ADDENDUM NO. 1

REQUEST FOR PROPOSALS 071-JJ10 FOR
DISTRICT HEALTHCARE BENEFIT PROGRAM
FOR
THE SCHOOL BOARD OF MIAMI-DADE COUNTY, FLORIDA

PURPOSE OF ADDENDUM

This Addendum has been prepared to advise proposers of updated proposal documents.

ACKNOWLEDGMENT OF ADDENDUM TO RFP

As required in the RFP, Section II Carrier Specifications, proposers are reminded that they should either acknowledge receipt of this Addendum on their proposal, or attach this Addendum to their proposal.

STATUS OF ADDENDUM

To date, this is the first Addendum that has been issued for the Request for Proposals #071-JJ10, District Healthcare Benefit Program.

All addenda may be accessed the district's website at:
http://procurement.dadeschools.net/bidsol/asp/undercone_QA.asp, under RFP 071-JJ10.

PLEASE NOTE: The following files are now available on the website specified above.

- 2009 Premium versus Claims report through March 31, 2009
- Additional pharmacy reports including:
    - Pharmacy and Drug Tier Match Exhibits 12-14 – revised 4-28-09.xls
    - Rx Utilization Report for UHC non-NHP CY2008.xls
    - Rx Utilization Report for UHC NHP CY2008.xls
    - Year End Rx Report for MDCPS UHC Plans Only (no NHP).xls
- Medical Provider Disruption Exhibits 8-9 REVISED.xls (corrects Disruption Exhibit 9a)

A good faith attempt will be made to deliver a copy of this addendum to those persons or firms who, according to the records of Procurement Management Services, have previously received a copy of this RFP.

1. We are in the process of responding to your request for healthcare benefits proposal, and came across some discrepancies in one of the files provided. In the provider listing for the medical disruption analysis, there are numerous Tax Id's and addresses that do not match the associated provider name.

   See Medical Provider Disruption Exhibits 8-9 REVISED.xls

2. I am reaching out to you for clarification regarding the claims data to be provided for the Miami-Dade County Public Schools RFP for PBM Services. Can you please advise if we should expect to receive detailed claims data, to include the NDC 11 and Pharmacy codes? Is so, can you please advise when to expect this information, the format, as well as the method of delivery?

   See the following attached reports:
   - *Rx Utilization Report for UHC non-NHP CY2008.xls*
   - *Rx Utilization Report for UHC NHP CY2008.xls*

3. Question 175 on page 71 starts with "M-DCPS wishes to obtain all proposals on a traditional basis," however the bullet points that follow seem to describe a transparent arrangement. Can you please confirm whether Miami Dade County Public Schools is seeking a traditional financial offer, a transparent financial offer, or both?

   You are correct. The requested pricing is more appropriately called "transparent" or "pass through." However you define it, the instructions are clear as to how M-DCPS wishes you to propose discounts, rebates and the release of information.

4. Will there be any bidders' conferences being held?

   No.

5. Will you be providing detailed claims data with unique member identifier, pharmacy NABP, and NDC 11? If detail data is not available, will you be providing a breakdown of the number and cost of claims by mail, retail, brand, and generic?

   See the following reports:
   - *Rx Utilization Report for UHC non-NHP CY2008.xls*
   - *Rx Utilization Report for UHC NHP CY2008.xls*

6. Please describe any programs the account may have in place to drive mail utilization (e.g. mandatory mail after so many retail fills, etc.). For this proposal, is the account interested in any programs to drive mail utilization? 90 day fulfillment at retail?

M-DCPS does not have a mandatory mail program with UHC. M-DCPS does have a mail promotion letter program where targeted members are mailed a letter informing them of the specific cost saving opportunity based on their medications (such as maintenance drugs) and their employer's benefit plans. The letter informs members on how to begin using the mail order pharmacy.

You may propose cost cutting programs along these lines to the extent they are voluntary from the member's perspective and clearly outlined in your proposal. If M-DCPS elects not to implement these programs, your proposed financial arrangement must remain firm.

7. Please describe any programs the account may have in place to drive generics utilization. For this proposal, is the account interested in any programs to drive generics utilization?

   M-DCPS utilizes a number of programs to drive generic utilization. Examples include plan design (10/30/50), automatic generic substitution where appropriate, targeted generic medication letter campaigns, and online pharmacy resources via myuhc.com

   You may propose cost cutting programs along these lines to the extent they are voluntary from the member's perspective and clearly outlined in your proposal. If M-DCPS elects not to implement these programs, your proposed financial arrangement must remain firm.

