DEPARTMENT OF
BUDGET & MANAGEMENT

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Q & A #3
to
REQUEST FOR PROPOSALS (RFP)
DPSCS INMATE MEDICAL HEALTH CARE AND UTILIZATION SERVICES
SOLICITATION NUMBER DPSCS Q0012013
NOVEMBER 12, 2011

Ladies and Gentlemen:

The following questions, for the above referenced RFP, were received by e-mail and are being answered and posted for all Offerors. The numerical sequencing begins with question #277; questions #5 through #276 were answered in Q&A #2, issued on November 4, 2011, and questions #1 through #4 were answered in Q&A #1, issued on July 21, 2011:

277. Question**:** RFP Pg. 158, Section 4.4, TAB T – Economic Benefit Factors: Providing the estimated dollars representing the economic benefit would produce a number very near the price proposal meaning pricing information would be available to the evaluation committee before the price proposal is opened. Did the State intend to ask for dollars or did it intend to ask for percentages of contract value?

Answer: As per Amendment #3, item 60, Tab T has been correctly relabeled as Tab W. For the purpose of determining Economic Benefit Factors, the State intended to ask for dollars. To answer why the provision of dollars will not in essence provide an Offeror's financial quote it is necessary to explain, as follows, certain particulars of how economic benefits for this procurement should be calculated, including certain aspects that should not be calculated.

First, the anticipated cost of off-site hospitalization ***should not*** be included in the benefits calculation. If an inmate requires treatment in a hospital setting the inmate will generally go to either a nearby hospital, or certain hospitals with agreements with the Department (Bon Secours, and Univ. of Md. hospitals). Any hospital that is used to treat inmates will be in Md., regardless of which offeror wins this contract. Vendors might negotiate an agreement to use a particular Maryland hospital over other Maryland hospitals when more than one hospital can be used within a geographic area, but that doesn't alter the fact that a Maryland hospital will be used because of geographic proximity. The use of Maryland hospitals is not a deliberate choice being made by offerors from among 2 choices, Maryland hospitals or out-of-state hospitals.

The number of Maryland resident employees working in Maryland under the contract if the Offeror is selected for award should be included, both in terms of the number of employees and the income and other tax revenue these employees will pay to Maryland and local subdivisions in Maryland. If there are any out-of-state employees (e.g., residents of W. Virginia, Pennsylvania, Delaware) who will be working under the contract these persons should be excluded from the employee count. Similarly, if these out-of-state employees pay income taxes etc. to their home state and not to Maryland any taxes paid by these persons should be excluded.

Gross total salaries paid to Maryland resident employees can be counted, including the value of fringe benefits. However, any overhead associated with these employees should not be included. e.g., if a firm apportions home/regional office support on the basis of direct labor hours, none of this overhead should be counted unless the home or regional office is in Maryland. Similarly, anticipated profit under this contract should not be counted unless it is known that the owners/stockholders of the offeror are located in Maryland, or only counted in proportion to the degree of ownership known to be attributable to Maryland resident owners or stockholders.

Since offeror are to establish several databases under the contract, including a new biometric timekeeping system, the value of these databases would only be counted if the vendor from whom the software is purchased or leased is a Maryland based vendor. If employees of the offeror develop any database in-house, or if the software was previously developed the value of such databases would only be counted if the personnel that created them are/were Maryland based, excluding employees working directly under the contract since these persons salaries would already have been reported and counted.

The value of any miscellaneous medical supplies (e.g., tongue depressors, latex gloves, bandages, splints) and durable medical equipment (e.g., wheelchairs, glasses) would only be counted to the extent these items are purchased from Maryland based vendors.

Any specialists or consultants to be used under the contract, including such persons that participate under the contract via teleconferencing, that are not located in Maryland cannot be counted.

Any training programs presented under the contract, whether to employees (e.g., in-service training) or Inmates (e.g., for women's health or Inmate workers) would only be countable if those programs were developed in Maryland. Also, any Maryland based personnel that present such training may be counted, excluding employees working directly under the contract since these persons salaries would already have been reported and counted.

Any claimed economic benefits for the three optional services should be described separately from the benefits claimed to be accrued under the main contract.

