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Miami-Dade County, Florida

RFP No.00196

SCOPE OF SERVICES

2.1 Background

The County implemented a self-funded health program in August, 2007. AvMed, Inc. has served as the County's administrator since the inception of such Program. Currently, the County employs approximately 26,000 individuals in South Florida, although the Program covers 46,000 lives. Covered groups include Miami-Dade County active employees, retirees (Medicare and Non-Medicare Eligible), Consolidated Omnibus Budget Reconciliation Act (COBRA) participants and their eligible dependents, in addition to both the Housing Finance and Industrial Development Authorities (refer to the census data provided in **Attachment 1, Census**). Jackson Health System (JHS) had been a covered group within the County's Program since the inception of the current agreement, with the exception of Plan Year 2011. However, JHS will not participate as a covered group in the County's future Program, resulting from this Solicitation.

The County's existing Plan Design includes two (2) Point-of-Service (POS) (redesign and non-redesign) options, and four (4) Health Maintenance Organization (HMO) options: two (2) Open Access High (redesign and non-redesign), one (1) Select (narrow network redesign) and one (1) Low (non-redesign). Additionally, there are three (3) 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. Design options and corresponding benefits are available for review at the County's Benefits Webpage. Please refer to the following link: <http://www.miamidadegov/humanresources/benefits.asp> for further 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 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, the County reserves the right, at its sole discretion, to alter the current Plan Design going forward. The County is not interested in proposals that only offer one of the above design options described herein.

The majority of County employees are covered by a collective bargaining agreement. There are ten (10) labor organizations representing County employees, listed below as follows:

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

*Labor Organization which has adopted Program redesign options. Plan design options available to employees are based on negotiated bargaining unit agreements.

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Note: The International Association of Firefighters Local 1403 (“IAFF”), offers a Union-sponsor medical plan to its members. Employees who are members of IAFF will be offered the opportunity to participate in the County’s healthcare Program, or the Union-sponsored plan, if eligible. To identify employees participating in the Union-sponsored medical plan, Proposers may refer to the census data provided in **Attachment 1, 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 Program. Both the JHS and IAFF group continue to participate in the County’s existing dental and vision programs.

Additionally, the County anticipates continuing with the existing contribution strategy, per employee, as the current Self-Funded Employee Group Healthcare Program. 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 purpose of this Solicitation is to verify competitiveness of the County’s current Program. The County is interested in receiving a comparative value-added Program design and fee, 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 options that address the County’s actively employed and retired populations. Proposer’s proposed Program shall match, to the utmost extent possible, the County’s existing Plan design. Please refer to the summary of benefits provided in **Attachment 2, Summary of Benefits Coverage (SOBC) Handbook**, for further information on existing Plan description.

In addition, the County is interested in the Proposer’s approach to offering up to two (2) Alternate Plan Option(s) for possible consideration and inclusion in the County’s Program, at the County’s sole discretion. Please refer to Section 2.11 for further information on Alternate Plan Option(s).

2.3 Qualification Requirements

A. Minimum Qualification Requirements

The Proposer shall:

1. Be licensed by the State of Florida, to transact the appropriate insurance, and/or administrative product and services, for which the proposal is being submitted for, as of the proposal due date.
2. Be financially stable to render the services listed herein, as of proposal due date. To satisfy this requirement, Proposer shall 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’s rating does not meet rating requirement, the Proposer shall provide to the County: 1) its most recent independently audited financial statements with the auditor’s notes for each of its past two (2) fiscal years, or 2) the U.S. Securities and Exchange Commission’s (SEC) Annual 10-K Report for its past two (2) fiscal years.

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

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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-contractors/sub-consultants.
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-contractors/sub-consultants.
3. Have sufficient provider networks and quality providers in the 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 Design as in-area participants. The minimum access standards are listed in Section 2.4 (12) (c). This preference is not applicable to the Wellness Program.

2.4 General Information and Specifications

1. **Attachment 3, Health Plan Premium Equivalent Rates**, outlines the 1) Monthly Active Employee Premium Equivalent Rates, 2) Monthly Pre-Medicare Retiree Rates, 3) Monthly Medicare Eligible Retiree Rates, 4) Dental and Vision 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 IRS provisions. The County reserves the right to change its contribution strategy at any time. Notwithstanding, the Proposer's fees and rates for the Program shall remain in effect regardless of the County's contribution strategy.
2. New full-time employees are eligible for benefits coverage on the first day of the month following (or coincident with) 60 days of employment. Any part-time, non-temporary status employee who consistently works at least 60 hours biweekly 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. Eligibility for part-time employees is subject to change and will coincide with the eligibility for healthcare benefits for "variable hour" employees as defined by the Affordable Care Act.
3. Dependent eligibility is defined as follows:

Eligible Dependents	
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.

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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 age 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.
Grandchild	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 ages 26 to age 30 (end of calendar year) are eligible for coverage. Over-age 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. Coverage may be continued to age 30. See below for adult children Eligibility Extended Medical Coverage.