8. Please describe any step therapy or prior authorization programs the account may have in place. If there are step edits in place can you please provide details on the programs (i.e., what product does the step edit drive utilization to, what products are subject to the step edit)? Is the account interested in any programs for this proposal for step therapy and/or prior authorization?

   Currently, M-DCPS does not utilize any step therapy programs. A Notification Program, an alternative to traditional prior authorization programs, is in place. Some of the therapeutic classes for Notification include growth hormones, immunomodulators, retinoids, and androgenic hormone inhibitors.

   You may propose cost cutting programs along these lines to the extent they are voluntary from the member's perspective and clearly outlined in your proposal. If M-DCPS elects not to implement these programs, your proposed financial arrangement must remain firm.

9. What clinical pharmacy programs/edits does the account currently have in place? Please provide details of such programs.

   M-DCPS utilizes concurrent DUR, retrospective DUR, quantity limits, and prior authorization. The table below provides more details.

Program Name	***Program Description***
Concurrent DUR ■ *Severe drug interactions* ■ *Excessive dosing* ■ *Refill too soon* ■ *Lethal-dose chemotherapy* ■ *Drug-drug interactions* ■ *Drug-age Interactions* ■ *Drug-disease inferred* ■ *Duplicate therapy* ■ *Duplicate claim* ■ *Underutilization* ■ *Under minimum dose* ■ *Drug allergy interactions* ■ *Drug-gender interactions* ■ *Drug-pregnancy interactions* ■ *Drug name confusion*	*The concurrent DUR program performs online, real-time DUR analysis at the point of dispensing, both in the retail pharmacy and mail service pharmacy environments. A clinical database is used to compare the current prescription to the member's inferred diagnosis, demographic data and prescription history. Specific criteria are used to evaluate potential inappropriate drug consumption and dangerous medical conflicts or drug interactions that may result if the prescription is dispensed.*
Standard Notification (Prior Authorization)	*Notification is a point-of-service program designed to support the pharmacy benefit. For certain drugs, physicians are required to provide additional information to our Coverage Review Unit in order to determine if coverage is consistent with the member's benefit design. Notification does not involve medical necessity review, but instead leaves the decision of when and how a drug should be used to the physician and the member. Standard notification includes several drug classes/categories, such as antiemetics, alfa-interferons and ribavirin, and growth hormone.*
Standard Quantity per Duration (QD)	*There are some medications that are subject to QD limits based on the manufacturer's package size, FDA-approved dosing guidelines and/or medical literature. The edits are designed to limit the quantity of medication dispensed within a certain period of time (e.g., 31 or 34 days). Standard QD includes several drug classes/categories, such as COX-IIs, erectile dysfunction, statins, triptans, sedative-hypnotics and Oxycontin/narcotics.*
Standard Quantity Level Limits (QLL)	*Certain medications may be subject to QLLs based on the manufacturer's package size, FDA-approved dosing guidelines and/or medical literature. The program establishes a maximum quantity per prescription or copayment. If the member's prescription exceeds the limit, the claim is stopped at the point of service, and the QLL amount is recommended.*

Program Name	***Program Description***
Retrospective DUR	*The retrospective DUR program consists of a quarterly review of prescription claims data in order to identify prescribing and/or utilization patterns that may indicate inappropriate medication use. A clinical database is used to review profiles for drug quantity considerations, dose and duration considerations, therapeutic duplications and potential misuse and abuse. Physicians receive a member-specific information package that identifies potentially inappropriate patterns of drug utilization and provides information regarding current treatment guidelines published in medical literature.*

You may propose cost cutting programs along these lines to the extent they are voluntary from the member's perspective and clearly outlined in your proposal. If M-DCPS elects not to implement these programs, your proposed financial arrangement must remain firm.

10. Is the plan sponsor interested in a restricted retail network to offer?

Not at this time.

11. Please describe any programs the account may have in place for specialty drug management. Does the account currently have an exclusive Specialty network? Is the account interested in any programs for this proposal to support specialty drug management? Is the account interested in an exclusive specialty network?