As per the economic benefit instructions in § 4.4 Tab W there should ***not*** be claims of overall cost savings benefiting Maryland because an offeror claims it can do a better job under the contract than any other offeror.

However, an offeror can count as economic benefit some action it will take if it is awarded the contract, even if the described benefit is not directly attributable to the contract. For instance, if an offeror contractually commits to open a Maryland regional office within 6 months of winning the contract, and maintain that office for the reminder of the contract, the value of the Maryland personnel who would staff that office can be counted, even if these persons do not directly work on the contract. Similarly, if an offeror commits to establish a Maryland based training academy whereby it will bring personnel from other locations into Maryland to be trained, even if those personnel do not end up working on the Maryland contract, the value of food, lodging, etc. for these personnel while they are in Maryland, and the value of Maryland resident instructors, etc. can be counted. An additional example might be a commitment if the Offeror is awarded the Contract to donate a certain amount to Maryland based charities, or establish a certain number and value of scholarships for colleges located in Maryland.

Based upon the answer to Question 33 in Q&A #2 that shows over $30 million was spent in each of 2009 and 2010 in offsite secondary care, plus all the other items described above that can or cannot be counted the final described economic benefit to Maryland in answer to § 4.4 Tab W may be as much as $200 million less over the entire contract duration than the actual cost of the contract to the Department. Given all the above, the Department will not change the requirements of this section, including the requirement for offerors to include the estimated dollar amount of Maryland economic benefits from their offers.

278. Question**:** Page 2, 1.2.34 appears to eliminate contractor staff from council participation. Please clarify whether or not contractor staff may participate on this council.

Answer: Please see Amendment #5, item 1, revising § 1.2.34 to reinstate the contractor's staff council participation requirement.

279. Question**:** Page 4, 1.2.76: Will the DPSCS enforce participation or rule that a patient care conference is not indicated when or if there is a dispute between disciplines?

Answer: Yes, it is an expectation that if the SDA's or the State's medical director feel that a patient care conference is necessary, all entities participating in that patient's care will be required to attend the patient care conference. In the event that one or more disciplines believe a patient care conference is needed whereas other disciplines oppose holding a conference, a SDA's or the State's medical director will become involved in determining whether a conference is needed.

280. Question**:** Page 4, 1.2.95: With the change in the definition by removal of the term "specialty", this allows healthcare delivery via telemedicine to include primary care. (A) Will the provision of telemedicine care by primary care providers be applied to the contracted hours required per Attachment R? (B) Assuming that hours provided via

telemedicine will be allowed to cover hours required per Attachment R, what documentation will the Department require for credit of hours provided?

Answer: (A) YES, if the state agrees to allow tele-medicine for the particular primary care service/SDA.

(B) Since hours provided via tele-medicine will be part of the provider hours provided in the Contractor's actual invoice submissions, standard reporting compliance for the billing requirements outlined in Section 3.3.1.1.1 will apply, to include the roster of inmates seen attached and documented in the EHR.

281. Question**:** Page 4, 1.2.101: Please clarify if Business Days includes or excludes officially observed State holidays that occur during Monday through Friday.

Answer: See Amendment #4, item 2 revising § 1.2.101, the definition of Business Days.

282. Question**:** Page 10, 3.5.2.1: Who is responsible for inpatient and specialty care costs for Federal inmates?

Answer: The Contractor is responsible for inpatient and specialty care costs for Federal inmates. All federal Inmates shall be treated in a manner consistent with that required for the entire DPSCS population. Utilization management practices are expected to be employed by the Contractor with respect to federal Inmates as required by DPSCS and the federal U.S. Marshalls Service. This includes notification of and seeking authorization for any services beyond those generally offered to Inmates for sick call, routine chronic care, or attention to On-site injuries.

283. Question**:** Page 11, 3.6.3.1: The DPSCS is asking bidders to take substantial risk in relation to costs for inmate healthcare services, staffing, performance measures and the potential for the assessment of liquidated damages. This risk necessitates that the vendor have the ability to direct and control its staff and subcontractor staff in order to mitigate this risk and ensure the provision of quality care through administrative means. With the obvious exception of clinical decision making, will the DPSCS please allow a reporting structure that permits medical staff, including clinicians and regional clinical staffs to report to the Contractor's Contract Manager, Regional Managers, Health Services Administrators, etc., in order for the Contractor to ensure that its staff and subcontractor staff meet the contract requirements and expectations of the DPSCS?