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. For Plan Year 2016, the County may elect to extend coverage for both dental and vision until the child turns 26, at its sole discretion.

***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.

**** 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 ineligibility for coverage.

4. **Attachment 1, Census** also identifies all active employees that are eligible for stand-alone dental and/or vision options.
5. Employees under the age of 65, who retire from County service, may continue POS, HMO or Select 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

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remitting the appropriate premiums to the County. The County reserves the right to make modifications, such as offering COBRA, as an alternative.

6. 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.
7. 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.
8. 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.
9. All provisions shall conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), where applicable. Please refer to the HIPAA Business Associate Agreement (BAA) included in the County's Form of Agreement herein as **Appendix C**. The selected Proposer is required to execute a BAA with the County as part of any award issued, resulting from 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.
 - (c) All employees and dependents enrolled as of December 31, 2015 are eligible for coverage with no actively at work exclusion.
10. The following rules apply for adding dependents:
 - (a) New Dependents - A dependent of an insured may be added to the Program 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.

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- (c) Change of Family Status - A dependent may be added to, or deleted from, the Program at any time during the year, under HIPAA special enrollment, or pursuant to IRS Section 125 provisions, as adopted by the County. Proof of the change in family status must be submitted at the time of request for change. Please refer to item 10(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.
11. 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.
12. The selected Proposer shall:
- (a) Adhere to generally accepted standards (as suggested by the National Committee for Quality Assurance "NCQA" or equivalent organization) 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 significant change to selected Proposer's financial position and/or credit rating. Notification of such change shall be provided to the County's Project Manager, no later than three (3) business days after the selected Proposer has been apprised of such change. Notification to the County shall include the submission of the selected Proposer's most recent independently audited financial statements for each of its past two (2) fiscal years, **or** the U.S. Securities and Exchange Commission's (SEC) Annual 10-K Report for its past two (2) years.
- Note:** After proposal submittal, the County reserves the right to require additional information from Proposers (or subcontractors) to determine financial capability (including, but not limited to, annual reviewed/audited statements with the auditor's notes for each of the past two (2) complete fiscal years).
- (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."

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2.5 Enrollment/Communications Provisions

The selected Proposer shall:

1. Provide promotional and 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, different languages, 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. The costs of printing and producing materials, in all formats, are the sole responsibility of the selected Proposer.
2. Print, mail and electronically produce the SPD directly to Members' homes at least thirty (30) days prior to the start of the Plan Year, effective January 1st, at no additional cost to the County. The selected Proposer shall provide additional supplies of SPD to the County, 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 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 Members/Subscribers can be identified by social security number, employee ID number **and** bargaining unit, as required by the County. The selected Proposer shall ensure that all social security numbers are maintained for all Members/Subscriber enrolled in the Program, and as such, shall bear the responsibility of protecting the privacy and legal rights of all Members/Subscribers.
6. Distribute all communication materials to the various County locations no later than two (2) weeks prior to the start of the County's annual 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 Program other than the selected Proposer's Program, or any other materials or "giveaways", at the County's sole discretion, which the County deems to be inappropriate.

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7. Review its Program-specific information to be included in the County's Employee Benefits Handbook for accuracy and provide the necessary updates to the County no later than September 1st, 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 annual open enrollment period meetings with the County's Project Manager, and subsequent annual open enrollment period meetings (estimated to be approximately 30 on-site meetings). Such meetings schedule will be 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 Program complies with federal guidelines for Cafeteria Plans pursuant to IRS Code Section 125, as adopted by the County, 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.
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 healthcare 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

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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. Accept the County's Employee Support Services Program (ESS) full authority to refer Members to the Program network for mental health/substance abuse services. The ESS shall bill and be reimbursed by the selected Proposer according to negotiated fees. Refer to http://www.miamidade.gov/assistance/employee_benefits.asp for details regarding the ESS program.
4. 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.
5. Provide the criteria for approval of organ transplants in the Program. 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 Program. The selected Proposer shall provide all explanations in layperson's terms.
6. 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 (ABMBS). 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 Program. The selected Proposer shall also provide all explanations in layperson's terms.
7. Provide the criteria and process for determining a "Medical Necessity" under the Program. This criteria and process shall be defined and incorporated by reference into any agreement issued as a result of this Solicitation.
8. Accept pregnant employees/dependents', who are beyond the first trimester, continuance with their current attending OB/GYN, through the time of delivery (if not currently an in-network OB/GYN). Such coverage shall be considered at the in-network level of benefits, with no balance billing to the Member.
9. 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 (e.g., Amputation of any extremity, brain injury, burn injury requiring hospitalization, electrocution requiring hospitalization, heart attack, stroke, or coma, injury requiring hospital stay, Paraplegics/Quadriplegics, patient transportation by ambulance or life-flight, reflex sympathetic dystrophy syndrome (RSD), serious spinal cord injuries), even if the provider utilized is not part of the selected Proposer's network, with no balance billing.