M-DCPS currently utilizes an exclusive Specialty network. The specialty pharmacy program is fully integrated to focus on high cost medications in both the medical and pharmacy benefit. This program offers adherence and education programs, utilization management and specialty care and disease management programs. In addition, for specialty drugs covered under the medical benefit, UHC offers several integrated drug and disease management programs. All of UHC's specialty programs are based on medical evidence, clinical criteria and best practices for medication and disease management.

ADHERENCE AND EDUCATION PROGRAMS

Adherence and educational programs are provided for all of UHC's specialty therapeutic classes. UHC's specialty vendors offer monthly refill reminder calls to schedule a member's next fill. They also inquire about remaining days' supply to proactively identify potential non-adherence and provide interventions such as education and counseling as necessary, if non-adherence is detected.

UHC tracks member utilization and adherence rates to compare them against groups with the same disease states that are not using the specialty retail network as well as to benchmark UHC's specialty vendors. UHC's analyses show a notable increase in

adherence rates for members using UHC's specialty network. For example, members with a transplant who use UHC's specialty retail network experienced an 88 percent adherence rate as compared with only 69 percent or 73 percent for members using the two most common retail pharmacies.

UHC's contracted specialty pharmacies also offer optimal clinical oversight. Pharmacists and nurses provide extensive member education and interventions as necessary. Educational materials are available in both print and Web-based formats. Additionally, UHC's specialty partners will provide training kits upon request.

Finally, laboratory test validation is conducted for medications in the therapeutic categories of anemia, oncology and growth hormone deficiency. UHC's specialty pharmacy partners offer numerous care and disease management programs for select disease states that require additional clinical education, support and ongoing monitoring to produce optimal outcomes. The specialty pharmacy care and disease management programs integrate with medical disease management programs where applicable. For specialty medications covered under the medical benefit, UHPS offers several drug and disease management programs that target the use of specific drugs to ensure clinically-appropriate prescribing and utilization.

You may propose cost cutting programs along these lines to the extent they are voluntary from the member's perspective and clearly outlined in your proposal. If M-DCPS elects not to implement these programs, your proposed financial arrangement must remain firm.

12. Is Miami Dade County Public Schools an ERISA account?

    No.

13. Can you submit the RFP and questionnaire in Microsoft Word format?

    Yes but hard copies must also be submitted.

14. In regards to question #16 in the questionnaire on page 23: "Medical vendor must agree to provide M-DCPS with funding for medical plan administration at M-DCPS' Risk Management Office. Vendor will provide funds in the amount of $2.50 Per Subscriber Per Year as of March 31st of each plan year.

    Please clarify what the medical plan administration includes.

    In this case, Medical Plan Administration refers to internal District administrative functions.

15. In regards to #18 on the questionnaire on page 23: "Proposer agrees to work with the TPA to update and approve all relevant pages of the employee benefit notebook. <u>Proposer also agrees to pay for their pages in the employee benefit notebook annually.</u>

How much was the expense for this last, year?

At this time, the District is not producing printed copies of the notebook. There is no charge to the vendors for production of the electronic version of the notebook.

16. Can we produce trade secret materials in a separate envelope to protect proprietary information?

    No. See "Public Records Law" on page 20 of RFP 071-JJ10.

17. Are there any custom forms used by M-DCPS for enrollment or other administrative functions? Can the carrier use its own forms?

    In general, the District utilizes on-line enrollment for its employees. When paper enrollment is required, the District uses its own forms.

18. Are there multiple agencies that have separate eligibility files? How many eligibility files will be sent for interface?

    FBMC is the source for all eligibility data.

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

    The Certificates of Coverage (COC) are posted on the District's website and are not mailed to employees unless they request it. Florida requires that HMO COCs must be made available within 30 days of the plan's effective date.

20. Can we have a copy of the existing stop loss contract?

    The District does not have stop loss in place for its fully insured employee healthcare plans.

21. What are the current stop loss ISL and ASL levels?

    The District does not have stop loss in place for its fully insured employee healthcare plans. In addition, internal pooling was eliminated in the 2009 renewal.

22. Who is the current stop loss vendor?

    The District does not have stop loss in place for its fully insured employee healthcare plans.

23. Should questionnaire responses focus only on the active medical plans or should retiree responses be included as well?