Answer: Whereas the questioner is apparently interpreting that § 3.6.3.1 prohibits a reporting structure that permits medical staff, including clinicians and regional clinical staffs from reporting to the Contractor's Contract Manager, Regional Managers, Health Services Administrators, etc., that is not a correct interpretation. The Department will agree that ultimately both nursing and clinical partners will report to a contract manager but clinical and nursing leadership input should and can be appealed to their statewide /regional counterparts when a dispute arises that can not be resolved locally. In addition, see Amendment #5, Item 9 that makes further changes to § 3.6.3.1.

284. Question**:** Page 12, 3.6.4: Please specifically define all "appropriate" entries that the DPSCS expects ACOMs to be able to make within the web-based staffing solution.

Answer: See Amendment #5, item 9, revising § 3.6.4 to reflect that ACOMS will only have the ability to enter approvals and denials of staffing schedule change requests in the system.

285. Question**:** Page 12, 3.7.1: The current Contractor has a statewide Contract Manager and Regional Managers currently in place. Will the DPSCS please provide approval through this question and answer process for all individuals currently occupying these roles? If one or more of these individuals will not be approved by the DPSCS during this question and answer process, please specifically identify the/those individual(s).

Answer: DPSCS will not use this question and answer forum to identify, give approval or disapproval, or critique any individuals occupying roles under the current contract. Please see Amendment # 4, item 60 revising 4.4 to include a Personnel Identification Caveat. Please also see the response to Question 113 in Q&A #2.

286. Question**:** Page 14, 3.9 (cont.): Is the Contractor responsible to secure a fingerprint service or will the DPSCS provide this service for the Contractor? If the DPSCS agrees to provide this service for the Contractor, is there a fee for this service and what is the amount?

Answer: As per the response to Question 24 in Q&A #2, the Contractor may elect but is not required to secure a fingerprint service. If the Contractor elects to conduct its own preliminary fingerprinting and criminal history check on prospective employees of the Contractor and/or subcontractor, it shall be at the Contractor's expense. The Department will still perform its own official check at no cost to the Contractor.

287. Question**:** Page 14, 3.10.1.2.1: Will the DPSCS please provide the criteria for the mentorship program of study that meets the approval of the Department DON?

Answer: DPSCS will not dictate how an Offeror will prepare a nurse via orientation for the assignment or post given or approval for the specific mentoring program. However, DPSCS will request a copy of the process and monitor the performance of the nursing staff to evaluate how new staff are phased into their role. As per § 4.4, Tab H, the Offeror must describe in its technical response its proposed mentoring program.

288. Question**:** Page 15, 3.10.3.1: Will all current staff of the current contractor who have completed the security orientation and training requirement be considered to meet this requirement on day one of the new contract?

Answer: Yes, as per § 3.10.3.1.1 and § 3.10.3.1.1.1, existing staff of the current contractor that will continue employment or have less than a 40 day break in service with the Contractor do not need to repeat the security orientation and training if there is documentation of the person's previous attendance at this training.

289. Question**:** Page 16, 16. 3.17: Please clarify the inclusion of Chemotherapy in this section as Chemotherapy is not typically a emergency service.

Answer: Please see Amendment #5, item 10, revising § 3.17 to delete the reference to Chemotherapy.

290. Question**:** Page 16, 17. 3.18.1: Is it the DPSCS's expectation that on-call physicians report to a facility in a manner that allows the successful achievement of documenting the encounters described in this section within the stipulated 12-hour time frame? For example: A physician takes a call on Friday evening and is not scheduled to report back to the facility until Monday. The period of time in this example substantially exceeds the 12-hour requirement. Will the DPSCS revise this requirement to state that documentation must occur the next business day?

Answer: Please see Amendment #5, item 11, revising § 3.18.1.

291. Question**:** Page 16, 18. 3.20.3: Will the DPSCS allow the Contractor to utilization voice or other recording devices during meetings to ensure that accurate and thorough minutes can be transcribed?

Answer: Yes, unless/until instructed otherwise.

