**EXHIBIT 1**

**3400001763**

**Supplier Requirements**

**Supplier Shall:**

The duties in this section are applicable to both Category 1 and Category 2 services, unless otherwise identified. By submitting a response to this RFP, the Supplier certifies they have the capability and demonstrated experience to fulfill the contractual duties as described within this RFP and proposed by the Supplier for these medical insurance premiums and/or medical insurance deductibles and co-payments, as applicable.

**1. Claims Processing**

Execute a timely and accurate payment process for the payment of medical insurance premiums (Category 1), and/or medical insurance deductibles and copayments (Category 2). Timeliness and accuracy will be measured against the claims made in the Supplier’s proposal response to this RFP.

Provide a claims processing system to include data entry, claims processing, adjustments, claims payments and recovery.

Daily verify client eligibility in the program database, checking for new approvals, approval status updates, and to verify eligibility of any client on whose behalf an assistance payment is processed that day. Supplier shall have a mechanism in place to determine if a person has been verified as eligible before any payment is made.

The supplier shall make payments for allowable costs directly to the insurance carrier or medical provider. Clients or their agents may not receive any funds for reimbursement of costs or expenditures provided under this contract.

**2. Client Information**

Maintain a current, accurate and functioning database of all eligible clients to track and report on client demographics and program utilization to meet the reporting requirements of this contract. The Supplier’s database or business process must be capable to identify eligible HIAP clients and to confirm client’s HIAP eligibility before premiums, medical deductibles and/or copayments are paid.

Verify and update changes in member address, member premium, or any other client information upon notification of address change in order to facilitate accurate processing of assistance payments. Update changes in member information within two (2) business days.

Notify OSDH of any client information received which indicates the client may no longer meet program or insurance eligibility criteria, such as no longer living in Oklahoma.

Comply with HIAP standards, requirements, and policies provided by OSDH.

Advise and collaborate with OSDH in the development of any instrument for HIPAA compliant client consent needed under the operation of this agreement and in the development of any information used for routine direct client communication or contact.

Provide initial and periodic system testing validation of the data management system.

**3. Compliance with Applicable Law**

Comply with all applicable state, and federal statues and regulations, including but not limited to, the Health Information Portability and Accountability Act (HIPAA), the Health Insurance and Accountability Act of 1996, National Standards to Protect the Privacy of Health Information <https://www.hhs.gov/hipaa/index.html> and the National Security Standards for the Security of Healthcare Information (<https://www.cms.hhs.gov/SecurityStandard/>).

**4. Quality Assurance**

Provide a quality assurance plan that shall monitor the program and is available upon request. This includes, but is not limited to, program administration, invoicing procedures, problem resolution (grievance) procedures, internal policy and procedures to ensure that services are timely and appropriate, and in compliance with program standards and procedures.

**5. Continuity of Operations**

Have a business continuity or emergency response plan with multiple options for differing situations depending on the severity of the event to ensure resuming normal operations within 48 hours.

**6. Contract Transition**

Provide a system to transition the services of clients from the previous Supplier to the new Supplier and the new Supplier’s delivery system.

Cooperate with any future transition to another Supplier.

**7. Customer Service**

Provide a designated contact for customer service and a specific account representative for this contract.

Maintain, at a minimum, business hours of 8:30 a.m. through 5:00 p.m. CST/CDT. Monday through Friday.

Provide a designated telephone line established for OSDH HIAP staff and providers to contact

Supplier’s customer service with questions from 8:30 a.m. to 5:00 p.m. CST/CDT, Monday through Friday.

Respond to verbal client requests within two (2) business days of receipt and written inquiries within ten (10) business days of receipt. Upon reasonable request, a summary of inquiry reason will be provided as a custom report to OSDH.

**8. Category 1 – Health Insurance Premium Assistance**

**Claims Processing**

Mail the premium payment checks to provider(s) within two (2) business days of the receipt of approval notice to pay from OSDH.

For urgent exception payment to stop insurance loss, a 24-hour processing/shipping turnaround time is required for premium payments.

Premium payments must be sent requesting proof of mailing.

Provide a system with the capability to receive and deposit refund checks from premiums paid and credit OSDH.

Payments and refunds may be processed electronically (EFT) provided such a system provides equivalent tracking and accountability.

**Reporting**

Cooperate with and participate in all programmatic performance monitoring and clinical quality activity required by OSDH, including the production of data summary reports requested by OSDH.

On a monthly basis, import the following client/claim level data in Excel format and using the specified layout below to the OSDH program database (currently PHIDDO) or to the program database and per the instructions provided by OSDH:

|  |  |
| --- | --- |
| **Column A:** | **NAME** |
| **Column B:** | **SSN** |
| **Column C:** | **ETHNICITY** |
| **Column D:** | **GENDER** |
| **Column E:** | **AGE** |
| **Column F:** | **DOB** |
| **Column G:** | **INSURANCE NAME** |
| **Column H:** | **INSURANCE TYPE** |
| **Column I:** | **STATUS** |
| **Column J:** | **ENROLLED** |
| **Column K:** | **NEW** |
| **Column L:** | **INACTIVE** |
| **Column M:** | **TOTAL** |
| **Column N:** | **PAID** |
| **Column O:** | **TOTAL** |
| **Column P:** | **CLAIMS** |

By the 15th of each month, import the following client level data to the OSDH program database (currently PHIDDO) in the monthly claims billing detail for claims processed the preceding month using the below format:

|  |
| --- |
| **Paid To** |
| **For Consumer** |
| **Check #** |
| **Paid On** |
| **Amount** |
| **Month(s) paid for** |
|  |
|  |
|  |
|  |

In addition to the other reporting requirements and documentation requirements for payment, the Supplier will provide proof of premium payment for an individual assistance payment(s) to the OSDH upon request.

