



# ORANGE COUNTY PUBLIC SCHOOLS

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## ADDENDUM NO. 1

August 25, 2008

RFP 08-07-133

Group Health Administrative Services (ASO), Disease Management, Prescription Benefit Management (PBM) and Behavioral Health Programs/EAP

**Solicitation Due Date/Time:** 2:00 P.M., EST, September 17, 2008; Orange County Public Schools, Educational Leadership Center, 1ST Floor Conference Room, 445 W. Amelia St. Orlando, FL 32801.

Please be advised of the following changes/clarifications to subject solicitation:

1. Section 1.1 on page 6 presents information about OCPS retirees. Can you provide more detail about the number and location of retirees who do not live in Central Florida?

**The retiree census provided in Attachment 5 of the RFP shows participants by zip code of residence.**

2. Section 2.3, item K, on page 14 requires a one day response time for the service representative. Could you discuss what types of issues might be subject to the one day response time? Does that timeframe include requests for custom reports, changes to employee materials, vendor website, etc? It seems likely such requests might require more than one day, while other requests for information and assistance would be expected to require no more than one day.

**The one business day response turnaround time refers to returning calls to OCPS Insurance Benefits staff. If an issue requires more time to resolve, it is expected the vendor will advise OCPS staff of the tentative resolution time frame and to keep OCPS staff informed until resolution.**

3. What led to the decision to add a Disease Management program to OCPS' benefit structure? For example, was it utilization and or disease prevalence? Would OCPS consider sharing data prior to the submission date with which the prospective bidder could gain insight into the extent of chronic disease within the employee population? This information would be helpful in evaluating population acuity and risk, and proposing financial risk-sharing strategies.

**Disease Management is part of the service structure and is currently provided by the Group Health Administrators (CIGNA and FHHS). OCPS is considering carving this service out to another vendor to improve services in this area with a single focus vendor. A good Disease Management program should help the patient remain stable thus decreasing, sick days, ER visits and inpatient admissions. Listed below (response to Question 4) are the current Disease Management programs, participants by program and medical plan.**

4. Will at least 18 months of historical medical and pharmacy claims be available to the successful Disease Management bidder with which to establish baselines and risk pools for intervention purposes? If data is not available, are you willing to provide us with prevalence rates for those diseases for which we should provide fee quotes?

**Current enrollment in the following Disease Management Programs:**

FHHS

**Asthma/COPD – 204**  
**Cardiac – 24**  
**Diabetes – 150**  
**Heart Failure – 3**  
**Total – 381**

**CIGNA Open Access**  
**Asthma – 602**  
**Cardiac – 586**  
**COPD – 66**  
**Diabetes – 1,015**  
**Weight – 3,120**

**CIGNA Open Access Plus**  
**Asthma – 306**  
**Cardiac – 809**  
**COPD – 104**  
**Diabetes – 861**  
**Weight – 2,344**

**Yes, eighteen months of claims data will be provided to the successful bidder.**

5. What percentage of OCPS' member population has access to a computer and the internet during their workday? At home?

**The only departments that do not have ready access to a computer at work are transportation, maintenance and food service. This represents approximately 15% of the OCPS employment. OCPS does not track access to a computer (Internet) at home.**

6. Does OCPS currently host on-site health fairs in which biometric data is collected?

**Typically this is not done, but may be requested in the future.**

7. Is OCPS interested in providing its members with access to a Health Risk Assessment tool?

**OCPS wants to review and approve any tool that would be used. OCPS will not support a Health Risk Assessment tool without a well documented follow-up plan outlining how the data will be used to improve clinical outcomes.**

8. Does OCPS currently offer internal or external wellness program services, such as Weight Watchers? Does OCPS extend any discounts for fitness centers, or fitness equipment, etc.?

**Yes: weight watchers at work and online, fitness center discounts, etc.**

9. What mediums does OCPS utilize to communicate with its membership? What is the frequency?

**OCPS communicates with members through a monthly newsletter, e-mails, intranet, benefit and health fairs, on-site Wellness Representatives, IVR enrollment, other meetings, executive leadership, union leadership, etc. The frequency varies depending upon the medium used.**

10. Please define 'actively at work' provisions shall be waived for all participants.

**Employees who OCPS deems to be eligible on the effective date of coverage, including employees who are on an approved Leave of Absence or confined to an inpatient facility.**

11. Are any other time frame options for satisfaction surveys acceptable such as annual vs biannual?

**OCPS conducts an internal benefit survey bi-annually. OCPS welcomes vendors to conduct their own satisfaction surveys more often and to share the results with OCPS staff.**

12. You have very precise directions regarding submission of the proposal document; will you accept any cover letters or Executive Summaries?

**Cover letters or executive summaries will be accepted, however, evaluations will be based on the information submitted in the tabs as requested.**

13. Respondent is considering co-bidding the Prescription Benefit Management, Behavioral Health Programs/Employee Assistance Program, and Disease Management services with our sister companies. In regards to on site meetings, would it be acceptable to send one team representing all interest rather than a team from each area of interest?