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10. 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.
11. Offer the POS, HMOs and Select Network Plans on an open access basis with no Gatekeeper, excluding the HMO Low Option.
12. Provide full transparency on the pharmacy rebates earned based on the County's prescription drug utilization. The selected Proposer shall provide credit to the County for such rebates on a quarterly basis. All earned rebates shall be credited to the County even if the contract resulting from this Solicitation is terminated. The County reserves the right to audit the pharmacy benefits manager services inclusive of the rebate benefit, on an annual basis.
13. Notify the County within sixty (60) days of changes in the preferred drug list prior to the change, with an 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. Positive additions are permitted at any time during the Plan Year, and with prior notification provided to the County. Deletions other than those resulting from Federal Drug Administration (FDA) requirements are only permissible one time per Plan Year, with a 60-day prior notification to the County.
14. Comply with the County's preference in receiving full transparency from the selected Proposer on provider discounts and billed charges and provider/facility contract terms.
15. Provide the County with full transparency on the Program'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 Program for this information, on an annual basis.
16. Have a technology-enabled solution to support reduction in cost of care through a quality and appropriate delivery system 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 and Disease Management Programs (Wellness Program)

The County is interested in a robust and sustainable wellness and disease management solution to help in addressing some of the critical issues that exist in the County's current healthcare Program, to include: costs, quality of services and Member experience. The selected Proposer's proposed wellness and disease management programs shall target local and regional market presence for delivering community-based healthcare and coordinated services. Selected Proposer shall offer an integrated strategy to promote the overall health, wellness and productivity of employees while

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utilizing its experience with health plan administration. Selected Proposer may subcontract the wellness and disease management service programs. Please see Form B-1, Price Proposal/Financial Schedule for further clarification on the Wellness Program's fee submissions. The Wellness Program's objective is to encourage healthier behaviors and measurable outcomes for all Eligible Members who agree to enroll in the Wellness Program. As Eligible Member(s) adopt and sustain behaviors that reduce health risks, improve quality of life, and enhance their personal effectiveness through the Wellness Program, they also drive a reduction in the County's healthcare costs/claims. Through highly effective offerings designed to identify, prevent and manage chronic conditions and other health factors, the selected Proposer shall work towards improving the overall health of all Eligible Members. The selected Proposer shall strategize and partner with the County in designing a Wellness Program tailored to the County's needs to include, at a minimum, the below listed services:

- Biometric Screening (Voluntary Basis)
- Flu Shot Administration Services – limited to interested employees at on-site location who have healthcare insurance
- Educational Seminars (e.g., Nutrition)
- Health Fair Coordination and Facilitation
- Onsite and Offsite benefit representatives
- Prescriptions for Healthy Living Program for diabetes, cholesterol, and high blood pressure medications

Note: AvMed currently provides the aforementioned wellness services as part of their ASO Fees.

A. General Wellness Program Requirements

The selected Proposer shall:

1. Provide for all enrolled Participants: 1) an annual Biometric Screening and Health Risk Assessment, 2) periodic health check-ins with a Health Coach, and 3) Wellness Risk-Targeting Programs, as described herein.
2. Perform all administrative functions for the Wellness Program including the monitoring and tracking of Participant compliance, producing all communication materials relating to the Wellness Program (including, but not limited to materials leading up to the launch of the Wellness Program), as well as ongoing communications to Participants. Selected Proposer shall also provide monthly Wellness updates and results tracking milestones for informational purposes to designated County officials and labor organizations. Additionally, the selected Proposer shall provide bi-monthly electronic data and trends for all Wellness Program Participants, to the County's Project Manager.
3. Secure and maintain any physical requirements for managing and providing the Wellness Program, including local office space and physical locations throughout the County, or as agreed to by the County. In order to maximize availability to the County Participants and remain cost-effective, the selected Proposer's facilities may be either on selected Proposer's owned/lease properties or housed at the County administration building and/or other County designated locations. County owned/leased properties may be made available for conducting

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Biometric Screenings at no cost to the selected Proposer (subject to prior approval by the County).

4. Provide one (1) health coach as a minimum, dedicated to rotating through all County locations that have Participants enrolled in the Wellness Program, for a minimum of 5 days per week. The selected Proposer shall provide sufficient health coaches to support coverage to all County Participants. The selected Proposer shall also provide computer terminals, printers and fax machines, etc. for its health coaches to: 1) readily have on-line access to Member eligibility and claims information, 2) provide customer service related functions, and 3) assist in Program administration. The on-site health coach(es) shall adhere to a business days/hours pursuant to the County's business schedule in order to be easily accessible to employees. If an on-site health coach is on vacation, or otherwise absent for an extended period, a replacement health coach shall be provided. Further, the County may request replacement of the on-site health coach(es) 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 may allow for a resolution timeline, prior to requesting such replacement.
5. Ensure that selected Proposer's Wellness Program's Account Executive/Manager and management team shall:
 - a. Devote the necessary time to manage the Wellness Program and be responsive to the County's needs pertaining to the Wellness Program, as defined herein. 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 functions that relate to the County's account; and,
 - d. Act on behalf of the County to effectively advance the County's action items through the selected Proposer's established approval structure.
6. Assume responsibility for all aspects of the Wellness Program compliance with HIPPA, GINA, ADA, ADEA, PDA, PPACA COBRA, and any other applicable laws and regulations.

