ATTACHMENT A
SCOPE OF SERVICES

A. Services to be provided:

1. General Description:

a. General Statement: This Contract is for the provision of Insurance Benefit Manager (IBM) services for clients identified by the Department as eligible to receive services offered through the Florida AIDS Drug Assistance Program (ADAP).

b. Authority: 42 USC 300ff-25, United States Code, sections 381.0011 and 381.003(1)(b), Florida Statutes, and Rules 64D-4.003 and 64D-4.007, Florida Administrative Code.

2. Definition of Terms:

a. AIDS Drug Assistance Program (ADAP): A Department program that provides access to life saving medications for the treatment of HIV/AIDS and opportunistic infections for low-income insured, underinsured, or uninsured individuals living with HIV/AIDS in Florida.

b. ADAP Formulary: A list of prescribed medication that ADAP offers to clients through direct dispensing or payment of insurance costs.

c. ADAP Premium Assistance: Payment of the insured's portion of the premium by the ADAP program.

d. Advance Premium Tax Credit (APTC): A tax credit that may be used by an individual to lower their health insurance payment or premium.

e. Americans with Disabilities Act of 1990, as amended (ADA): A federal law that prohibits discrimination against individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public.

f. Client: An individual deemed eligible by the Department to receive Ryan White Part B services in Florida pursuant to Rule 64D4.003, Florida Administrative Code.

g. Client ID: A unique identifier issued to clients through the Department's program management software system.

h. Consolidated Omnibus Budget Reconciliation Act (COBRA): Health benefit provisions that amend the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to require group health plans to provide a temporary continuation of group health coverage that otherwise might be terminated.

i. Electronic Data Interchange (EDI): The exchange of routine business transactions from one computer to another in a format using the National Institute of Standards and Technology (NIST) standards. For purposes of this Contract, EDI is referring to the sharing of information between IBMS and the Program Management Software.

j. Explanation of Benefits (EOB): A statement sent by health insurance companies to its covered individuals explaining what medical treatments or services where paid on their behalf.

k. Federally-Facilitated Marketplace (Marketplace): Is an organized marketplace for health insurance plans operated by the U.S. Department of Health and Human Services.

l. Insurance Benefit Management (IBM) services: Financial and educational services provided to clients to initiate and maintain access to care through health insurance coverage.

m. Insurance Benefit Management System (IBMS): A dedicated, secure electronic information data system owned or leased by the Provider and is used to manage client information.

n. In network service provider: A health service provider contracted with a health insurance company to provide services to its members at a specific pre-negotiated rate.

o. Out of network service provider: A health service provider that does not have a contract with a health insurance company.

p. Program Management Software: Software developed and customized by a Department contracted provider to assist ADAP in managing and reporting on client data.

q. Transaction Fee: A fee imposed by the Provider for each binder or premium payment it makes on behalf of a client as part of the IBM services deliverable.

r. Agent of Record: An individual or a legal entity with a duly executed contractual agreement with an insurance policy owner, in line with the Florida insurance regulations.

B. Manner of Service Provision:

1. Scope of Work: Provider must implement an IBM, perform IBM services through the delivery of insurance enrollment assistance and client outreach, and pay insurance premium payments for clients.

a. Task List: Provider must perform the following tasks:

1) Establish the IBM services infrastructure by October 1, 2019 as follows:

a) Meet with the Department two weeks from the date of contract execution to develop the plan for receipt and transfer of client data within the EDI. Submit the plan to

the Contract Manager by October 1, 2019.

b) Maintain an established line of credit or cash flow reserved to maintain services continuously for 120 days based on the premium payment history.

c) Administer an IBMS by October 1, 2019 and maintain it throughout the term of the contract. Document the completion of this requirement in the Department's IBM Task Validation form (Attachment L) and submit it to the Contract Manager. The IBMS must incorporate the following components:

(1) Available 24 hours, 7 days a week, except during approved downtime for maintenance.