**The Account Team who will attend onsite meetings must have the knowledge and experience to participate and add value to the meetings at hand. Vendors may use one Account Team if the members of the team have the requisite experience and knowledge on the OCPS account and are verse in all product lines. During the monthly Operation meetings utilization is reviewed, programs are discussed and new programs are presented. When issues are identified, assignments are given. Timely and complete follow up is expected in each service area at the next scheduled meeting.**

14. Are there any custom forms used by Orange County Public Schools for enrollment or other administrative functions? Can the carrier use their own enrollment forms?

**Refer to page 9, Section 1.5 of the RFP for the current eligibility process. Carriers may not use their own enrollment forms.**

15. Are there any legislated time requirements to complete a contract or SPD/employee booklet once the award is provided?

**Once the School Board approves the recommendation, OCPS will negotiate the contract with the top ranked proposer(s). If the contract is not successfully negotiated in a timely fashion (acceptable to OCPS), OCPS will seek Board approval to negotiate with the next highest ranked proposer.**

**OCPS prepares the initial Insurance Benefits Handbook with input from each vendor. All vendors are expected to review the draft document for accuracy and completeness. Refer to Attachment 2 of the RFP for the 2007 version. Also refer to the Scope of Services section in the RFP for each component for vendor requirements regarding the Insurance Benefits Handbook.**

16. How often are members going to in network providers?

**All Open Access Plans are in-network benefits only. In the Open Access Plus Plan, actives are 92% in-network and the retirees (both early and 65+) are 80% in-network. Statistics on percentage of utilization of contracted providers is not readily available.**

17. Please itemize the disease management programs currently included in the medical plan.

**Refer to response to Question 4 in this Addendum.**

18. Please itemize the wellness programs currently included in the medical plan.

**FHHS and CIGNA currently administer a healthy pregnancy program, weight management/obesity program, periodic physicals, adult immunizations, screening**

**mammograms, health reminder letter, notification to faceless patients (24 month without a claim) and a monthly health promotion topic which is coordinate with the Wellness Representatives.**

19. Please provide an updated census for the active, under 65 and over 65 eligible population. The files should include date of birth, zip code, gender, medical tier and plan identifier.

**This was provided in Attachment 5 of the RFP.**

20. Will the current administrative fees be made available?

**Proposers should submit best pricing for the services being proposed. Current administrative fees should not be material to the submission.**

21. Section 4, page 21 is requesting a completed response in Microsoft word 6.0. Our systems operate on Microsoft 5.1 which is readable by Word 6.0. Is this acceptable?

**Responses may be submitted in any format that is readable and usable (not PDF) by Word 6.0 or higher. If your submission cannot be read by Word 6.0 or higher, the vendor will not be allowed to resubmit.**

22. Please itemize any programs currently included in the administrative fees today.

**Refer to Appendix A Group Health ASO in the RFP. All the services listed are currently included in the Administrative fees plus Disease Management and an on-site Benefit Representative.**

23. Please provide the current HMO and PPO plan designs.

**Plan designs were provided in Attachments 1 and 2 of the RFP.**

24. Is there any flexibility to propose alternative plan designs?

**OCPS will not allow for any flexibility to propose alternate benefit plan designs.**

25. Would OCPS consider using alternative enrollment methods from the current IVR (i.e. web-based etc.)

**OCPS will not consider alternative methods of enrollment.**

26. Can they provide their current eligibility file format?

**See attached format in which OCPS currently provides eligibility data to CIGNA.**

27. What kind of DM and wellness reporting are they currently receiving?

**Monthly participation in each program compared to the prior month and quarterly ER visits and inpatient admissions (cumulative from quarter to quarter through the plan year) compared to same time frame for the prior year for each disease management program.**

28. Please provide claims data by month for the most recent 15 months along with lives to match the claims experience.

**Excess Loss coverage is not being sought in this RFP, therefore monthly claims and enrollment are not material to this submission. Refer to RFP Section 1.3 for average enrollment and Attachment 6 of the RFP for plan cost.**

29. Please confirm the level/percentage of MWBE/LDB spend on the current contract.

**The current contracts do not include MWBE/LDB participation; however, OCPS procurement practices have changed since the contracts were executed.**

30. Please confirm what level of MWBE/LSB is being requested. On page 27 in the requested table of contents, tab 5, item D, number 2 states 12% and Appendix F states 20%. Further page 56 in the services agreement states there are stated goals 12% for MWBE and 10% for LDB.

**All numbers should read 12% for MWBE and 10% for LDB.**

31. Please provide the current MBE/WBE percentage and describe how it's being achieved.

**Refer to response to Question 29 of this Addendum.**

32. Is it required that all fees be administered on a PMPM basis, or is it acceptable to display the PMPM fees in the RFP response but handle the billing administration on a PEPM basis?