B. Enrollment

1. Manage the Wellness Program enrollment process for all Eligible Members, as determined by the County to be eligible for participation. (Refer to census data provided in **Attachment 1, Census**).
2. Produce all enrollment documents and forms and process and manage the dissemination of these. The selected Proposer shall include a process for reviewing and approving Eligible Member exemptions and claims data from the administrator to help identify potential Participants for the Wellness Programs, which will ensure compliance with all applicable federal and/or state laws or extraordinary life situations. Enrollment in the Wellness Program for the purpose of becoming a Participant is not mandatory for Eligible Members.
3. Create a Wellness Program affirmation statement to be utilized in committing Eligible Members to becoming a Wellness Program Participant. By signing said affirmation, Eligible

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Member agrees to be an active Participant in all aspects of the Wellness Program. This affirmation shall clearly define active engagement criteria and how Participant will comply with such criteria. Eligible Members not interested in enrolling in the Wellness Program shall have the right to decline participation. Additionally, Wellness Program Participants may, at any time, cancel their participation.

C. Health Risk Assessment (HRA)

1. Coordinate and conduct an annual Health Risk Assessment (HRA) designed to identify existing and emerging health issues, and to provide a baseline for establishing a health improvement/maintenance plan electronically. Such Health Risk Assessment should consist of two components: a Health Questionnaire and Biometric Screening.
2. Implement Health Risk Assessments within 30 days of Plan Year effective date, or as agreed to by the County. In subsequent Plan Years, such assessment will be conducted during the first quarter of the Plan Year, or as agreed to by the County.
3. Create the Health Questionnaire and administer its dissemination and receipt to all Eligible Members. Such questionnaire shall consist of posed inquiries which provide a basis for the assessment of health risks, identify tests to be administered in biometric screenings or other healthcare venues, areas of behavioral lifestyle changes necessary, and the identification of beneficial Wellness Risk-Targeting Programs. The questionnaire should contain sufficiently plain language for the ease of completion by Eligible Members without assistance from a medical professional. The questionnaire should also request multiple points of contact for each Eligible Member.
4. Provide employees and their eligible dependents with convenient access to, and options for, the submission of the health questionnaire, to include electronic submission.
5. Develop a biometric screening process consisting of cost-efficient health tests that can be administered by qualified individuals in locations convenient and accessible to Eligible Members. The biometric screening should supplement the Health Questionnaire in identifying health risks, areas of behavioral lifestyle changes and triggering actions which encourage Wellness Risk-Targeting Program participation, such as:
 - a. Provide and manage a system to schedule biometric screenings, with options to do so via a central Wellness website, and telephonically (which may consist of an Interactive Voice Response (IVR)). Selected Proposer shall provide frequent reminders to schedule biometric screenings to facilitate Participant compliance.
 - b. At a minimum, the biometric screening should include tests to measure body fat (e.g. body mass index, waist measurement, or other method of body fat measurement) and blood pressure for all Members.
 - c. All Members should be encouraged to take lipid profile and/or A1C blood draw tests, including very strong encouragement for Members who demonstrated a need for these tests.
 - d. Additional testing as necessary to identify health risks that will be addressed by corresponding Wellness Risk-Targeting Program, supply scientific or empiric rationale, and a cost-benefit case for all additional tests and Risk-Targeting Programs.

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6. Comply with the County guidelines concerning Eligible Member choice with respect to testing:
 - a. Eligible Member shall not be required to take any given test to be considered compliant with the Wellness Program. Tests shall be available to all Eligible Members, regardless of indicators from health questionnaire or other tests.
 - b. Wellness Program personnel administering Biometric Screenings should clearly explain to Eligible Members which tests are recommended for them based on clinical circumstances and strongly encourage and explain why it is not recommended that they undergo a given test when clinical circumstances indicate low or no value in them doing so. Notwithstanding, selected Proposer must provide the Eligible Member with the option of undergoing the test if they so choose to.
7. Maintain physical locations for biometric screenings (selected Proposer is responsible for all permits and regulatory compliance) which may include:
 - a. Selected Proposer locations throughout the County and temporary locations at County-owned properties (primarily central workplaces), but also including options to be discussed with the County (e.g. libraries, parks, etc.) and Union halls of participating unions.
 - b. Provide any necessary equipment (e.g., Kiosks, etc.) and/or facility modifications (e.g., partitions for privacy).
 - c. Ensure all physical locations are compliant with the ADA and other applicable regulations
 - d. Provide necessary privacy screens or other privacy protections for biometric screenings.
8. Ensure convenient access to the health questionnaire and biometric screening for all Members, including spouses. Biometric screenings should also be available at convenient times during weekdays to allow County employees to undergo their biometric screening during allowed breaks and before or after work shifts that occur throughout the day. Biometric screenings should also be available outside of normal work hours, including evenings and/or weekends. Proposer is strongly advised to have arrangements with independent labs in order to accommodate Participants needs.
9. Complete the Health Risk Assessment for Eligible Member, including all Health Questionnaires and Biometric Screenings, within 100 days of the start of the Wellness Program, providing any necessary opportunities for missed assessment make-ups.
10. Develop a system in which Eligible Members may have recent test results (within six months prior to the start of the biometric screening date range) forwarded from their doctors in lieu of a Wellness Program provided biometric screening, if these were the same tests as the biometric screening the would have been performed.
11. Provide Health Risk Assessment results to Eligible Members in a timely manner through an initial Health Check-in, or other personalized results web-based sharing procedure. Results shall:

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- a. Be supported by the results of the health questionnaire and all tests conducted in the biometric screening
 - b. Identify potential individual health risks, and how to address them specifically through Wellness, including offering recommendations for their enrollment in Wellness Risk-Targeting Programs.
 - c. Multiple/high-touch methods of communication are encouraged for presentation of results (e.g. during first Health Check-in).
12. Provide Eligible Members paper or email output of their Health Risk Assessment results so that they may share with their physician or other healthcare professional, if they so desire.

D. Health Check-Ins

1. Perform telephonic and or face-to-face Health Check-Ins for the purpose of:
 - a. Discussing Participants' progress has made with respect to the major health issues identified in the annual Health Risk Assessment. Participants should have the ability to compare annual HRA's, year over year, to track improvements in health.
 - b. Reviewing the status of Risk-Targeting Program participation and engagement including strategies for maximum health impact.
 - c. Address any Wellness related questions that Participant may have regarding their health and recommend options to Participant seeking follow-up advice and care, as needed.
 - d. Motivate and encourage Participants to set health goals. Provide coaching on results tracking methods which may assist with reaching such goals as:
 - Lifestyle Changes
 - Wellness Education
 - Healthier Decision Making
2. Establish and manage system to schedule Health Check-Ins, with options to do so via a central Wellness website or telephonically (which may consist of an IVR-based automated system or personal assistance). Participants should receive frequent reminders to schedule necessary Health Check-Ins to facilitate Participant compliance.
3. Initiate Participant Health Check-In by the health coach on the scheduled date and time specified. Check-in may last up to 30 minutes in length.
4. Provide alignment of Health Coaches with Participants for each Health Check-in to help foster trust between Participant and Health Coach.
5. Provide convenient times during week days for Health Check-Ins to allow County employees to perform their Check-in during allowed breaks and before or after work shifts that occur-throughout the workday. Health Check-Ins should also be available during outside of normal work hours, including evenings and/or weekends.
6. Develop clear guidelines for the number and frequency of Health Check-Ins based on Participant's enrollment. Additional Health Check-Ins should not be required based on Participant health.

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7. Provide health coach(es) with all applicable certifications and trainings as required by law, and as necessary to be effective advisors to Participants.
8. Provide Participant report to the County's Project Manager which incorporates the metrics from each of the above tasks and provides actionable information to improve health, in the aggregate.

E. Wellness Risk-Targeting Programs

1. Create and maintain a varied complement of Wellness Risk-Targeting Programs aimed at driving healthier behaviors and outcomes (or continuing healthy behavior) for Wellness Participants. Selected Proposer shall provide education, challenges, outcome awareness, behavior tracking, and biometric measurement components. Risk-Targeting Programs shall address common health risks for a broad spectrum of Participants' risk levels ranging from low-risk (e.g. weight maintenance, exercise optimization, etc.) to high-risk (e.g. obesity, smoker, etc.). Risk Targeting Programs may include, but are not limited to the following:
 - a. Hypertension
 - b. Hyperlipidemia
 - c. General Fitness
 - d. Significant sedentary risk
 - e. Tobacco usage
 - f. Diabetes and/or pre-diabetes
 - g. Nutrition/Weight Management
 - h. Other risks (e.g. asthma, stress, alcoholism, etc.)

Risk-Targeting Programs shall be designed to drive significant health improvement/condition treatment, which will then lead to reduced future healthcare expenditures to the County. Risk-Targeting Programs must be sufficiently robust to drive health improvements, but still be reasonably convenient for Participants. This is a critical component to the Wellness Program's success.

2. The County's Wellness Program will be year round, with regularly occurring Risk-Targeting Programming. The expectation of the County is that Risk Targeting Programs will include regular reporting and tracking of program adherence and be conducted on a weekly basis or other such basis as long as the selected Proposer can demonstrate commensurate or improved effectiveness at driving improved health outcomes and lower costs.
3. Provide flexibility in all required Risk-Targeting Programs considering Participant vacation and holidays.
4. Allow Participants to select specific Risk-Targeting Programs for participation, without restrictions or limits other than those required by the Participant's health. The selected Proposer must generate strong recommendations for Participants as to the Risk-Targeting Programs in which they should consider enrolling based on risks, especially emerging chronic conditions or unsatisfactory chronic condition treatment, identified by the Health Risk Assessment, health questionnaire, biometric screening, or prior Risk-Targeting Program progress.