(2) Ability to maintain records for a minimum of 30,000 clients throughout the term of the contract. Each record must include the client's first and last name, date of birth, and Client ID number sent from the program management software. All client records must be maintained in accordance with section 408.05(3), Florida Statutes, and the Department's Retention Schedule DOH 119, Exhibit I, which is incorporated by reference.

(3) Allow for all clients and their services to be audited by the Department as needed.

(4) Ability to connect to the program management software through a continuous EDI to receive eligibility and enrollment files.

(5) Contain a back-up mechanism to allow for continued operation of the IBMS and support centers (e.g., the Help Desk) in the event of an emergency.

d) Use a secure server to establish a secure and continuous EDI by October 1, 2019 and maintain it throughout the contract term. Send one test file through the EDI and receive it back from the Department to demonstrate EDI connectivity. Document the completion of this requirement in Attachment L and submit it to the Contract Manager. The EDI must meet the following requirements:

(1) Uses the American National Standards Institute (ANSI) SCC X 12 standard;

(2) Uses the standard HIPAA EDI format for the

electronic exchange of health-sensitive information;

(3) Uses Secure File Transfer Protocol (SFTP) for transmission; and

(4) Able to exchange data with multiple systems simultaneously

e) Ensure 99.9 percent uptime of EDI connection is maintained throughout the contract term.

f) Establish and maintain a secure file transfer server, and, in case of an emergency, a secure fax line, to send and receive confidential information to and from the Department if the EDI fails by October 1, 2019. Test the file server and fax line by sending a test fax page and test file to the Department and receiving it back. Document the completion of this requirement in Attachment L and submit it to the Contract Manager. The server must meet the following requirements:

(1) Uses a HIPAA compliant SFTP service; and

(2) Uses an IP blacklist and whitelist

g) Provide the Department with four login credentials for the IBMS by October 1, 2019. Ensure IBMS access credentials include the following:

(1) Ability to check the status of processed payments for clients, and

(2) Ability to run daily, weekly, monthly, and annual reports to manage resources, monitor and evaluate the program, and meet state and federal reporting requirements.

h) Provide the Department with user instructions for operating the IBMS by October 1, 2019. Update user instructions based on any IBMS enhancements and submit them to the Contract Manager within five business days from the date of the enhancement. The user instructions must include guidance for the following:

(1) Logging into IBMS,

(2) Research of client data, and

(3) Generating reports.

i) Establish a toll-free telephone line by October 1, 2019 to receive and address customer inquiries and complaints. Maintain the telephone line throughout the term of the contract. Have the telephone line operate Monday through Friday from 8:00 a.m. to 6:00 p.m., Eastern Standard Time (EST), excluding state holidays. Document the completion of this requirement in Attachment L and submit it to the Department's Contract Manager. Provider must have the ability to:

(1) Measure the response time from receipt of a call to the answering of the call;

(2) Ability to satisfactorily resolve caller issues promptly; and

(3) Ability to perform quality assurance on client calls.

j) Provide clients access to multilingual customer service support through the toll-free telephone line as needed. Have multilingual support available Monday through Friday from 8:00 a.m. to 6:00 p.m., EST, excluding state holidays. Document the completion of this requirement in Attachment L and submit it to the Contract Manager. Ensure the multilingual support includes, at a minimum, the following:

(1) Have assistance available in English, Spanish, and Haitian Creole, with real-time interpreter services for other languages, and

(2) Provide a telephone number and text telephone services for the hearing impaired in compliance with ADA requirements.

k) Develop a complaint resolution process by October 1, 2019 and submit it to the Contract Manager for approval. Implement the resolution process after receiving Department approval and maintain it throughout the term of the contract. Submit changes to the approved resolution process to the Contract Manager for review prior to implementation. Ensure the resolution process includes, at a minimum, the following:

(1) Response timeframes to include responding to verbal client requests within two business

days of receipt and written inquiries within ten business days of receipt;

(2) Telephone, web-based, or mail-in customer satisfaction survey to gather customer service data as needed; and

(3) Plans to address any gaps or systematic concerns.

l) Develop draft notification letters to be used to communicate with health insurance providers and submit it to the Contract Manager for review by October 1, 2019. The draft notification letters must include the following information:

(1) Name of Provider's primary contact person;

(2) Provider's name, address and phone number;

(3) Identify the Department only as the "Florida Department of Health" and must not include any name, logo, or reference to the division, bureau, section or program within the Department;

(4) Not contain information that could reveal personal health information;

(5) Include Provider's insurance payment authority and intent to make payment.