**All fees should be proposed on a PMPM basis. The successful vendor may bill administrative fees on a PEPM basis.**

33. Please provide large claim information.

**Plan Year to Date (10/1/07 through 5/30/07) Claims in excess of \$100,000:**

**FHHS:**

ICD 9	Description	Paid
38.9	Septicemia Nos	\$212,675
775.6	Neonatal Hypoglycemia	\$180,685
38.9	Septicemia Nos	\$145,849
416.8	CHR Pulmon Heart Dis Nec	\$133,288

**CIGNA Open Access Plan (10/2007 – 6/2008):**

Includes all claimants with claims in excess of \$50,000

MEASURES as values	Paid Amount	Admissions
02 Neoplasms	<b>\$2,687,491</b>	<b>36</b>
12 Circulatory & Heart	<b>\$2,364,178</b>	<b>39</b>
13 Gastrointestinal Disorders	<b>\$873,526</b>	<b>21</b>
18 Musculoskeletal Disease	<b>\$783,192</b>	<b>17</b>
11 Diseases of the Lower Resp	<b>\$583,765</b>	<b>9</b>
15 Renal and Urologic	<b>\$550,825</b>	<b>9</b>
19 Pregnancy & Childbirth	<b>\$448,739</b>	<b>4</b>
08 Neurological & Cerebrovasc	<b>\$393,262</b>	<b>14</b>
20 Newborns	<b>\$353,729</b>	<b>7</b>
01 Infectious & Parasitic	<b>\$204,965</b>	<b>5</b>
14 Biliary Tract and Liver	<b>\$131,536</b>	<b>4</b>

03 Endocrine, Nutritional	<b>\$131,305</b>	<b>5</b>
21 Int/Ext Injury (exc Fract)	<b>\$126,589</b>	<b>0</b>
05 Diseases of the Blood & Blood	<b>\$126,280</b>	<b>1</b>
17 Skin, Sub Tissue, & Non-Mal Br	<b>\$114,570</b>	<b>1</b>
16 Reproductive	<b>\$108,082</b>	<b>3</b>
Major Diagnostic Grouping	<b>\$9,982,034</b>	<b>180</b>

**Includes claimants with claims in excess of \$100,000. Diagnosis not available on the report.**

	Paid Amount	Admissions
<b>1</b>	<b>\$553,201</b>	<b>2</b>
<b>2</b>	<b>\$457,462</b>	<b>11</b>
<b>3</b>	<b>\$312,231</b>	<b>3</b>
<b>4</b>	<b>\$280,811</b>	<b>2</b>
<b>5</b>	<b>\$207,748</b>	<b>3</b>
<b>6</b>	<b>\$206,548</b>	<b>1</b>
<b>7</b>	<b>\$204,866</b>	<b>1</b>
<b>8</b>	<b>\$187,687</b>	<b>6</b>
<b>9</b>	<b>\$167,873</b>	<b>1</b>
<b>10</b>	<b>\$160,860</b>	<b>4</b>
<b>11</b>	<b>\$155,405</b>	<b>0</b>
<b>12</b>	<b>\$154,841</b>	<b>10</b>
<b>13</b>	<b>\$145,461</b>	<b>2</b>
<b>14</b>	<b>\$138,223</b>	<b>1</b>
<b>15</b>	<b>\$126,000</b>	<b>8</b>
<b>16</b>	<b>\$121,557</b>	<b>1</b>
<b>17</b>	<b>\$120,843</b>	<b>0</b>
<b>18</b>	<b>\$117,714</b>	<b>1</b>
<b>19</b>	<b>\$117,451</b>	<b>2</b>
<b>20</b>	<b>\$115,500</b>	<b>2</b>
<b>21</b>	<b>\$111,238</b>	<b>1</b>
<b>22</b>	<b>\$110,087</b>	<b>0</b>
<b>23</b>	<b>\$108,528</b>	<b>2</b>
<b>24</b>	<b>\$106,438</b>	<b>1</b>
<b>25</b>	<b>\$105,270</b>	<b>3</b>

**CIGNA Open Access Plus Plan (10/2007 – 6/2008):**

**Includes all claimants with claims in excess of \$50,000**

MEASURES as values	Paid Amount	Admissions
02 Neoplasms	<b>\$2,321,747</b>	<b>29</b>
12 Circulatory & Heart	<b>\$498,268</b>	<b>16</b>
18 Musculoskeletal Disease	<b>\$420,705</b>	<b>11</b>
11 Diseases of the Lower Resp	<b>\$274,064</b>	<b>7</b>
08 Neurological & Cerebrovasc	<b>\$259,588</b>	<b>8</b>
15 Renal and Urologic	<b>\$157,335</b>	<b>6</b>
03 Endocrine, Nutritional	<b>\$149,556</b>	<b>3</b>
22 General Medical Diagnosis	<b>\$140,473</b>	<b>3</b>
13 Gastrointestinal Disorders	<b>\$75,205</b>	<b>4</b>
05 Diseases of the Blood & Blood	<b>\$72,028</b>	<b>1</b>
21 Int/Ext Injury (exc Fract)	<b>\$67,106</b>	<b>2</b>
01 Infectious & Parasitic	<b>\$64,321</b>	<b>3</b>
17 Skin, Sub Tissue, & Non-Mal Br	<b>\$46,768</b>	<b>2</b>
20 Newborns	<b>\$46,095</b>	<b>1</b>
10 Diseases of the Ear/Nose/Thr	<b>\$15,843</b>	<b>1</b>
09 Disorders of the Eye	<b>\$5,360</b>	<b>0</b>
14 Biliary Tract and Liver	<b>\$2,918</b>	<b>0</b>
16 Reproductive	<b>\$2,148</b>	<b>0</b>
06 Mental Disorders	<b>\$748</b>	<b>0</b>
04 Immune Disorders	<b>\$631</b>	<b>0</b>
07 Substance Use Disorders	<b>\$0</b>	<b>0</b>
19 Pregnancy & Childbirth	<b>\$0</b>	<b>0</b>
Major Diagnostic Grouping	<b>\$4,620,907</b>	<b>97</b>