292. Question**:** Page 18, 20. 3.22.1: Will the DPSCS ensure that sufficient transportation resources will be available?

Answer: Although it is our expectation that adequate resources will be available, DPSCS cannot ensure that sufficient transportation resources will be available in every situation at every facility. In the event that transportation for patients cannot be transported using facility transportation, the contractor staff shall be responsible for assuring the right mode of transport and immediately notifying custody of the transport that will occur at the Contractor's expense. Please see Amendment #3, item 20, and Amendment #5, item 14 revising § 3.22.1.

293. Question**:** Page 18, 20. 3.22.3: (A) How many interstate compact inmates does the DPSCS currently have in other correction departments? (B) Which amount $315,000 or $427,500 does the 10% escalator apply for year 2? (C) Does the DPSCS maintain interstate compact inmates for other states? Who is responsible for inpatient and specialty care costs for interstate compact inmates housed by DPSCS?

Answer: (A) The number of interstate compact inmate cases of Maryland inmates housed in other States for the last 3 fiscal years and their associated cost are:

FY09 4 cases $83,000
FY10 10 cases $29,000
FY11 3 cases $23,000.

The Department cannot provide case and cost information regarding other States inmates housed in Maryland as each State paid for its own cases/inmates.

As of September 2011, MD housed 77 inmates for other States and 109 MD inmates were housed in other States'.

(B) The $315,000 amount is the one that would be used to be escalated by 10% for the second Contract Period ambulance cost cap. Please also see Amendment #4, item 26, revising § 3.22.

(C) For other States' inmates who are housed in Maryland, the Contractor must seek pre-certification from the other States prior to offsite specialty care, elective inpatient and non-emergent/urgent services being rendered, irrespective of whether they are provided offsite or via telemedicine. It is expected that the other States will reimburse the Contractor for payment of any such services that have been pre-certified by that State. Any Interstate Compact inmate (i.e. other States' inmates who are housed in Maryland) requiring emergent care offsite should have those services completed thru the offsite medical facility and then subsequently reported to the other States within 24-hours so that retroactive certification can be obtained. It is expected that the other States will reimburse the Contractor for payment of approved offsite services.

For Maryland inmates housed in other States, it's expected that the other States will obtain pre-certification from the Contractor prior to offsite specialty care, elective inpatient and non-emergent/urgent services being rendered. The Contractor will be responsible for payment of services for Maryland inmates housed in other States for the offsite care that is authorized by its Utilization Management (UM) team. Any Interstate Compact inmate (i.e. Maryland inmates housed in other States) requiring emergent care offsite should have those services completed thru the offsite medical facility and then subsequently reported to UM within 24-hours so that retroactive certification can be provided. The Contractor is responsible for these offsite emergent care services when retroactively certified.

If the DPSCS Medical Director or other States' Medical Director makes the determination that the inmate is to return to their primary state for continued medical treatment, the Contractor shall facilitate the medical transportation arrangements to transport that inmate back to its home state. The DPSCS Medical Director in their sole discretion shall make the final determination of the mode of transport to return the inmate to Maryland. As per § 3.22.3.1, the Contractor may then bill the Department for the actual cost, without additional markup, of any such special transportation expense regarding out-of-state Inmates being returned to Maryland. Please see Amendment #5, item 18, adding the above wording as a new § 3.79 (Responsibilities for Interstate Compact Inmates).

294. Question**:** Page 21, 3.25.8: Will the DPSCS ensure that all newly admitted inmates will be presented to Contractor staff in a manner that reasonably allows the Contractor to be compliant with the 2-hour threshold?

Answer: It is anticipated that such resources shall be made available. However, in the event that actions or inactions by DPSCS deter the Contractor from meeting the 2-hour threshold, the Contractor shall document the reason for non-compliance with the 2-

hour threshold. If the DPSCS Contract Manager agrees that any instance of non-compliance with the 2-hour threshold was not reasonably attributable to the Contractor, liquidated damages will not apply.

295. Question**:** Page 21, 3.25.10.1: As the Contractor does not control the custody of an inmate, their location, movement or availability; will the DPSCS ensure that it will assist as necessary the development of the written plan to ensure compliance with the 2-hour threshold?

Answer: Please see the response to Question 294.