2) Provide printed and electronic outreach, education, and technical assistance to clients as needed throughout the contract term. Prepare a monthly summary report detailing the number of clients receiving or accessed the materials, printed materials and the web location for the web-based materials and submit it to the Contract Manager within 30 days from the end of each month, but no later than the invoice. Ensure all education, outreach and technical assistance comply with the following:

a) Obtain approval of all outreach and education material and web content from the Contract Manager prior to use.

b) Ensure all written material provided to clients are at a fourth grade to sixth grade reading level.

c) Ensure all material (web and printed) are ADA compliant.

d) Address selection of the ADAP-supported Medicaid, Medicare, employer sponsored plans, COBRA, and individual insurance policies offered through the

Marketplace.

e) Advise client on the selection of the appropriate insurance plan for the client. Selection is dependent upon the client's available insurance options, which plan is most cost-effective for the Department, and which plan best fits the client's needs.

f) Describe the information found on an EOB including the services, the total cost, the amount paid by the insurance, adjustments, and any amount the client is responsible for paying.

g) Address the difference between an EOB and a bill or invoice,and defines and explains the terms included in the Glossary Exhibit (Attachment M).

h) Address the use of supported health care program or insurance and the use of in-network versus out-of-network service provides.

i) Address the importance of reporting changes in name, mailing or residential address, phone number, employment, income, eligibility for any type of health insurance coverage, changes in the Marketplace, if applicable, and changes with insurance coverage benefits such as drug formularies.

j) Address the use of the ADAP formulary and the ability of clients to pick up medications through an in-network pharmacy.

k) Address other topics as requested in writing from the Department.

3) Provide updated client data through the secure EDI for each client receiving the services outlined below. Prepare a Monthly Data Error Summary Report, documenting the below completed activities, and submit it to the Contract Manager within 30 days from the end of each month. Ensure the Data Error Summary Report includes all client files transferred or attempted to be transferred indicating 100 percent resolution. Complete the following:

a) Receive program enrollment data from the program management software and enter it into the IBMS. Update 100 percent of the client records as outlined in the Department's schema and schedule. Resolve errors within seven days from the date of the occurrence. Document the date the error was resolved in the Data Error Summary Report.

b) Record updated and accurate account data for the supported health care program or insurance for each client. Document the account data in the Data Error Summary Report. Ensure data includes the following information:

(1) source of the supported health care program or insurance (e.g. employer, COBRA, and Marketplace),

(2) the health plan carrier or company,

(3) the plan marketing name,

(4) the unique identification number of the client for billing,

(5) the policy coverage effective date,

(6) the initial binder premium amount due on behalf of the client,

(7) the recurring premium, and

(8) the amount of any APTC with the premium amount due from the client, the total amount on behalf of the client and the payee company name and address.

c) Record binder payment amounts for all new health insurance policies. A binder payment is required each time a client begins a new insurance policy contract. Ensure EDI data includes, the date binder payment is made, the payee, the amount paid, billing ID, the policy effectuation date, and the date payment is posted. Document all binder payments made each month in the Data Error Summary Report.

d) Record payment history for each client, including payments, refunds and credits from the insurance carrier. Ensure EDI data includes, the date recurring premium payment is made, the payee, the amount paid, billing ID, the policy coverage dates, and the date payment is posted. Document all recurring premium payments made each month in the Data Error Summary Report.

e) Identify and rectify any incorrect payment or non-payment of clients' insurance premiums. Ensure EDI data includes, at a minimum, the date the error was

identified, the date the error was corrected, the amount of the adjustment, and the cause of the underlying error. Document all identified errors resolved each month in the Data Error Summary Report.