Responses should apply to active and retired employees,

24. Are the current M-DCPS claim files for the same population/plans as the claim lag reports provided?

    There was no claim lag for the PPO, and when comparing the PvC to the claim lag, the claim lag for POS only includes CHOICE PLUS HMO (POS), where the majority of POS members are enrolled. When comparing the PvC to the claim lags for 2008, we find the claims lags to be within 1% of claims + other payments + capitations.

25. Please provide identifiers for each suffix account combination provided with the experience (e.g. AA 0027 = Active or retiree in a PPO).

    The file entitled MDCPS Membership By Month 2007-2008.xls provides the complete account structure.

26. Page 33, #11 - Please define the electronic experience and utilization reports referenced.

    This refers to a Proposer's ability to provide on-line access to experience and utilization data.

27. Page 59, #96 - Please define "special enrollment provisions."

    Refer to the HIPAA regulations.

28. Page 62, #111- Please define "change in applicable network composition."

    Any major change in the network of providers offered to the District's eligible employees and retirees.

29. Page 12, Authorized Signature - Will M-DCPS accept the signature of an employee authorized to bind the company instead of a duly authorized Officer?

    No.

30. Section G. Quality Assurance, Q. 67 -- eValue8TM scoring evaluation: Please state whether the eValue8 scoring evaluation relates to PBM bidders, and if so, please describe the eValue8 process as it relates to this RFP.

    eValue8 is intended for health plans – not PBMs.

31. Section III. Performance Guarantees: Please indicate whether the Claim Turnaround Time (TAT) relates to PBM bidders since 99% of pharmacy claims are electronically adjudicated on-line at point of sale.

This is not applicable to PBMs.

32. Section III. Performance Guarantees: Please indicate if Provider Network: PCP physician turnover relates to PBM bidders.

    This is not applicable to PBMs.

33. Section VII. Financial Bid Response Exhibits. Please confirm that PBM bidders should submit only the General questions (Section VIII), PBM Questionnaire, Pharmacy Network and Formulary Exhibits 10-14B, Financial Exhibits 23-25, PBM Non-Financial Exhibits 34-36, and Additional Attachments Requiring a Response.

    Bidders must complete Proposal Specifications questions 1-67, performance guarantees, Sections V (plan design), VI (network), and VII (financials), noting N/A for medical only questions/exhibits, in addition to those noted below (section VIII 1-101, PBM questionnaire). The exhibits for PBMs are 1-5 (plan design), 10-11 (network access), 23-25 (financials), 34-36 (non-financials), 12-14 (pharmacy and drug tier disruption).

34. Section VII. Financial Bid Response Exhibits. Financial Questions #4 - "Confirm that all fees and premiums can be paid within a 30-day grace period without penalty." Please confirm that pharmacy claims reimbursement billing is not subject to the 30-day grace period without penalty.

    Confirmed.

35. Section VII. Financial Bid Response Exhibits. Financial Questions #10 -"Please provide a detailed illustration of your underwriting to develop the self funded claims projections…" Please confirm that the 16 sub-points in Question 10 are not applicable to PBM bidders, or if any are so, please indicate which are applicable.

    Not confirmed. We are asking the PBMs to provide an Rx claim projection as well. To the extent that a sub-bullet is not applicable, you may exclude it from your claim projection response.

36. Section VII. Financial Bid Response Exhibits. Financial Questions #12 – "What is your estimated claims cost percent increase to waive all member cost sharing… " Please indicate which, if any, of these sub-points a-d, are applicable to PBM bidders.

    This is not applicable to PBMs.

37. Section VII, Financial Bid Response Exhibits. Financial Questions #14 - "Please confirm that your proposal includes coverage for procedures to treat morbid obesity. Please indicate if this is applicable to PBM bidders.

    This is not applicable to PBMs.

38. Section VIII. General Questions. Provider Network. Q. 36 - "Describe your ability to offer tiered networks in the south Florida marketplace." Please describe how this question might be applicable to pharmacy networks.

This is not applicable to PBMs.

39. Section VIII. General Questions- Reporting. Q. 48. "Confirm that your proposal includes the cost of providing monthly stop loss reports to a third party stop loss reinsurer." Please indicate if this is applicable to PBM bidders, and if so, describe what specific information would be desired.

You will be required to provide reporting of member name/number, Rx utilization data, and paid claim amounts to the stop loss carrier for the highest paid M-DCPS members on an annual basis or more frequently (depending on the frequency and size of catastrophic Rx claim utilization).