**9. Category 2 – Medical Co-Pay Assistance**

The duties in this section are applicable to Category 2 services only.

**Claims Processing**

Supplier shall be the agent providing outpatient medical ambulatory cost medical co-payment, co-insurance and deductible payment for Part B approved participants in a qualified insurance plan for visits to medical providers.

Supplier shall coordinate all aspects of payment assistance benefits with insurance companies, hospitals, clinics, private medical offices or other providers for all out-of-pocket responsibilities of the HIAP-approved client’s allowable health care costs (medical deductibles and co-payments).

Supplier agrees to coordinate these payments directly to medical and diagnostic providers, hospitals, clinics.

Supplier will provide a process so that the medical provider will not request the payment from the patient/HIAP client at the time of an appointment but will instead receive payment from the Supplier.

Supplier shall be solely responsible for working with the providers to coordinate payments.

Supplier shall be solely responsible for managing client contact regarding billing and medical payments.

Supplier shall coordinate benefits and coverage with billing private insurance, Medicaid, Medicare, and/or other third-party coverage before utilization of these Ryan White Part B funds.

Supplier shall have the ability to back-bill Medicaid or an insurance plan for services for up to 6 months back or according to the policies of stated insurance carrier.

Medical services are allowable under this agreement with exclusion to the following services that are explicitly restricted per the Ryan White Treatment Extension Act of 2009:

* Client share costs for all inpatient care and services.
* Client share costs for all emergency care and services.
* Client share costs associated with treatment or care for fertility/infertility or abortion.
* Client share costs associated with treatment or care for a sexual reassignment.
* Client share costs associated with treatment or care for erectile dysfunction or sexual performance.
* Client share costs associated with cosmetic treatment or care including but not limited to hair growth, cosmetic Botox treatments, or outpatient cosmetic procedures.

Eligibility for payment assistance under this contract shall be determined based on the date of service, not the date of payment. Payments may be made on behalf of clients who were eligible on the date of service, but who are inactive/ineligible on the date the payment is processed by the Supplier.

Payment assistance claims must be supported by the following documentation:

Explanation of benefits showing the procedure(s) provided to the patient, the amount covered by the client’s health insurance plan, and the amount remaining due from the patient (i.e. patient co-payment or co-insurance amount).

A detailed bill that would otherwise have been mailed to the patient showing the procedures provided to the patient, the amount paid by the patient’s insurance, and the amount remaining due from the patient (again, the patient co-pay amount).

Supplier will not be paid or reimbursed for payments made on behalf of any client for whom they do not provide both an explanation of benefits and detailed bill.

Supplier shall be solely responsible to address and resolve any overpayments, any late payments, and any mis-applied payments to assure all Ryan White funds are used solely for their approved purpose.

Supplier shall have the capacity to process a minimum of 300 payment assistance transactions per month dealing with a variety of transaction types and/or other related transaction activities.

**Reporting**

Supplier shall cooperate with and participate in all programmatic performance monitoring and clinical quality activity required by OSDH, including the production of data summary reports requested by OSDH.

Supplier shall rovide client profiles, program utilization, and expenditure data necessary for efficient statewide program management and required reporting for federal funding as required by this contract.

The Supplier’s system, at a minimum, shall be able to track and report on the following:

* Type of payment: deductible, co-payment, % co-insurance.
* Type of service: medical visit, lab, etc.
* Provider of the medical service
* Procedure code
* Amount billed to insurance by the provider
* Amount covered by the plan
* Amount paid by the plan to the provider
* Remaining client share amount
* Amount paid by this contract on behalf of the client toward the client share amounts

The Supplier’s system, at a minimum, shall be able to provide client summary reporting that includes the following information:

YTD total for each client of costs toward any applicable medical deductible. This information is to be provided with the monthly invoice.

Supplier will provide an end of year reconciliation of all transactions paid under this contract by May 31, and covering the service period from 4/1 of the prior year through 3/31 of the current year.

In addition to the other reporting requirements and documentation requirements for payment, the Supplier will provide proof of payment for any individual assistance payment(s) to the OSDH upon request.

Supplier shall provide monthly client level summaries of expenditures.

The Supplier will be responsible for submitting timely and accurate client level data to OSDH consistent with the HRSA Ryan White HIV/AIDS Services Report (RSR), and reporting requirements from the State of Oklahoma. Currently this report is due in March for the annual report. There are requests as needed from HRSA for other reports. HRSA reporting elements are located at:

<https://hab.hrsa.gov/program-grants-management/ryan-white-hivaids-program-services-report-rsr>.

The Supplier will accommodate evolving state and federal data reporting requirements.

**DUTIES OF THE OSDH:**

Determine client eligibility for HIAP assistance.

Provide client data through the program database:

* + Client name and information necessary to process assistance payments.
	+ Date eligibility begins and ends for HIAP.
	+ Information needed on client’s insurance plan to make payments.

Provide a signed “Certification of Understanding and Agreement for Services” (Exhibit 2) and appropriate client releases and insurance information.

Publicize and inform the public about the HIAP program.

Notify eligible HIAP clients of changes in the program.