losing group coverage due to age or loss of dependent status must be notified of their COBRA rights. The selected Proposer shall notify the County within 60 days after the open enrollment effective date (January 1<sup>st</sup> of each year) of any discrepancies in eligibility including employee name, dependent to be deleted and any change in coverage level.
9. Provide all COBRA administration, including mailing of initial COBRA notification after receiving notification of a qualifying event from the County. The services required also include billing of beneficiaries and collection of appropriate premiums.
10. Issue HIPAA Notices of Privacy Practices to new enrollees and reminder notices to all enrollees as required by HIPAA.
11. Verify dependent eligibility at initial enrollment and over age dependents and dependents with different last names at subsequent open enrollments, and notify the County within 60 days of any discrepancies in eligibility. The selected Proposer shall verify eligibility for new hires and new enrollees within 30 days and notify the County of any discrepancies in eligibility.
12. Perform a bi-weekly reconciliation of accounts based on bi-weekly eligibility files (daily for retirees) provided by the County. The selected Proposer shall notify the County in writing within 10 business days of any discrepancies, to include Member name, Member identification number, name of ineligible dependent and change in coverage level, if any.

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13. Provide a local account representative (who shall be physically located in the Tri-County area, and be approved by the County) with full account management capabilities. The account representative shall assist the County in the administration of the Plan approved by the County, in providing all necessary and related services for employees, in obtaining the appropriate resolution of issues including claims problems, and in any other way requested, related to the Services stated herein.
14. Ensure that selected Proposer's Account Executive/Manager and account management team shall:
  - a. Devote the necessary time to manage the account and be responsive to County needs pertaining to this Scope of Services (this includes being available for frequent telephone calls and On-site consultations with the County staff located in Miami, FL.);
  - b. Provide the County with mobile phone numbers and email addresses of all key account management personnel;
  - c. Be thoroughly familiar with all of the proposing company's functions that relate to the County's account; and,
  - d. Act on behalf of the County to effectively advance County action items through the selected Proposer's corporate approval structure.
15. Provide one (1) on-site customer service representative as a baseline - and one (1) additional on-site customer service representative per 6,000 members enrolled in the plan(s). On-site representatives will be housed at the County administration building and/or other County designated locations. The selected Proposer shall provide computer terminals, printers and fax machines for its representatives that have on-line access capabilities of employees' eligibility and claims information, provide customer service related functions, and assist in plan administration. The on-site representatives shall adhere to regular business days/hours pursuant to the County's business schedule in order to be easily accessible to employees. If an on-site representative is on vacation, or otherwise absent for an extended period, a replacement representative shall be provided. Further, the County may request replacement of the on-site representative if he/she is not performing in a satisfactory manner, at the County's sole discretion. The County will advise the selected Proposer of any performance concerns and allow adequate time to resolve before requesting such replacement.
16. Comply with the Performance Standards Provisions (See **Attachment 3 for Current Performance Standards**). Compliance with Performance Standards shall be measured annually at the end of each Plan Year and any non-compliance shall be assessed as liquidated damages. The Performance Standards shall remain in effect for the duration of any contract issued, and renewal options exercised, as a result of this Solicitation.
17. Ensure that the claims processing system is fully integrated with the eligibility system.
18. Allow the County, or its representative in addition to the rights contained herein, the right to perform an annual audit of all medical and prescription claims, utilization management files, financial data and other information relevant to the County's account. The results of this independent audit will determine liquidated damages, in addition to recoveries, for failure to meet Performance Standards. The selected Proposer shall maintain appropriate internal audit procedures for claims and customer service administration. Additional audit Benefit

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Programs such as pre-disbursement audits, audits of selected providers, and audits of specific services are also desirable. Fraud prevention and detection procedures shall be maintained by the selected Proposer, including appropriate reporting to authorities.

19. Allow the County or its representative access to audit physician, hospital, and pharmaceutical provider contracts.
20. Allow the County or its representative to perform an audit up to 36 months after plan termination.
21. Provide all necessary data, reporting and reconciliation support as needed for the County's participation in the Retiree Drug Subsidy ("RDS") Benefit Program under Medicare Part D. Such support will not include the preparation or submission of the actuarial attestation required for participation in the RDS Benefit Program. Selected Proposer shall provide at no additional cost to the County, Medicare Part D prescription subsidy filing.
22. Provide all necessary data, reporting and reconciliation support as needed for the County to comply with the Patient Protection and Affordable Care Act, at no cost to the County.

**2.10 Customer/Member Services**

The selected Proposer shall:

1. Communicate any significant changes in Member Services, (e.g., phone messages or prompts and personnel) to the County in advance. The selected Proposer shall receive the County's approval prior to implementing major changes to unit structure and service center.
2. Provide the County with a dedicated live Member Customer Service Team via a toll-free telephone line. This Team shall receive training on the specifics of the County's Benefit Plan. There shall also be a dedicated Interactive Voice Response phone number for County employees to access 24/7, 365 days a year.
3. Agree to the County's or the County's Benefits Consultant's, as approved by the County, developed and administered customer satisfaction survey tools specific to the County's Benefit Plan. The County and the selected Proposer will work together to develop the survey. The survey shall be conducted annually at the County's discretion. All customer satisfaction tools must be approved by the County prior to execution. Results of the survey shall be provided to the County with appropriate analysis and response by the selected Proposer.
4. Provide to all Plan Members selected Proposer's standard grievance procedure (included in the SPD) for Member's claim disputes when services are denied. Every new Member shall receive notification of a detailed explanation of grievance procedures within 30 days of the effective date of coverage.
5. Provide all claims data, as requested by the County, within 10 business days of such written request. Such claims data shall include, but is not limited to:
  - a. paid claims data by month,
  - b. incurred claims data by month,

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- c. disruption and network data as requested,
- d. prescription drug and behavioral health care claims data, and;
- e. large claims and utilization data as requested.

**2.11 Optional Plan Services**

The County may consider incorporating the option of bundling dental, vision and ancillary benefits to the existing medical Administrative Services Only Program in the future. Optional Plan Services and bundling of benefits will not be scored and are only for informational purposes. The County will determine whether it is in its best interest to incorporate such benefits in the future. In making such determination, the County will consider, among other things, whether savings for the referenced items can be achieved.

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