**Includes claimants with claims in excess of \$100,000. Diagnosis not available on the report.**

	Paid Amount	Admissions
<b>1</b>	<b>\$157,180</b>	<b>4</b>
<b>2</b>	<b>\$154,918</b>	<b>3</b>
<b>3</b>	<b>\$140,777</b>	<b>2</b>
<b>4</b>	<b>\$137,190</b>	<b>3</b>
<b>5</b>	<b>\$135,191</b>	<b>3</b>
<b>6</b>	<b>\$131,182</b>	<b>2</b>
<b>7</b>	<b>\$129,282</b>	<b>2</b>
<b>8</b>	<b>\$124,127</b>	<b>5</b>
<b>9</b>	<b>\$122,045</b>	<b>1</b>
<b>10</b>	<b>\$103,417</b>	<b>3</b>
<b>11</b>	<b>\$101,672</b>	<b>1</b>

34. Please provide current carrier projected trend for claims from the end of the experience period to the plan effective date.

**OCPS uses an independent actuary. The current vendors do not project trend for claims for OCPS. Trend for the OCPS Medical Indemnity Plan has been running well below the industry (Refer to page 10 of the RFP, section 1.8) and is expected to continue.**

35. Please provide current plan utilization reports (for the current and prior 12 month periods).

**Refer to Attachment 6 of the RFP for historical plan cost information and Attachment 8 of the RFP for prescription drug utilization of high cost and high volume drugs.**

36. What are the discounts achieved for the current plans.

**Current medical plan network discounts are not material to the submission.**

37. Can fees be provided on a per employee per month (PEPM) basis rather than the PMPM basis requested?

**Refer to response to Question 32 of this Addendum.**

38. What are the 2007 and 2008 administration fees? What do they include?

**Refer to response to Question 20 of this Addendum.**

39. Are there any special instructions on marking confidential information?

**Confidential Items shall be placed in a separate envelope and clearly marked "Confidential". The only items that may be submitted "Confidential" are Financial Statements and any contracts for goods/services pertaining to this RFP (such as provider fee schedules). The information will remain confidential from the public but not from the Evaluation Committee.**

40. Will you withhold anything we mark as proprietary from disclosure under local public record rules?

**In compliance with Procurement policies and statutes, the only information that can remain confidential and proprietary are financial statements and your contracts for goods and services pertaining to this RFP (such as provider fee schedules).**

41. Are you willing to sign a Non-Disclosure Agreement to protect proprietary information?

**No. OCPS will not sign Non-Disclosure Agreements. Please refer to questions #39 and #40 for further clarification regarding proprietary information.**

42. Scope of Services - Please define the services that would be included in the assistance in the bi-annual Employee Survey.

**Currently, vendors assist OCPS with incentives for employees to participate. Vendors are encouraged to respond with other services offered that will lead to increased employee participation. In addition, if corrective actions are necessary due to the results, OCPS expects vendors to develop corrective action plans, follow-up as needed and report the status of the corrections often. For example, one vendor conducted Focus Groups in response to some of the survey results and used results of the focus groups to develop corrective actions.**

43. Appendix H - How would you like to see deviations to the proposed contract - via redlining, or a bullet point list?

**Ideally, providing deviations in a bullet point list.**

44. MWBE/LDB - Is there an exception to the 20% subcontracting requirement for healthcare companies that utilize an integrated, national delivery model? Unlike transportation and construction companies that routinely solicit bids from subcontractors to perform the contract, the vast majority of services are performed by employees of United Healthcare.

**Proposers are encouraged to participate in the OCPS MWBE/LDB procurement initiatives. Proposals will be evaluated and scored based upon participation in these programs.**

45. Section 1.0 A3 - Could you explain/elaborate on why OCPS is requesting both a July 1, 2009 and October 1, 2009 effective date?

**OCPS reserves the right to implement a change in PBM services before the start of the next Plan Year (10/1/2009).**

46. Section 5.0 Tab 5 - Please provide the MWBE/LDB participation reports from Cigna.

**Refer to response to Question 29 of this Addendum.**

47. 2.3 Disease Management – F - Assuming a 10/1/09 effective date, when does OCPS wish to begin receiving Quarterly Savings reports?

**By, May 1, 2010.**

48. 2.3 Disease Management – K - Throughout the RFP, “dedicated” personnel for Account Management, Clinical, Customer Service etc. is required. Please define “dedicated”.

**OCPS desires specific named individuals be assigned to the OCPS Account to ensure knowledge, accurate and timely responses to OCPS administration. OCPS members should have access to a dedicated service unit.**

49. 2.3 Disease Management - L. Please describe “data/claims feeds” to include type of data, format (file or FTP), frequency, potential number of “other vendors” etc.

**The Disease Management vendor must have the systems in place to accept claims data from the Group Health ASO necessary to identify members for Disease Management programs and the ability to report on the effectiveness of the programs. The Disease Management vendor will determine the type of data necessary, file format, frequency of data necessary. Data will be necessary from each component provided, which may be contracted individually or collectively through this RFP.**

50. 2.5 Behavioral Health Programs/Employee Assistance Programs (EAP) - G. What is meant by “a system that schedules appointments...and does not require call backs?”