f) Collect updated and accurate health insurance policy utilization data (e.g. outpatient medical, laboratory, pharmaceutical among others typically contained in an EOB statement) for each eligible client outlining all their services paid on behalf of the client. Document all services received by clients each month in the Data Error Summary Report. Ensure collected data includes the following:

(1) the date of service,
(2) the type of service,
(3) the service description,
(4) the cost of the service charged to the insurance policy and the cost charged to the client.

g) Notify the Department of any change in clients' data that would make them ineligible for insurance services or potentially require an eligibility review by the Department, as follows:

(1) Send an email to the Department identifying the change and transmit the change through the EDI.

(2) Include the date of the change, the type of change, and the description of the change.

(3) Document in the Data Error Summary Report all data changes sent to the EDI.

4) Coordinate data set transmission changes with the Department. Any changes to the data set transmission require the Department's written consent prior to implementation. Document in Attachment L the specific changes to the files, data fields and schema two weeks prior to the implementation of the changes and submit the change request to the Contract Manager for approval. Submit documentation of the change, approval notices received from the Department, and Attachment L to the Contract Manager within 30 days from completing the change.

5) Research insurance options that clients may be eligible for prior to the annual open enrollment period or the special enrollment periods throughout the year. This should include identifying Medicaid, Medicare, employer sponsored plans, COBRA, and

individual insurance through the Marketplace. Send notices of available insurance options to the list of clients provided by the Department. Prepare a monthly summary report of all notice formats and list of clients sent notices and submit it to the Contract Manager within 30 days from the end of each month.

6) Obtain written informed consent from the client prior to making any change to the agent of record or broker of record listed in the Marketplace or with the client's insurance company. Prepare a summary report listing the number of new consent forms executed and transmitted through the EDI and submit it to the Contract Manager within 30 days from the end of each month. The signed consent must include the following:

   a) disclose any financial gain for the Provider from the insurance carrier,

   b) define the Agent of Record or Broker of Record,

   c) identify the current Agent of Record or "Broker of Record, and

   d) identify any financial gain for the Provider from the insurance carrier.

7) Manage the enrollment of clients into available ADAP-approved health care program or insurance plan during the annual open enrollment period and special enrollment periods due to qualifying events (e.g., death, marriage, childbirth) and become the client's Agent of Record. This includes Medicaid, Medicare, employer sponsored plans, COBRA, and individual insurance policies offered through the Marketplace. Prepare a client enrollment summary report, outlining the number of clients enrolled, and submit it to the Contract Manager within 30 days from the end of each month. Client enrollment must include the following:

   a) Provide a daily list of clients enrolled in insurance through the EDI. Ensure the list includes the following information:

      (1) source of the supported health care program or insurance (e.g. employer, COBRA, Federal Exchange),

      (2) health plan carrier or company,

      (3) plan marketing name,

      (4) unique identification number of the client for billing,

(5) policy coverage effective date,

(6) initial premium amount due on behalf of the client,

(7) recurring premium,

(8) amount of any APTC that reduced the premium amount due from the client, the total amount due on behalf of the client and the payee company name and address.

b) Verify the list of beneficiaries for the policy and compare each person to the enrollment data provided by the Department via the EDI, prior to issuing each payment. Notify the Department through the EDI of any policy benefiting a person who is not a client. Prepare a summary report that details all new policies verified each month and submit it to the Contract Manager within 30 days from the end of each month.