296. Question**:** Page 22, 3.26.1: Please specifically define the type of vision and hearing test identified in this section.

Answer: DPSCS will not provide any specific definition or requirement for the types of vision and hearing tests to be conducted. In its Technical Proposal response, as per Amendment #5, item 19, § 4.4, Tab D has been revised to include a new #1.26(A) and 1.26(B) whereby Offerors shall describe the type of testing that will be used to evaluate Inmate's near and far vision and the type of equipment (other than a tuning fork alone), used to test and assess low pitch and high pitch hearing deficiencies in Inmates; with specific emphasis on the testing of juveniles.

297. Question**:** Page 25, 3.28.4: Will the DPSCS ensure that custody will provide inmates in a manner that facilitates the completion of sick call?

Answer: Yes, however in the event something deters the Contractor from meeting sick call requirements, the Contractor shall document the reason for non-compliance with sick call requirements and the DPSCS will review if the non-compliance was due to the Contractor or DPSCS. Please also see Amendment #4, item 30, revising § 3.28.4.

298. Question**:** Page 34, 31. 3.33.4: Based on the requirement to maintain a minimum census of 10 patients daily at the Bon Secours Hospital, a continuous cost for 10 inpatient days, each and every day would be incurred by the Contractor. As such, does the DPSCS intend for every bidder to account for this fixed census and associated cost within their pricing proposal?

Answer: Please see the response to Q&A #2, Question 127 and Question 253, and Amendment #4, item 32, revising § 3.33.4.

299. Question**:** Page 35, 3.34.5: Adding the requirement of credentialing off-site specialists in accordance to the credentialing requirements of the DPSCS policy creates a very laborious human resource process given the volume of offsite specialty providers. Will the DPSCS allow verification of off-site provider credentialing by a JCAHO accredited hospital where they are on staff as meeting this requirement?

Answer: As per Amendment #5, item 14, a new § 3.34.5.1 has been added to the RFP to eliminate separate credentialing of Off-site specialists who are University or

community hospital based. For other than University or community hospital based specialists, the Contractor is required to independently verify credentialing. DPSCS' experience is that the independent verification of the credentials for private practice/solo specialty groups has not been a problem or burden.

300. Question**:** Page 40, 3.41.4.1: The release planner position for Cumberland SDA is not listed on Attachment R as are the other release planner positions for the remaining SDAs. Please clarify if this is an error of omission or if a release planner is not required for the Cumberland SDA. Please specifically define the minimum education and licensure requirements for these positions.

Answer: Please see Amendment #5, item 19 noting that Offerors must include positions specifically required anywhere within section 3 of the RFP, and Amendment #5, item 25, revising Attachment R Contract Staffing Matrix (Suggested).

301. Question**:** Page 43, 3.42.6: Please provide the DPSCS definition of non-significant.

Answer: Non- significant means no injurious impact to the health of the inmate.

302. Question**:** Page. 43, 3.42.6: May the vendor send a written notice via the inter-institutional mail to the patient indicating that their lab results were normal or fall within the range of acceptable/satisfactory to avoid extra movement through institution and volume for both security and health care staff?

Answer: Since DPSCS has no established procedure for distribution of inter-institutional mail to inmates, DPSCS will not agree to any changes from what is required in § 3.42.6. However, if during the course of the Contract, a reliable methodology is developed, DPSCS will entertain a change at that time.

303. Question**:** Page 44, B. 3.47.3: Will the DPSCS require the Dental Contractor to submit referrals as applicable through the utilization management process?

Answer: Yes.

304. Question**:** Page 50, 3.54.3: Please provide a listing of all cases and the total cost by case of that care that the department has proceeded with under this sections description for each of the calendar years 2009, 2010 and 2011 through September.

Answer: DPSCS is unable to provide this information. Tracking of this information is not a requirement under the current contract. However, it's believed that over the past 10 years there have been no more than 4 such instances.

305. Question**:** Page 51, 46. 3.56.1: Is the Pharmacy Contractor responsible to supply and for the cost of prophylactic medication?

Answer: Yes.

306. Question**:** Page 57, 3.69.1.2: Will the DPSCS consider changing the 3 – 5 years of correctional services experience as a minimum requirement for the UM Medical Director position to a preference in order to include candidates with significant UM practice background?