**OCPS wants members to be able to schedule an appointment at the time the member calls for an appointment. OCPS does not want members to call into a call center to schedule appointments where the call center has to call the member back at a later time.**

51. Appendix L8 - Please describe “ad hoc reports” to include possible data required, frequency, format, turnaround time etc.

**Ad hoc reports are required periodically to determine why costs and utilization of a particular service have changed. The information is needed in PMPM costs and utilization per thousand with historical data being compared to current data and also comparisons to national or regional trends. Also the data will frequently focus on clinical outcomes. All data should track by plan year not calendar year. OCPS would expect a two to four week turnaround timeframe**

**unless an explanation was provided for a longer timeframe. All ad hoc reports MUST be reviewed for reasonableness before delivery to OCPS.**

52. Appendix M - Do the broad-based Performance Guarantees (PG's) proposed for "Plan Implementation", "Network", "Member/Customer Service" "Claims Payment", "Reporting", "Audits", "Actuarial Reports", "Eligibility Processing", "Grievance Procedure", "Meeting Attendance" pertain only to the Medical Carrier? Or, do these PG's also pertain to Behavioral Health, EAP, Disease Management and Wellness?

**All proposers are required to include Performance Standards with financial penalties for services the vendor will perform. Some of the Performance Standards that apply to a specific component are identified as such. Proposers are to indicate N/A for the Performance Standards that do not apply specifically to the component proposed.**

53. Is OCPS willing to accept a Behavioral Health proposal on an ASO basis as an alternative to capitated full-risk?

**Behavioral Health Proposals are to be submitted on a capitated full-risk basis.**

54. Regarding Letter E on page 17 of the RFP, we do not contract with Orlando Behavioral Healthcare. Is providing to OCPS a letter reaching out to Orlando Behavioral Healthcare for possible inclusion in our network sufficient enough for us to still quote Behavioral Health?

**Providing a letter reaching out to Orlando Behavioral Health is not sufficient. Proposers must have either a contract executed with OBH or a Letter of Intent to contract by the submission date of September 17, 2008. If the Proposer has a Letter of Intent, it must include progression dates clearly outlining the steps necessary to contract with definitive timeframes. The Letter of Intent to contract must be signed by the proposing company and Orlando Behavioral Health. A contract must be executed no later than December 1, 2008. If a Proposer is evaluated and is determined to be the highest ranked Proposer and DOES NOT have an executed contract with OBH by December 1, 2008, they will be eliminated. The next highest ranked Proposer who has an executed contract with OBH will be recommended to the Board.**

55. Regarding Letter A on page 6 of the RFP, it is indicated that the EAP should be quoted on a self-funded basis. We only offer our EAP on a fully-insured basis. Is quoting EAP on a fully-insured basis acceptable?

**OCPS will contract for Behavioral Health and Employee Assistance Programs on an all inclusive capitated full-risk basis. Pricing needs to be separated for Behavioral Health and EAP services since these services are funded from separate areas.**

56. Please detail the current EAP plan, including the number of face-to-face sessions, on-site training hours, and critical incident services.

**EAP services are provided by Orlando Behavioral Health and currently do not limit the number of face-to-face sessions, on-site training and critical incident services. The EAP is integrated with Behavioral Health and dependent upon the presence or absence of a diagnosis. If a diagnosis, the services are provided under the Behavioral Health benefit.**

57. Please specify which session model(s) we should quote for EAP.

**It is up to the Proposers. Proposers are to identify the session model(s) proposed in the pricing.**

58. Please provide the number of on-site training hours and critical incident services we should include in our EAP pricing.

**Refer to response to Question 56 of this Addendum.**

59. Please supply your description of Fitness for Duty.

**A formal Fitness for Duty evaluation is done when a member is referred by management for issues affecting the person's ability to perform their job, possible safety issues or if a person is not willing to seek help and it is known the person's issues are or may affect their ability to perform their job. If a person knowingly has an issue affecting their ability to do their job and is willing to get help, the services are provided under the Behavioral Health benefit.**

60. Please provide the number of DOT cases that were handled in 2008, 2007, and 2006.

**There have been no DOT cases handled because OCPS has a zero tolerance policy.**

61. MHNet has over 300 providers in the service area. Do we have to have Orlando Behavioral Health as one of those providers? If so can you share the reason behind the answer?

**See response to Question 54 of this Addendum. Orlando Behavioral Health has been a quality focused and cost efficient provider of services for the OCPS membership. Over 75% of OCPS outpatient visits and Employee Assistance Programs are provided by Orlando Behavioral Health.**

62. How many free face to face visits are included in your EAP?

**Refer to response to Question 56 of this Addendum.**

63. Do Walgreens and Cigna integrate medical, lab/diagnostic, and pharmacy claims? What credit does CIGNA give? Please describe the pharmacy integration requirements.

**Walgreen's Health Initiatives provides the Health Care Administrators (CIGNA and FHHS) with monthly prescription drug claims data for the Disease Management, Case Management and Gaps in Care programs. In addition, WHI provides OCPS and the Health Care Administrators with ad hoc reports for quality initiatives and other programs as needed.**

**In addition, the Health Care Administrator's (CIGNA and FHHS) provide monthly claims data to WHI for the Med Monitor program and the Patient Compliance Program.**

**All vendors provide OCPS a at a minimum with quarterly cost and utilization reports. Vendors are expected to note trends and address problems with corrective action plans.**

64. If the data is integrated, how often are claims files passed and what is charged for this services?

**Refer to response to Question 63 of this Addendum. Current pricing for data integration is not material to the submission.**

65. Does the Orange County Public Schools have any specific services issues with Walgreens' retail, mail or specialty drug programs?