8) Conduct APTC reconciliations for all clients enrolled in insurance through the Marketplace. Submit an APTC summary report to the Contract Manager by June 30 of each contract year. The APTC reconciliation must include the following:

a) Notify Marketplace clients that they must elect to have 100 percent of any APTC they are eligible for, must be paid directly to the insurance company in order to be eligible for ADAP premium assistance. Notice to clients must contain a link providing APTC information on the Marketplace and the Internal Revenue Service (IRS) websites.

b) Inform clients that they should notify ADAP, the Marketplace, and their insurance company about all changes in circumstances so that their APTC can be adjusted. Explain that this will help clients avoid insurance interruption and an APTC reconciliation tax liability. The notice to clients must address the need for accurate information and the consequences to the client and to the Department of reporting inaccurate or out of date information.

c) Collect IRS forms for each client with a policy issued through the Marketplace who qualifies for an APTC, unless the client refuses to provide them. Collect and transmit the following information through the EDI:

(1) Either an attestation of refusal from the client to provide the IRS forms which may be verified by the Department, or the three IRS forms that follow,

(2) IRS Form 1095-A Health Insurance Marketplace Statement which documents coverage by month for enrolled individuals and the amount of APTC sent monthly to Qualified Health Plans,

(3) IRS Form 8962 Premium Tax Credit form which calculates the actual premium tax credit due and reconciles it with the advanced premium tax credit paid, and

(4) IRS Form 1040: U.S. Individual Tax Return form which is the annual income tax return filed by citizens or residents of the United States.

d) Review the forms listed above to determine if clients have either an excess APTC repayment or reported a net premium tax credit. Complete the review of forms no later than June 30 of each year and inform the Department of the results. Prepare a summary report listing the attempt(s) to collect forms and information, the number of clients with an excess APTC repayment or a net premium tax credit, all new tax forms collected each month and send it to the Contract Manager within 30 days from the end of each month.

9) Review client insurance policies and premium payments to ensure compliance with ADAP requirements. Submit an evaluation summary report that includes information on all new plans or policies reviewed each month and submit it to the Contract Manager within 30 days from the end of each month. The review must consist of the following:

a) Ensure the plan meets federal requirements for minimum value standard
using the “mv-calculator” available from the CMS website.

b) Ensure the client’s entire prescribed regimen is available on the insurance plan’s formulary.

c) Ensure the client and their health plan are willing and able to coordinate with the ADAP contracted pharmaceutical benefits manager provider, for the client to obtain ADAP formulary medications.

d) Ensure all insurance policy beneficiaries are clients.

e) Ensure the client’s employer or insurance company are willing to receive third-party premium payments on the client’s behalf.

f) Verify each client’s continued eligibility for their

designated health care program or insurance policy each month. At a minimum, identify any client who no longer meets the eligibility requirements of their health care program or insurance policy. Notify the Department through the EDI of any policy benefiting a person who is not a client. Document in the evaluation summary report, the number of clients verified, and the clients found to no longer be eligible for their health care program or insurance each month.

g) Determine the payment amount according to the updated account information for the number of months of coverage directed by ADAP. Verify the amount due for each client each month prior to sending the payment. Document in the evaluation summary report the number of clients verified each month.

10) Forecast the expected monthly expenditure of contract funds for insurance premium payment for each month remaining in the contract year. This forecast is to be submitted to the Department no later than the tenth day of each month. The forecast must identify the algorithms used, the historical expenditure data used for forecasting, and the expected monthly expenditure for the contract budget period. Submit a monthly forecast report to the Contract Manager within 30 days from the end of each month.

11) Have a business continuity plan or an emergency response plan and test it by August 31 of each contract year. Prepare a summary of the test results and submit it to the Contract Manager within 10 business days from the test completion date. The business continuity plan or emergency plan must include the following:

a) Classification of emergency events;

b) Use of response teams;

c) Use of formalized communication strategies, including alternate communication options;

d) Use of planned recovery efforts; and

e) Use of scheduled testing of system backups.

12) Comply with the requirements of the Department's Data Security and Confidentiality Policies (Attachment G) throughout the term of the contract.