Answer: DPSCS declines to modify the RFP as requested.

307. Question**:** Page 58, 3.69.5: The RFP notes that the State is responsible for medical costs by any county for any Local Inmate (as defined in 1.2.58). Please clarify: (A) does the interpretation of "local inmate" solely include individuals that are DPSCS offenders? (B) Does "local inmates" include all individuals housed, regardless of the jurisdiction of incarceration? (C) Please clarify which department of the State of Maryland has the financial responsibility for the costs in excess of $25,000.

Answer:
(A) No.
(B) No. All Baltimore City arrestees are automatically in the custody of the Department. As per § 1.2.58, "local inmates" only applies to arrestees other than those in Baltimore City.
(C) DPSCS, however as per § 3.69.5, any local inmates for which medical costs have exceeded $25,000 may be admitted to a DPSCS facility, in which case they become an "Inmate" and must receive services from the Contractor as required by this Contract.

308. Question**:** Attachment R: The revised Attachment R provides a total of facility staffing of approximately 754 FTEs, which is approximately 61 FTEs more than the prior RFP staffing and about 73 FTEs more than the current approved staffing levels in the current contract. Additionally, the current contract only funds staffing levels at 92% of the approved staffing plan. With the new required staffing levels, this equates to about a 20% increase in staffing levels at an estimated additional cost of over $11 million annually. While RFP section 1.18 expressly prohibits multiple or alternate proposals, Tab D section 1.6.A &B notes that the Offeror may propose a different clinical staffing plan. In order to accommodate a price proposal that the DPSCS can fund, please confirm that Offerors may propose a staffing level different than the staffing included in Attachment R.

Answer: Whereas it is correct that the suggested staffing will increase the number of positions working under this contract, the end objective is to decrease cost overall. By increasing onsite staffing it is expected that instances of off-site treatments and transportation will be reduced to a greater extent than the cost of the increased staffing. While acknowledging the increased expense of these positions, we can't comment on the accuracy of the $11 million number suggested in this question. Again, however, the Attachment R positions are suggested only.

In reference to the current contracted 92% fill rate, this is the basis for current reimbursement for the current contractor, which significantly differs from the current RFP scope.

It is correct that § 1.18 expressly prohibits multiple or alternate proposals, however as been made abundantly clear through the answers to previous questions and changes in

amendment #4, the contents of Attachment R are suggested staffing only. Except for positions that have been specifically required in a section of the RFP (see Amendment #5, Item 19 adding new requirements to § 4.4 Tab D, 1.6 A), (e.g the Discharge/Release Planning Nurses identified in § 3.41.4.1), Attachment R does not represent required staffing to which any Offeror must adhere. Accordingly, Offerors are to propose their single best staffing solution to accomplish the objectives of the contract. This single solution is neither an alternate nor a multiple proposal.

309. Question**:** RFP Page 42, 3.6.1.2: This section states a minimum of 96% fill rate for all positions listed on the current staffing plan and a failure to meet the 96% will result in liquidated damages. The 96% fill rate indicates two weeks allowance for vacations, holidays, continuing education, and management team meetings. Is it the intent of the State for site Administrators and other site and regional office administrative staff to maintain a 96% fill rate?

Answer: Please see Amendment #4, item 16 and Amendment #5, item 9, revising 3.6.1.2 so that the 96% fill rate only applies to the identified 5 Clinical positions. In addition, the 100% fill rate added in Amendment #4, item 16 for 3.6.1.2 only applies to nursing positions for infirmaries and sick call.

310. Question**:** RFP Page 42, 3.6.1.2 and 3.6.1.3: This section indicates positions with unscheduled absences left unfilled for more than 24 hours shall be filled on a temporary or permanent basis. Is it the expectation of the State that positions are scheduled and worked at 100% although the penalties are not assessed until the level falls below the 96%? If so, does this include all administrative positions as well?

Answer: Please see the response to Q&A #2, Question 177, and Amendment #4, item 16 and, as noted in the answer to Question 309, Amendment #5, item 9.