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- a. **Example 1:** A Participant demonstrating a risk for diabetes should be encouraged to enroll in a Risk-Targeting Program that may help mitigate their risk, but should not be required to enroll in any specific Risk-Targeting Program.
 - b. **Example 2:** A Participant who does not smoke should not be allowed to enroll in a tobacco cessation program specifically designed to mitigate smoking risk.
5. Update curricula as necessary to refresh Risk-Targeting Program materials and incorporate findings from County/selected Proposer quality control reviews of the Wellness Program results.
 6. Manage Risk-Targeting Program enrollment process at initiation of Wellness and any subsequent Risk-Targeting Program selections by Participants. Wellness may impose reasonable limits upon the ability of Participants to switch Risk-Targeting Programs during the plan year.
 7. Provide Participants with easy and convenient access to Risk-Targeting Programs by offering:
 - a. Various engagement methods for Participants such as, online, telephonically, health kiosks, etc.,
 - b. Compliant common systems requirements. Any online programming must be easily accessible with standard computer programs and browsers,
 - c. All programming in English. Spanish is optional.

Note: Active participation in the Wellness Program's diabetes management program qualifies as participation in a weekly program – and no additional participation is necessary. Information about this program should be communicated via health check-ins to self-identified diabetics.

8. Provide periodic, optional Risk-Targeting classes for parents and/or families with children having childhood asthma or childhood diabetes.
9. Provide periodic, optional infant care educational classes for parents and/or families.

F. Member Tracking

1. Manage Eligible Member sign-up during the Wellness Program's enrollment period. Selected Proposer must maintain a master list of:
 - a. Enrolled Participants, and;
 - b. Any Eligible Member enrolled in the County's healthcare program which elects to not participate and/or opted-out of the Wellness Program.
2. Develop reasonable criteria for Active Engagement in each Wellness Program component:
 - a. Health Risk Assessment scheduling and attendance,
 - b. Health Check-Ins scheduling and follow-through,
 - c. Active participation in Risk-Targeting Programs.

Criteria should balance rigor of the Wellness Program with reasonable convenience for Participants, with specific attention to low impact engagement for healthy Participants. The goal of this criterion is to ensure active engagement and minimize non-active participation.

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3. Identify critical component for compliance criteria is Active Engagement. Active Engagement cannot be defined in terms of attaining set targets in physical characteristics or behavior (e.g., target blood pressure, weight, food consumption, exercise goal attainment, etc.)
4. Include a process to acknowledge and track approved Participant short-and long-term absences from the Wellness Program (e.g., grievance period, sabbatical, medical leave, etc.), temporarily exempting Participants from the Wellness Program's Active Engagement criteria.
5. Track Participant compliance with Health Risk Assessment, Health Check-Ins, and Risk-Targeting Programs (through maintenance/updating of the master list).
6. Establish a system of warnings for Participants to alert them of instances of non-compliance. The system should be flexible and attempt to notify Participants via multiple means including phone, e-mail, or any other practical means. All warning notifications must produce a verifiable receipt and audit path.
7. Allow for a minimum of two separate non-compliance infractions and subsequent warnings without consequence. Non-compliance that results in expulsion from the Wellness Program will be determined at third infraction.
8. Identify communication method and define all Active Engagement compliance criteria, infractions, and warning system to be utilized in notifying Participants.
9. Facilitate the County's right to audit compliance process and resulting opt-outs annually. In the event the audit shows the compliance criteria was not adhered to, resulting in an understatement of Participant opt-outs, the Proposer will be obligated to reimburse the County for all overstated Participation payments.

Note: This audit will be conducted by a third party, if at any point, any private medical information or records are encountered.
10. Notify Participants of their removal from the Wellness Program due to their third infraction caused by their non-compliance with the Wellness Program requirements. The selected Proposer's notification shall inform the Participant of the change in their status, along with any additional information deemed necessary by the selected Proposer.
11. Provide participation details to the County for any County-administered process for hearing disputes or appeals by Participants who feel they have been unduly declared non-compliant with the specified Active Engagement criteria. This process will occur monthly to make allowances for extraordinary life events on a verifiable, good faith basis. The selected Proposer's responsibilities will include providing details validating the decision to declare a Participant non-compliant (e.g. documentation of timing of when warnings were issued, Participant receipt of warnings, etc.). The selected Proposer will also be expected to reinstate Participants who are deemed to have been unfairly removed from the Wellness Program. No appeal based on that necessity will be heard by County personnel.