**Not material to this submission.**

66. How long has the Walgreens PBM contract been in place?

**The current contract has been in place since October 1, 2004.**

67. What are the current Step Therapies, Prior Authorization, and Quantity Limits and how long have they been in place?

**Provided in Attachment 2 of the RFP Insurance Benefits Handbook exclusions and limitations.**

68. Will Orange County Public Schools provide 12 months of detailed Pharmacy Claims Data to include NDCs, Pharmacy Name/NABP numbers, Date of Service for pharmacy claims, and Unique Member IDs. Please include the plan design and as much information on fees and discounts as possible.

**A complete claims file will not be provided. Refer to Attachments 1 and 2 of the RFP for current plan designs and Attachment 8 of the RFP which are the top 100 drugs by cost and volume for each pharmacy category (retail-30, retail-90, and mail). Proposers should submit proposals using best pricing; current fees and discounts are not material to submissions.**

69. Does the Walgreens retail 90 program exclude CVS or any other major chains like Rite-Aid?

**Participants have access to contracted retail-90 pharmacies (a list of contracted retail-90 pharmacies was included in Attachment 2 of the RFP).**

70. What is the current pharmacy rebate arrangement?

**Proposers should submit proposals using best pricing (including rebates or net pricing structure); current rebates are not material to submissions.**

71. Will the selected PBM vendor's program be utilized by all eligible participants provided in the census? How many total lives (actives and dependents are currently part of the WHI pharmacy benefit plan?

**The census provided includes all eligible employees regardless of their participation status. Enrollment figures on page 7 and 8 of the RFP include participants. All participants in the CIGNA or FHHS plans have pharmacy benefits (i.e. the PBM provides services to all plan members and one of the Alternatives to the Medical Plan).**

72. Please further explain what is being requested in the PBM Questionnaire section questions #27 and #28. Is the County asking for guarantees that include drug ingredient costs or is the request for AWP minus discounts?

**Proposers are to include pricing in an AWP minus discounts, MAC or other pricing methodologies the Proposer is offering.**

73. What is the proposed prescription drug program plan design that will start in 2009?

**No plan changes are anticipated for 2009. Refer to Attachment 2 of the RFP for the plan design.**

74. Attachment 8 drug reprice, does that include all claims? If so, over what time period? If not, can detailed claims data be provided?

**Prescription drug claims in Attachment 8 of the RFP are only high volume and high cost prescriptions which accounts for 85% of the total drug spend. A full claims file will not be provided.**

75. Attachment 8 does not include all claims, only a selection.

**Refer to response to Question 74 of this Addendum.**

76. What date should be used for the reprice in attachment 8?

**Proposers should use pricing as of July 2008.**

77. Why is the County out to bid? What is the current satisfaction level with WHI?

**Refer to response to Question 65 of this Addendum.**

78. Provide the percent of eligible / covered retirees that reside outside of Florida under the Pharmacy benefit?

**Refer to Attachment 5 of the RFP for participating retirees by zip code.**

79. Is the expectation that the plan will continue to administer the pharmacy benefit through a carve-out PBM?

**OCPS will select the best PBM based upon the evaluation criteria, regardless if the proposer is a carve-out vendor or not.**

80. Please provide the total cost associated with postage/mailings for 2006 & 2007 including all fulfillment related services currently provided by WHI.

**Proposers should develop Administrative Fees using company statistics regarding standard services that would require communication to members. Standard services may include historical changes and anticipated future changes in formulary, clinical prior authorizations, claim denials and other services that are provided standardly. Proposer should identify all services that considered standard services in which member mailings/postage would be included. OCPS does not expect Proposers to include postage for any non-standard services or special requests.**

81. Provide the number of inbound and outbound file feeds required by the PBM vendor and the frequency of each feed.

**Eligibility: weekly inbound updates from medical plans and outbound to work discrepancies and monthly full eligibility file.**

**Claims: monthly outbound to all medical plans and disease management**

**RDS: monthly outbound and inbound to CMS**

82. Please supply the number of inbound and outbound customer service calls and minutes if available for 2007 or the last twelve months available.

**Data on Customer Service indicators is not material to this submission.**

83. Confirm that the Plan will require assistance with RDS submissions to CMS.

**OCPS requires the PBM to submit data monthly to CMS on the RDS and complete a full reconciliation.**

84. Confirm the Plan will accept, in full, the PBM's formulary.

**No; OCPS must negotiate deviations from the current formulary.**

85. Provide a list of drugs currently subject to clinical edits. Please also confirm the Plan will accept the PBM's recommended edits.

**See response to question 67 of this Addendum. All plan recommendations must be approved by OCPS prior to implementation.**

86. Does the Plan have a mandatory mail order provision in place today? If so, will that continue with if a new PBM is selected?

**See Attachment 2 of the RFP Insurance Benefits Handbook. No changes if a new PBM is selected.**

87. Page 15, 2.4, F – How many enrollment and health fairs for employees/retirees are anticipated during (each) year of the contract period that will require attendance by the PBM?