311. Question**:** RFP Page 42, 3.6.3.1: This section indicates Healthcare Professionals and other staff, including nurses, clerks, schedulers, and other staff necessary to perform daily functions of inmate healthcare will report to a facility DON. Will the State consider allowing site specialty clerks (off-site schedulers) to report to the Utilization Management RN vs. the site/Regional Directors of Nursing? Will the State consider allowing medical records clerks to report to the Statewide Medical Records Director vs. the site/Regional Directors of Nursing?

Answer: Please see Amendment #5, item 9, revising § 3.6.3.

312. Question**:** RFP Page 75, 3.29.3.4: Attachment R includes Certified Medical Assistants (CMA), however in this section, the requirement for medication distribution indicates only an LPN or higher level is allowed to distribute medications. What does the State envision the CMA's duties will be?

Answer: The current Attachment R issued with Amendment #4 does not include any CMA positions. As per Amendment #5, item 19, Section 4.4, Tab D, #1.6(A) has been revised to prohibit the use of CMAs (Certified Medical Assistants) under this contract and to encourage the use of CNAs (Certified Nursing Assistants) and GNAs (Geriatric

Nursing Assistants) in infirmaries. Please also see Amendment #5, item 25, revising Attachment R Contract Staffing Matrix (Suggested).

313. Question**:** RFP Page 129, 3.72.1: This section requires the Contractor's UM Director to manage the CQI process. Will the State consider the assignment of an alternative physician to manage the CQI process provided he/she is qualified to perform those duties?

Answer: No. The Contractor's UM Director is required to manage the CQI process.

314. Question**:** Amendment 3, Page 62, 3.78: The insurance requirements provide that the Contractor will maintain Malpractice Insurance coverage in the amount of $7,000,000 in the aggregate and Errors and Omissions (E&O) liability coverage in the amount of $2,000,000 in the aggregate. An E&O policy for a medical provider or professional is a malpractice policy. As a result, we would ask for clarification as to how the Department is differentiating between E&O and Malpractice coverage, if at all.

Answer: Please see Amendment #5, item 17, revising § 3.78 to eliminate the Errors and Omissions liability limit.

315. Question**:** In RFP Amendment #3, Section 3.35.3, it states that "a licensed optician(s) or subcontractor who shall prescribe and fit eyeglasses (or contact lenses)". Please confirm that licensed opticians and subcontractors do not need to do onsite routine dispensing of eyeglasses and contact lenses.

Answer: We cannot provide the confirmation requested because the apparent interpretation of the Questioner is incorrect. Licensed opticians, either employees of the contractor or of a subcontractor, **are** expected to provide Onsite routine dispensing of eyeglasses and contact lenses.

316. Question**:** As per RFP Amendment #4 in Section 3.43.4, we understand that the DPSCS expects all analog equipment to be converted to digital. Please confirm that converting current DPSCS x-ray equipment with the appropriate equipment and peripherals to produce digital x-rays meets this requirement.

Answer: At a minimum yes, however Offerors should fully describe the benefit that will accrue to the Department for their proposed solution in terms of the number of machines offered, the capabilities of those machines, etc. Each Offeror's proposed system will be evaluated in terms of both its potential to increase patient care and decrease collateral Departmental expenses; e.g. custody overtime, transportation expenses, etc., in addition to the actual proposed price of the proposed solution.

317. Question**:** We understand that the Optional Enhanced programs (EHR, Telemedicine, Digital X-ray) will be scored against each Technical and Financial Proposal. Please confirm that the prices of these Optional Enhanced Programs do not count toward required MBE dollars.

Answer: Please see Amendment #5, item 5, revising § 1.19 which excludes the value of the Optional Services from the MBE requirements.

318. Question**:** We have received and reviewed the Staffing Matrix provided with Questions and Answers #2 (Attachment 2B). Upon review of this matrix, there is missing data throughout the entire document in the FTE column. Please provide all missing FTE data.

Answer: Although it's correct that there are some positions for which the FTE column is blank, Offerors were provided the data in Q&A #2 [as attachment Q&A2-B.Current Medical Contract Staffing Levels (2012)] to calculate the missing FTE data.

Should you require clarification of the information provided, please contact me at (410) 260-7374 as soon as possible.

Date Issued: **November 12, 2011**

By: Andrea R. Lockett
<signed>
Procurement Officer