40. Section VIII. General Questions. Reporting. Q. 49. "Confirm that you will, on a monthly basis, discuss large claim activity with M-DCPS... " Please indicate if this is applicable to PBM bidders, and if so, what would be the threshold for a large pharmacy claim.

PBMs should be prepared to make large claim reports available to M-DCPS on a monthly basis. Reports should include scrambled member ID, paid amount, and drug utilization data, by member, for all members with $25,000 or more in Rx claims in the prior month as well as year to date totals.

41. Section VIII. General Questions. Customer/Member Service Q. 64. The vendor(s) must provide M-DCPS with a dedicated member service team... " Please define "dedicated." May the dedicated team field other plans' calls when not answering M-DCPS' calls?

Yes.

42. Section VII. General Questions. Communications. Q. 87. "The vendor(s) must obtain M-DCPS' approval prior to the distribution of any member communication materials." For the purposes of this procurement, please indicate whether M-DCPS would exempt emergency communication e.g. drug recall notices from the PBM's mail service pharmacy, from this approval requirement.

Confirmed.

43. Section VIII. General Questions. Communications. Q. 90. "The vendor(s) will be responsible for bearing the cost of drafting (both initial and final) Summary Plan Descriptions (SPDs) for various plans ..." Please indicate if there will be a separate SPD for the pharmacy benefit if carved out of PBM. If not, please indicate what portion the PBM bidder will be responsible for, including postage costs.

We do not anticipate requiring a separate SPD or COC for pharmacy benefits.

44. PBM Questionnaire. Q. 175. " At the close of each plan year, the successful bidder will report the total pharmaceutical revenue generated from M-DCPS's claims (base rebates, market share rebates, rebate administrative fees, data sharing fees, etc.) and compare this to the minimum guaranteed rebates and reconcile any differences between each."

    Please explain how this comparison is to be performed, specifying what the comparison is between.

    The text to this bullet point is corrected as follows:

    "At the close of each plan year, the successful bidder will report the total pharmaceutical revenue generated from M-DCPS's claims (base rebates, market share rebates, rebate administrative fees, data sharing fees, etc.) and compare this to the minimum guaranteed rebates and reconcile any differences between each."

45. PBM Questionnaire. Formulary. Q. 186. "Vendor agrees to move immediately to the formulary third tier any prescription for which a generic drug becomes available." Please indicate what timeframe would be acceptable as "immediately"

    Within 30 days of the generic becoming available.

46. Current Wellness Programs - Please confirm that PBM bidders are not to include Wellness and/or Disease Management questions 248-259 in their responses

    This is not applicable to PBMs.

47. Would M-DCPS please provide summary pharmacy utilization data, e.g. retail and mail claims utilization for 2008, brand and generic claims utilization for 2008, etc.?

    See the following reports:
    - *Rx Utilization Report for UHC non-NHP CY2008.xls*
    - *Rx Utilization Report for UHC NHP CY2008.xls*

48. Would M-DCPS provide blinded patient-level detailed 2008 pharmacy claims data for analysis and recommended utilization management strategies?

    M-DCPS may consider releasing this data to the winning PBM or health plan.

49. PBM Questionnaire, Q. 175. Please describe the pharmacy pricing at retail M-DCPS would like to see. The description here sounds as though pass through pricing is preferred, but is called Traditional pricing.

    The requested pricing is more appropriately called transparent or "pass through."

50. We would like to respond to your RFP for Exhibit 4A Medicare Supplement Plans. At the

other 40+ School Boards and Counties we are using the Model Medicare Supplements commonly seen in the Chart A-J, but the format of your plan design seems to follow that normally seen in an HMO, PPO, etc. with details about Deductibles, Co-pays and out of pocket, etc. The Medicare Supplements A-J, specifically C, F & J, require No deductible, no co-pay and no out of pocket.

When I look at your AARP exhibit 4b I see a request more typical of a Medicare Supplement, i.e., no deductible, no co-pays, no out of pocket etc.

So, are you looking for something unique on the 4a Medicare supplement vs. the 10 Models A-J.

Also, the RFP asks us to try and match your current plans as close as possible, but I do not see a copy of your current Medicare Supplement plans.

Where do we go to see:
1. Current Carrier
2. Plans Offered
3. Rates

The current programs for Medicare-eligible retirees are listed on page 6 of the RFP. The current carrier is United Healthcare. Plan designs and rates for the programs are contained in attachments to the RFP. The District is requesting proposals in accordance with the "Purpose of Solicitation" section on page 6 of the RFP.