**3 to 12 events annually.**

88. Page 15, 2.4, I – Please indicate the elements that must be included on the billing statements to meet OCPS's standard, or, please supply a current bill that meets the standards.

**Costs by plan type in summary with cost data by drug class showing individual drugs (separate out by strength and route) utilization and costs with reversals broken out separately.**

89. Page 15, 2.4, K – Please describe the expected participation and frequency of an account manager and Pharm D in OCPS's grievance hearings.

**The PBM has participated in one Grievance Hearing in the past 17 months. OCPS is not able to provide expectations on the frequency for hearings involving prescription drugs.**

90. Page 16, 2.4, N – Please provide OCPS's established customer service standards.

**Current customer service standards are not material to the submission.**

91. Page 96, Q71 – Please define Coverage Management Programs.

**Coverage Management Programs include step therapies, clinical prior authorizations, quantity limitations and any other programs that impact the cost and utilization of drugs covered in the PBM benefit design.**

92. Page 94, Q46 – Please clarify if the requested costs should be discounted or undiscounted.

**Proposals should provide the discounted cost.**

93. Is OCPS planning on seeking any sort of accreditation or plan on reporting HEDIS measures independent of the medical vendor chosen? Or do you want the PBM to provide the pharmacy claims data to the medical vendor?

**OCPS is not planning on seeking accreditation, however, will review a proposers HEDIS outcomes to evaluate quality.**

94. Can we get total script counts broken out by MOD/retail in order to provide a competitive quote. We see there is Walgreen data but it is drug name and number of total tablets dispensed.

**Proposers should provide ingredient pricing for unit of dosing or per day of therapy.**

95. Claims data request – see attached. The most important aspect of this request is providing quantity information, current formulary status, and Rx Count (as the last two would allow us to perform a formulary impact analysis).

**The list of prescriptions is a sample listing of high volume and high cost prescriptions. Proposers are requested to provide ingredient cost per unit and formulary status on these drugs. Proposers are also requested to provide a complete formulary in a manipulable excel format.**

96. Regarding the following questions, what is this information to be based on?

**Provide your proposed ingredient cost and dispensing fees for brand name drugs. Are these costs/fees guaranteed for a minimum of three years?**

Retail 30  
Retail 90  
Mail Order  
Specialty Drugs

Refer to response to Question 72 of this Addendum. Proposer to indicate if the pricing structure proposed is guaranteed.

**Provide your proposed ingredient cost and dispensing fees for generic drugs. Are these costs/fees guaranteed for a minimum of three years?**

Retail 30  
Retail 90  
Mail Order  
Specialty Drugs

Refer to response to Question 72 of this Addendum. Proposer to indicate if the pricing structure proposed is guaranteed.

97. Is monthly billing a requirement, or is OCPS willing to accept a bi-monthly billing schedule?

**Billing statements must be submitted monthly in a format acceptable to OCPS.**

**Can be submitted bi-monthly with appropriate backup.**

98. Please confirm that the PBM may make additions to the formulary at any time of the year, with additions only occurring once a year per calendar year.

**Maintain a constant formulary for a minimum of 12 months, unless FDA changes occur within the 12 months (no mid-year changes)**

**OCPS will entertain formulary changes that improve costs but these changes would need to be discussed with OCPS and be done with their consent in advance of any change.**

99. Please confirm whether the data will be sent via FTP, CD delivery or secure e-mail.

**Provide a monthly data dump of all claims data and eligibility data to OCPS designated Consultant, Actuary or other vendor hired by OCPS.**

**OCPS uses real time, raw claims data for various projects and audits. The data must be provided in a format acceptable by the OCPS designated consultant, actuary, etc. who will be using the data.**

100. The Sample Agreement makes a few references to "Exhibit C." Where is this exhibit located?

**Exhibit C as referenced in the Sample Agreement refers to the pricing terms that will be negotiated and included in the final agreement.**

101. Clarify if the 12 months of constant formulary is over a calendar year or plan year? i.e. if the formulary remains constant from Jan - Dec, is that acceptable?

**ALSO - can drugs be moved to a lower tier (better for the member) within this time period?**

**OCPS will accept changes once per year on a Plan Year or Calendar basis. Refer to response to Question 98 of this Addendum for additional detail.**

102. Is it possible to obtain a copy of the RFP in Microsoft Word format?

**The RFP cannot be provided in Word format for integrity reasons. However, the Appendices have been converted to Word Format and are available at [www.procurement.ocps.net](http://www.procurement.ocps.net) and [www.demandstar.com](http://www.demandstar.com)**

103. In the following question, please explain what "no balance billing" means from a PBM perspective.

**Proposers will agree to no balance billing to OCPS members who receive services from in-network providers.**

**This applies more to medical providers (non-pharmacies). But in the context of the PBM, network pharmacies may not bill participants the difference between the non-discounted cost and the discounted cost.**

104. PBM postage responsibility - ask if this is on standard programs, or will it also apply to customized plan requests over the life of the contract?

**i.e. on Mandatory 90 mailing that was not part of the original bid, would proposer be able to charge additional postage costs?**

**Refer to the response to Question 80 of this Addendum.**

105. Define "maximize employee participation" in the PBM role for the bi-annual member survey. Will the plan define methods to use, or is it at our discretion?