13) Process insurance payments on behalf of each client as follows:

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a) Remit binder payments to the insurance company, employer, or other entity as identified in the client enrollment record upon receipt of the data. Binder payments for each client must be paid to the insurance company, employer, or other entity by the deadline set by them for receipt of binders. Each binder payment is considered a transaction that generates a transaction fee.

b) Remit premium payments between 30 and 45 calendar days prior to the due date. To protect the client's personal health information, the check and its envelope should not refer to HIV or AIDS in any way or any other personal health information. Accurate payments must be sent to the payee in time to allow 20 business days to post the payment to the clients' accounts before the established deadline. Each premium payment is considered a transaction that generates a transaction fee.

c) Remit payments for all requests for Expedited Payment via Expedited Mail services or by Automated Clearing House (ACH) or credit/debit card within one business day of receipt. Issue all expedited payments within one business day following authorization and request by the Department.

d) Receive premium payment refunds from insurance companies and employers. Refunds must be reflected as reductions on the monthly invoice to the Department for the period in which the refund is received. Refunds must be deposited and credited to the client's account within 5 business days. Each refund received and posted is considered a transaction that generates a transaction fee payable by the Department.

e) Verify receipt of the payment and posting to the clients' accounts with the insurance companies, obtain confirmation of payment postings weekly from the insurance companies for each premium payment made on behalf of clients.

f) Provide documentation of payments sent and scans of cancelled checks as requested by the Department. Provide copies within 5 business days of request. Prepare a summary report of all scans of cancelled checks sent each month to the program management software.

b. Deliverables: Respondent must complete or submit the following deliverables in the time and manner specified:

1) As completed: IBM infrastructure implementation with submission of supporting documentation as specified in Tasks B.1.a.1)

2) Monthly: Transaction Fee for Insurance Benefit Manager services with submission of supporting documentation as specified in Tasks B.1.a.2) through B.1.a.12).

3) Monthly: Client insurance payments with submission of supporting documentation as specified in Task B.1.a.13).

c. Performance Measures: This section will be completed as specified in section 4.9 of the solicitation.

2. Financial Consequences: This section will be completed as specified in section 4.10 of this solicitation.

3. Service Location and Times:

a. Location: Provider will provide services from a remote location.

b. Changes in Location: Notify the Department's Contract Manager in writing within 30 days of any location change that will affect the Respondent's ability to complete the deliverables under this contract.

c. Service Times: Services under this Contract must be provided Monday through Friday from 8:00 a.m. to 6:00 p.m., Eastern Standard Time, excluding state holidays.

4. Staffing Requirement:

a. Staffing Level: Provider must maintain an adequate administrative organizational structure and support staff sufficient to complete the deliverables under this contract.

b. Professional Qualifications: Provider must maintain throughout the term of this contract an active Insurance Agency License issued in the state of Florida. Provider must notify the Department immediately if the license becomes inactive or suspended for any reason.

c. Subcontractors: The Department will allow subcontractors for the provision of services under this contract.

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C. Method of Payment:

1. Payment: This is a fixed price, fixed fee and cost reimbursement contract. The Department will pay the Respondent upon completion of the deliverables as specified in Section B.1.b., in accordance with the terms and conditions of this Contract, and the Provider's price sheet, which is hereby incorporated by reference.

2. Unit of Service: A unit of service will consist of one month of completed required deliverables as specified in Section B.1. A month of deliverables includes all deliverables due in that month, including quarterly or annual deliverables scheduled for delivery in a particular month.

3. Invoice Requirements: Provider must submit a properly completed invoice to the Contract Manager within 15 days from the date of completing the deliverable as specified. At a minimum, each invoice must be submitted on the Respondent's letterhead, contain a description of all deliverables for the invoice period, number of units delivered per deliverable, total amount due per deliverable, total invoice amount, invoice number, invoice date, and period of services.

D. Special Provisions:

1. Contract Renewal: This contract may be renewed on a yearly basis for no more than five years beyond the initial contract or for the original term of the contract, whichever is longer, and is subject to the same terms and conditions set forth in the initial contract. Renewals must be in writing, made by mutual agreement, and will be contingent upon satisfactory fiscal and programmatic performance evaluations as determined by the Department and will be subject to the availability of funds.

2. Priority: This contract, its exhibits and attachments, RFP18-026, Insurance Benefits Management, and Respondent's response to this RFP, contain all the terms and conditions agreed upon by the parties. In the event of any conflict among these documents, the order of precedence will be this contract, the RFP and then Respondent's Response.