51. Currently only summary data has been provided, is claim level data available that includes:

- Date of Service
- Mail / Retail Indicator
- NDC11
- Quantity Filled
- Days Supply
- Patient Identifiers
- Ingredient Cost
- Dispensing Fee
- Copay/ Coinsurance
- Deductible
- U&C Price
- NABP
- Formulary Indicator

See the following reports:
- *Rx Utilization Report for UHC non-NHP CY2008.xls*
- *Rx Utilization Report for UHC NHP CY2008.xls*

52. Are there any union groups that are included in the Miami-Dade Public Schools request for proposal?

Yes. See page 4 of RFP 071-JJ10.

53. Can you provide the current mail penetration rate?

Refer to the data disclosed in the RFP and Addendum.

54. Can you provide the current generic dispensing rate?

Refer to the data disclosed in the RFP and Addendum.

55. Can you provide a list of pharmacy related clinical programs currently in effect through current pharmacy program?

Previously answered.

56. What is the main or underlying reason that M-DCPS has decided to change the current benefits set up and take the program out to bid?

The District wishes to move from a fully-insured (guaranteed cost) funding arrangement to a self-insured arrangement.

57. On page #72 of the RFP document states that M-DCPS wants a traditional pricing proposal but the bullet points underneath describes a pass through pricing model, we just want to clarify with M-DCPS that you want a pure pass through/admin fee only pricing offer?

The requested pricing is more appropriately called transparent or "pass through."

58. Does M-DCPS need a 90 day retail network pharmacy option included in our response?

This is not required.

59. Please confirm that the entire population is covered under the 3 tier plan described in the RFP document.

Confirmed. However, retirees enrolled in a Medicare Advantage plan have different benefits.

60. Are any members covered under a consumer driven health plan (CDHP)?

No.

61. Are there any commissions to be included in the bid?

M-DCPS recognizes the existence of Florida Statutes, Section 624.1275. M-DCPS requires full and total transparency in its vendor relationships. Therefore, any commission, service fee or other form of remuneration paid to any agent, broker, lobbyist or third party must be identified in the proposal and throughout the term of the contract.

62. Do you require a custom formulary?

M-DCPS reserves the right to customize the formulary.

63. Please confirm the exact number of Medicare part D members covered under the plan.

All pharmacy benefits offered retirees are "creditable" as defined in the Medicare Modernization Act of 2003. As for the number of true Medicare Part D members, there are none that we are aware of.

64. Are detailed pharmacy claims available for at least 12 months? Member specific is preferred:

- Unique Patient identifier
- DOB of the member
- NDC11#
- NABP/NCPDP #
- Mail/Retail Indicator
- Brand/Generic
- Date of Service
- Days Supply
- Qty dispensed
- AWP
- Copay
- Prescriber ID

If member specific is not available can summary data be provided including Retail / Mail GDR's.

See the following reports:

- *Rx Utilization Report for UHC non-NHP CY2008.xls*
- *Rx Utilization Report for UHC NHP CY2008.xls*

65. Is MDCPS interested in a 90 Day Retail Benefit option?

Not at this time.

66. Is MDCPS interested in mandatory mail?

Not at this time.

67. Can you confirm the number of covered members?

Refer to the file MDCPS Membership by Month 2007-2008.xls.

68. What clinical programs are in place and what additional clinical programs are of interest?

Previously answered.

69. How is specialty covered? Is there different copay?

Subscribers call Medco regarding specialty drugs and are then transferred to the specific specialty area. Specialty drugs are covered the same as regular prescription with the same 3-tier co-payments for the medication. Self injectables require a 25% co-payment with a $250 per month maximum under the NHP gatekeeper plan except for diabetic drugs. The medical equipment components fall under DME.

70. Page 23, question 16. Item states that vendor will provide funds in the amount of $2.50 per active EE or retiree per year each plan year. Please clarify "medical plan administration". Will these funds be used for wellness services or a wellness coordinator at the District, member incentives, enrollment, etc.?

In this case, Medical Plan Administration refers to internal District administrative functions.

71. Page 26, question 37. Any changes to key staff must be done with 30 days notice and with the approval of M-DCPS. Please define key staff.

All client-facing personnel.