**Refer to response to Question 42 of this Addendum.**

106. Clarify monthly data dump of claims and eligibility to vendors. What is the expectation of an ELIGIBILITY dump to another vendor?

**No PDF files will be acceptable. The data provided must be able to be manipulated and acceptable to all parties. Refer to attached file format for eligibility.**

107. Can we submit 2 separate bids addressing the admin fee? One would be all services inclusive and one would be straight admin fee with FFS pricing on other services.

**Proposers may submit additional proposals showing FFS pricing in addition to all inclusive pricing on a PMPM basis for each component with the exception of Behavioral Health/EAP.**

108. When referring to Central Florida for reporting purposes, what counties are included?

**Refer to page 6 of the RFP, Section 1.0 (H).**

109. Is Orlando Behavioral Health (OBH) required as part of the network in the behavioral health and employee assistance program?

**Refer to response to Question 54 of this Addendum.**

110. Are there two starting dates for the PBM: 10/1 and 7/1 and are there any other services with the option of two starting dates?

**Proposers submitting proposals for PBM services are to reflect two possible effective dates as noted. And “No”, no other component has the option of two different effective dates.**

111. Page 24 D. What does it mean with the requirement that OCPS cannot represent more than 25% of a proposer's business? Is it for the Orlando area, Florida or national?

**25% of National membership.**

112. Do the bed days outlined on page 114 in the Risk for Performance section refer to Disease Management proposals?

**“No”, those are in reference to the group ASO medical section and it applies to the utilization management of inpatient bed days. However, OCPS expects effective Disease Management will reduce bed days, ER visits, etc. All proposers are encouraged to offer Risk for Performance models in the Cost Worksheets with the administrative fees.**

113. Page 15 G. Postage costs are to be paid by the Proposer. Does this mean all postage costs are to be assumed by the proposer?

**“Yes” all standard postage costs involved with providing quoted services are to be assumed by the proposer, such as notification of formulary changes, addition of step therapies, changes in drugs from brand to generic, etc. Any custom programs that require mailings or other non-standard communications are not expected to be included. These additional postage costs would be mutually agreed upon between OCPS and the vendor.**

114. What constitutes “dedicated personnel or a dedicated service group”? Suppose you have a group that services OCPS and another account, is that OK, or does the group have to solely service OCPS?

**“No” the dedicated personnel or dedicated service group can service accounts other than OCPS. OCPS wants specific contacts identified to service the account.**

115. Page 1 item P what does “maximizing employee participation”, mean?

**Assist OCPS in encouraging employees to complete an insurance benefit questionnaire which is done every two years and the results are shared with vendors. For example providing gift certificates for drawings is one example.**

116. Please explain what a dedicated onsite representative means? Are all components to have an onsite representative?

**This applies only to the Medical ASO section. OCPS is looking for the selected vendor to provide a full time on site Member Services Representative who will assist the staff in dealing with high level issues such as claim denials, benefit interpretation issues, etc. OCPS will supply the computer, chair, desk and office supplies for this person.**

117. Is the onsite representative to be available during the calendar year or just the school year?

**Available year round (12 months).**

118. Page 14Z What kind of data dump is required? Is data provided on a CD OK? Is FTP OK? Does OCPS use an aggregator?

**OCPS uses real time, raw claims data for various projects and audits. The data must be provided in a format acceptable by the OCPS designated consultant, actuary, etc. This may vary by who is using the data. Data dumps are expected monthly. OCPS does not use an aggregator.**

119. Clarify what it means where “no midyear formulary changes are allowed”? Is this calendar or plan year? Does this apply to additions or just deletions?

**Refer to response to Question 101 of this Addendum. OCPS will entertain formulary changes that improve costs but these changes would need to be discussed with OCPS and be done with their consent in advance of any change.**

120. Will OCPS entertain a fee-for-service PBM bid?

**Yes, in addition to an all inclusive administrative fee, but OCPS wants costs to be as predictable as possible over a three to five year period.**

121. What if there is a subsidiary of a parent company and the parent company has five or more years of experience; can the parent company’s experience count toward the experience of the subsidiary?

**The Proposing entity must have five or more year’s experience. If the proposing entity is the Subsidiary, then the Subsidiary must have five or more year’s experience.**

**All other Bid terms and conditions originally issued remain unchanged.**

SCHOOL BOARD OF ORANGE COUNTY, FLORIDA

By Nellie Nido  
Sr. Administrator, Procurement Services

Acknowledgement of Addendum by Respondent

The Respondent hereby acknowledges receipt of the following Addendum:

This addendum shall be completed and signed by an authorized representative and returned with the RFP submittal. If the RFP response has already been mailed, this addendum must be delivered to the above address in a sealed envelope clearly marked on the outside: “Addendum to RFP”, RFP title and number. The Acknowledgement of Addendum” receipt will become an integral part of the solicitation document. In acknowledging receipt of this Addendum, the undersigned understands and accepts the foregoing solicitation changes and clarifications.

All other bid terms, conditions, and specifications as originally issued remain unchanged.

\_\_\_\_\_  
Officer (or Principal) Title

\_\_\_\_\_  
Manual Signature Date

\_\_\_\_\_  
Company Name Address

\_\_\_\_\_  
Telephone Number Fax Number