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G. Launch of Wellness Program/Annual Enrollment

1. Develop and design various brochures, pamphlets and materials, including any individual Participant waivers of liability (against the County) as may be required and as subject to the approval of the County's Project Manager. If such printed materials need to be mailed to Participants, then the selected Proposer must arrange to have the most cost efficient method and mechanisms in place to execute this task when required.
2. Provide presentation and informational materials to support the County's launch of Wellness (e.g., a "Know Your Numbers" campaign encouraging employees to know three key health metrics; BMI, blood pressure and cholesterol).

Note: The County anticipates approximately 50 rollout events after the announcement has been made, and before the Wellness Program is launched. Selected Proposer shall provide sufficient material and staff as needed, at the County's sole discretion, to be utilized at said meetings for the benefit of County employees and labor union representatives.

3. Acknowledge that no contractual provisions, correspondence to the County or other document, shall limit the selected Proposer's responsibility for the accuracy and completeness of these materials or for compliance with all laws, statutes and ordinances.
4. Develop and maintain a Wellness Program website specifically for the County that provides readily accessible and substantive information about the Wellness Program for Eligible Members seeking additional information.
5. Conduct a minimum of one training session for approximately 50 County benefit/human resource professional drawn from various departments, in preparation for the Wellness Program launch. Such training session(s) shall serve as "train the trainer" events to fully prepare the Wellness Program's representatives and County personnel to answer common/anticipated questions during the enrollment period.

H. Ongoing Reports

1. Develop monthly informative and actionable communications highlighting the progress of the Wellness Program and indicating trends and utilization. Communications should summarize high-level macro trends including participation, program enrollment, and key behavior and biometric benchmarks. Provide identified performance data (in conformance with 45 CFR Section 165.514 which in form and substance protects the privacy of County employees) to the County once a quarter; such reports must conform to HIPAA requirements.
2. Produce monthly reports electronically in a file-format necessary to interface into a County-designated application which include, but are not limited to:
 - a. Complete Master List refresh update of current Participant population by unique identifier tag and work location, monthly, unless requested otherwise,
 - b. List of opt-out population, by unique identifier tag and work location,
 - c. Wellness Risk-Targeting Program enrollment population by Program type,
 - d. Active participation.

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3. Tailor communications and presentations, as deemed necessary by the County, at its sole discretion, for the purpose of updating County officials. The selected Proposer shall also develop a newsletter-type format for updates to Wellness Program Participants.
4. In the event the County enters into a separate agreement (with the selected Proposer or third party administrator at a future date) to integrate medical and pharmacy claims data through predictive modeling to develop risk profiles, Selected Proposer shall share data as required by law in an accessible format.

I. Miscellaneous Communications

1. To the extent permitted by law and only if directed by the County, selected Proposer shall participate in a data exchange with any third party administrator authorized by the County, for purposes of Wellness Program analysis.
2. Provide telephone (advisory) and face-to-face service (on-site) to Participants for the purpose of answering questions about the Wellness Program, during reasonable hours.

J. Other Requirements

1. Advise and orient the County on the Wellness Program's initiatives and industry trends. The selected Proposer shall be responsible for advising the County of all operational changes, industry specific litigation, practices and pending legislative changes that may affect coverage provided under the services during the term of the Agreement.
2. Provide all information that is necessary for the effective provision of the Wellness Program, including legal and administrative advice and assistance as needed.
3. Maintain confidentiality of County employees' records in compliance with all federal, state, and local regulations, in addition to maintaining other information deemed proprietary or confidential by the County or pursuant to applicable law. Any data provided by the County, employees or encountered by to the selected Proposer during the performance of the services relating to any County employees, shall be kept strictly confidential, and may not be sold, marketed, furnished or otherwise made available to any person or entity for any purpose.
4. Ensure that any Wellness Program participating providers are appropriately licensed, insured and of high quality and meet all other requirements specified by the selected Proposer.
5. Retain all records directly or indirectly related to its performance of services during the term of any contract and for a period of 5 years after termination or expiration of any contract, or until all pending disputes are resolved. The County has the right to review, abstract, audit and copy all records and accounts of the selected Proposer directly or indirectly related to any contracts with the County.
6. Ensure that in no case may services be offered except by persons and firms authorized and duly licensed as required by federal, state and/or local laws or regulations. The selected Proposer(s) must provide to the County's Project manager annual evidence of all licenses and certifications, as may be necessary, to provide the Wellness Program's Scope of Services, as described herein.

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7. Provide such services in conformance with applicable federal and state laws and regulations, County ordinances, personnel policies, procedures, rules and the terms of the applicable Wellness Program.

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 15th 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 Utilization Data Report is due to the County within 90 days of the close of the Plan Year, showing in-patient utilization by hospital, outpatient utilization and physician by type of service.
 - (c) **Annual Care Management/Disease Management Reports**
Annual Care and Disease Management Reports are due to the County within 30 days of the close of the Plan Year, showing utilization by Benefit Program (High Risk Stratification, Disease Specific, and Quality Management).
 - (d) **Annual Prescription Drug Management Reports**
Annual Prescription Drug Management Report is due to the County within 30 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 are due to the County or its assigned consultant within 30 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 Quality and Performance Management Dashboards showing a graphical presentation of the current status (snapshot) and historical trends of the County's key performance indicators to enable instantaneous and informed decisions to be made.
 - (g) **On-Demand Reports**
On-Demand Reports showing trends over time on advanced analytics to identify drivers of Plan quality, cost and utilization, as requested by the County. On-Demand Reports shall be 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), as requested by the County.