72. Page 27, question 48. Vendors(s) must retain all fiduciary responsibilities, including, but not limited to responsibility for all appeals. Vendors must be responsible for HIPAA administration (notification and certificate of coverage). Any cost associated with responsibility must be included in the administrative fees exhibit contained within the Financials Exhibits attachment. Please clarify what level of fiduciary responsibility you are asking the vendor to accept. What additional services outside of HIPAA and appeals is M-DCPS looking for?

Proposers must offer all services required to exercise fiduciary responsibilities for the District.

73. Page 28, Section E. Please clarify as the Paragraph E reads: "The vendor(s) must be able to accept all definitions without exception, <u>and accept responsibility</u> for coverage eligibility verification." However, question 52 directly below goes on to state that eligibility verification will be the <u>responsibility of Fringe Benefits Management Company (FBMC).</u> Please confirm who has responsibility for eligibility verification.

The vendor(s) is/are responsible for coverage eligibility verification. FBMC transmits weekly feeds of eligibility data to the vendor(s).

74. Page 30, question 66b. Beneficiary reports that track improvements or deterioration in our member's health status (wellness program). Please clarify the statement. How do you define a member's health status?

    This question asks you to describe your wellness reporting and longitudinal tracking capabilities. Carriers define health status differently – provide us with your definition.

75. Page 40, question 7. Confirm that your first year ASO fee proposal reflects MATURE fees.

    Please clarify this is to process the 12 month member submitted run-out claims as is detailed on page 79 # 240 Administrative fees - item d).

    Confirmed.

76. Page 42, question 23. Will you allow retirees who are entitled to Medicare but not yet age 65 to enroll in either your insured Medicare HMO or insured Medicare Supplement PPO plans? Please clarify if M-DCPS is referring to the non-differential PPO plan UHC currently has in place. If not, then what is considered the insured Medicare Supplement PPO plan?

    The current AARP Medicare Advantage PPO plan does not allow retirees under the age of 65 to enroll. We are asking the Proposers if their proposed Medicare Advantage PPO or PFFS plans will allow these retires to enroll.

77. Page 58, question 87. The vendor(s) is responsible for all costs of producing, printing and mailing/distributing adequate quantities of administrative supplies as designated by M-DCPS. The format and content of all materials used for the M-DCPS account must be satisfactory to M-DCPS. Please clarify "administrative supplies", estimated quantities and frequency.

    Administrative supplies consist of office supplies for the onsite representatives (pens, staplers, paper clips, toner for fax machine, etc.), claim forms, flyers of educational materials for retiree presentations at 3 locations each June, wellness materials/posters, etc.

78. Page 59, question 90. The vendor(s) will be responsible for bearing the cost of drafting (both initial and final) Summary Plan Descriptions (SPDs) for the various plans. The vendor(s) will also be responsible for the cost of printing and mailing the SPDs directly to member homes. Currently COCs are available online with the current vendor. Please clarify if M-DCPS will require mailing of SPDs to member's

homes. If so, please state how often.

Currently, the carrier is required to mail printed COCs only when a request for one is made by an employee or retiree.

79. Page 59, question 92. The medical vendor will provide enrollment kits including directories of participating providers. Current carrier participates in the M-DCPS Enrollment Notebook and does not provide enrollment kits. Please confirm that M-DCPS is requesting enrollment kits with directories. Also confirm what else would be included in the kits and the quantity, including frequency. Will these kits be bulk shipped or mailed to member's homes?

Currently, enrollment kits are not being utilized.

80. Page 59, question 93. The vendor(s) will provide all necessary materials according to a schedule stipulated by M-DCPS. Please clarify the statement. What type of schedule? Provide definition of necessary materials

A schedule will be developed during the implementation process as well as selection of necessary materials.

81. Page 64, question 123. Describe your capabilities related to the establishment of on-site clinics for M-DCPS. Please describe the scale of services that M-DCPS is interested in for on-site clinics?

On-site clinics are generally primary care clinics and may or may not have laboratory and imaging capabilities.

82. General: We received a blue envelope which directs us to provide the original RFP sealed within this envelope. Given the request of 4 originals and the anticipated size of the documents, is it possible to submit in an alter fashion (such as a box or larger envelope) with the required blue envelope sealed on top?

Yes.

83. Split Enrollment: Please advise - is the intention of M-DCPS to have the accumulators for deductible and out of pocket maximums roll up to an overriding family maximum?

No.

84. Split Enrollment: When members elect this option, is it the intention of M-DCPS that the selected carrier is able to tie the dependents to the subscriber for Member Service calls? In other words - when the current subscriber calls member services regarding their benefits is the carrier representative able to easily see that the dependents are on another plan?

Yes.

85. Claims Data: In the interest of producing our most accurate possible claims project, may we receive a claims dump (all claims on a claim by claim basis) of the most recent 12 months?

No.

86. Claims Data: In the interest of producing our most accurate possible claims project, then may we receive claims utilization by facility (hospital, doctor, pharmacy, etc)?

We have requested these data from the incumbent and will post an addendum upon receipt if time permits.

87. Quote Requirements: If a carrier does not propose stop loss, then is the carrier automatically eliminated from consideration?

No.

88. Quote Requirements: May a carrier propose stop loss with limitations on maximum liability?

The District wishes to have stop loss coverage without limitations on maximum liability. .

89. Plan Designs: If a carrier does not propose a Hospital Confinement Plan Design, will the medical quote still be accepted?

Yes.

90. Medicare: Does M-DCPS prefer to have different benefits for Broward and Miami Dade County? If not, which benefit would M-DCPS prefer Humana to match with our proposal?

Yes. Different benefit levels by County are acceptable.

91. Please provide a job description for the requested service representative. (page 23, #15).

Job requirements include, but are not limited to, the following:

- *Answer telephonic and walk-in inquiries involving verification of coverage, claims, covered benefits, ID cards*
- *Assistance with employees' enrollment during Open enrollment period and throughout the year (new hires, etc.)*
- *Handling enrollment of retirees and mailing out retiree packages*
- *Handling enrollment of part-time employees who have access to District's*

program

- *Billing for the Florida mandated adult child (25-30) participants*
- *Processing of COBRA applications for coverage*
- *Handling change in status urgent issues (eg. Newborns)*
- *Administer Florida Retirement System (FRS) deductions*
- *Reconciliation of FBMC enrollment files with carrier information*

92. Please provide the percent of claims flowed through the Baptist Hospital.

The following claim data represents paid claims from calendar year 2008 (pulled from the medical disruption reports and reflective of the plans included therein). Bidders can calculate their own estimate of the percent of total paid claims represented by Baptist.

UHC
BAPTIST HOSPITAL $22,711,101
BAPTIST MEDICAL CENTER $41,402
Total $22,752,502

NHP
BAPTIST OUTPATIENT SERVICES, INC.: $1,742,008
BAPTIST HOSPITAL: $4,585,394
Total $6,327,402

93. The current POS benefit plan shows "Prior Notification Required" for specific inpatient and outpatient services. Is prior notification similar to requiring authorization?

Yes.

94. Does M-DCPS provide EAP benefits?

M-DCPS offers an onsite EAP program and is not seeking to replace this program at this time. The EAP is intended to help employees and their families who are suffering from persistent problems that tend to jeopardize an employee's health and continued employment. The problems may include alcoholism, drug abuse, emotional or other concerns, such as health, family, stress, marital, financial, legal, or vocational difficulties. M-DCPS recognizes behavioral disorders and mental health problems as illnesses that can be successfully treated. The program goal is to help those individuals by providing consultation and referral to treatment and rehabilitation, in order to prevent their condition from progressing to a degree at which they cannot work effectively.

The primary objective of the EAP is to assist employees who need help in resolving their personal problems as soon as possible. When employees contact the program, a face to face conference will be scheduled; an Employee Assistance professional will assess the problem, discuss with employees available alternatives for solving the problem and then help employees find the best solutions. The EAP can help

employees gain some perspective, and refer to professional counseling. Employees' special needs (language, culture, geographic location) will be considered. Proposals to replace the current EAP program will not be considered.

95. Will a Cancer policy fall in the category of Hospital Indemnity Benefits?

    No.

96. The current POS and HMOs include a vision benefit. Must we include this in our proposal?

    We request that bidders match the existing plan designs as closely as possible. Any deviations should be identified as instructed in the plan design bid form exhibits.

97. Exhibit 31 lacks the HealthSouth Rehab Tax ID Number. What is it?

    630860407

98. Will Deloitte Consulting enter into a confidentiality agreement regarding the data requested?

    No. All data is ultimately subject to the FL Sunshine laws.