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On Demand Claims Data Report shall be provided within 10 business days of the County's request. Such report shall include, but not be limited to:

- a. paid claims data by month,
- b. incurred claims data by month,
- c. disruption and network data as requested,
- d. prescription drug and behavioral health care claims, and;
- e. large claims and utilization data as requested.

(h) **Quarterly Reports**

Quarterly Reports due to the County 30 days from the close of the quarter, showing Return on Investment (ROI) for the Wellness Program, and or 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 to the County and its designated consultant, as applicable, 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 and data available 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 November of 2015, as deemed necessary by the County.
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 but not limited to COB, subrogation, bill negotiations, etc. In addition, the selected Proposer shall provide a quarterly report on claims that have been recovered, including the total amount, amount of recovery, fee/percentage and amount reimbursed to the County.
7. Coordinate directly with Medicare, on behalf of retirees, in processing Program 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 1st 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. 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.
11. 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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12. 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.
13. Ensure that selected Proposer's Account Executive/Manager and account management team shall:
 - 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.);
 - Provide the County with mobile phone numbers and email addresses of all key account management personnel;
 - Be thoroughly familiar with all of the proposing company's functions that relate to the County's account; and,
 - Act on behalf of the County to effectively advance County action items through the selected Proposer's corporate approval structure.
14. Provide four (4) dedicated on-site customer service representatives. 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.
15. Provide an off-site dedicated member service team, based on one (1) dedicated member service team representative per 5,000 members enrolled in the Plan. The selected Proposer's designated member service team shall receive training on the specifics of the County's Program, to be provided by the selected Proposer. There shall also be a dedicated phone, fax number and webpage for County employees to access.
16. Comply with the Performance Guarantee Standards Provisions (see **Attachment 4 which provides an outline of the current Performance Guarantee Standards**). Compliance with Performance Guarantee Standards shall be measured annually at the end of each Plan Year and any non-compliance within each category shall be assessed the amount at risk penalty, payable to the County. The selected Proposer shall identify within **Attachment 4** any deviations from the current Performance Standards.
17. Ensure that the selected Proposer's claims processing system is fully integrated with its eligibility system, which continuously receives feeds from the County.

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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 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 review and audit physician, hospital, and pharmaceutical provider contracts, to include, but not limited to, the pricing and terms and conditions of such contracts.
20. Provide all necessary data, reporting and reconciliation support as needed by the County for its 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.
21. Provide all necessary data, reporting and reconciliation support as needed by the County for its compliance with the Patient Protection and Affordable Care Act (PPACA), 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, prompts and personnel, etc.) to the County in advance of such changes taking place. The selected Proposer shall receive the County's approval prior to implementing such changes to member service center and unit structure.
2. Provide the County with a dedicated (i.e., exclusive for Miami-Dade County) live Member Customer Service Team accessible via a toll-free telephone line. Such Team shall receive training to be provided by the selected Proposer on the specifics of the County's 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, developed and administered customer satisfaction survey tools specific to the County's Plan. The County and the selected Proposer will work in unison 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.

This document is a draft Scope of Services for a future solicitation and is subject to change without notice.

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Provide, within 30 days of the effective date of coverage, every new Member with a detailed explanation of the grievance procedures. Such notification shall be provided to Members through the County's preferred method of delivery.

2.11 Alternate Plan Design Option(s)

As the County evolves its healthcare benefits strategy, the selected Proposer should be able to adapt to any future changes to the Self-Funded Employee Group Healthcare Program that will achieve efficiencies and cost savings to the County, such as the design and creation of Alternative Plan Option(s). Proposers are highly encouraged to submit information for Alternative Plan Option(s) as part of their proposal. The Alternative Plan Option(s) should target cost savings for the County and its employees through a viable approach of Alternate Plan designs and cafeteria type of plan election, such as Benefit Tiered HMO, high deductible plans, and limited networks, etc. Proposers providing for an Alternate Plan Option(s) should consider the following criteria:

1. The plan designs should be outlined including plan summary for each benefit level. All state-mandated benefits must be covered and all exclusions, limitations and non-covered items should be fully described.
2. The network should have sufficient providers, to include all specialty levels and facilities.
3. Description of how cost savings can be achieved within the Alternative Plan Option(s), including assumed enrollment within each offering.

The Proposer's proposed approach and willingness in developing a viable Alternate Plan Option(s), will be utilized for technical criterial scoring purposes, as listed in Section 4.2.

2.12 Optional Services

The County may also consider incorporating the option of bundling dental, vision and ancillary benefits to the existing healthcare 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.