Department of Public Safety and Correctional Services

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QUESTIONS AND RESPONSES #2
SOLICITATION NO. Q0016025
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
PHARMACY SERVICES
NOVEMBER 17, 2017

Ladies/Gentlemen:

This list of Questions and Responses #2, questions #176 through #233, is being issued to clarify certain information contained in the above RFP.

In most instances the Department's response to the submitted questions merely serves to clarify the existing requirements of the RFP. Sometimes, however, in submitting questions potential Offerors may make statements or express interpretations of contract requirements that may be inconsistent with the Department's intent. To the extent that the Department recognizes such an incorrect interpretation, the provided answer will note that the interpretation is erroneous and either state that the question is moot once the correct interpretation is explained or provide the answer based upon the correct interpretation.

No provided answer to a question may in and of itself change any requirement of the RFP. If it is determined that any portion of the RFP should be changed based upon a submitted question, the actual change may only be implemented via a formal amendment to the RFP. In this situation the answer provided will reference the amendment containing the RFP change.

Questions and Answers

176. Item 1.2.17 on page 8 of the RFP states that the Contractor's Program Manager will work from an office located in Maryland. This requirement is not typically seen in most solicitations, as the physical location of the program manager is not correlated with the knowledge, value, and expertise they will provide in program management.
What are DPSCS's reservations regarding a program manager—with extensive experience and expertise—working at a location outside of Maryland?
If an out-of-state pharmacy vendor can clearly document that the pharmacy is properly licensed to conduct business in Maryland, would the DPSCS accept a program manager working for an out-of-state pharmacy vendor not physically residing in Maryland if that program manager is competent and responsive to the facilities' and DPSCS's needs and completely familiar with Maryland's pharmacy laws and regulations, so additional competition to the bid process can be achieved

through an out-of-state pharmacy?

RESPONSE: No, DPSCS will not change its requirement that the Program Manager shall be based in the State of Maryland, and may not work from a location outside of Maryland. To clarify, the RFP Section 3.2.17.5E requirement that the Program Manager be based in Maryland refers to the RFP Section 1.2.17 definition of Program Manager which requires that the Program Manager work out of an office in Maryland. See RFP Section 3.2.17.5 and Amendment 5, Item 5. The Program Manager is not required to be a legal resident of Maryland.

177. Item 1.2.57 on page 11 of the RFP defines "Post Order." Please describe how post orders are incorporated into daily pharmacy operations? Regarding post orders, what does a pharmacy vendor needs to be cognizant of operationally or clinically?

RESPONSE: Post Orders may impact on delivery of Pharmaceuticals and Supplies. Additionally, Pharm.D.s working in the facilities must be familiar with Post Orders that impact their performance of services under this contract. These may vary across facilities.

178. Item 1.3.1.1 on page 12 of the RFP states, "The purchase of indefinite quantities of all Pharmaceuticals and Supplies shall be via cost reimbursement of the AAC…" As you know, the prices of brand name medications and some generic medications are more likely to increase than decrease over the course of a month. If a pharmacy charges their AAC of medications on the last day of the month for all medications dispensed within that month (a practice of some pharmacies in the correctional industry), this will result in higher medication costs to your Department. Will DPSCS require your awarded vendor to bill the medication AAC at the time of dispensing instead of the AAC on the last day of the month?

RESPONSE: The Contractor shall invoice DPSCS for the AAC at the time of dispensing less any applicable discount rather than the AAC at the end of the month. See Amendment 6, Item 4.

179. For limited distribution medications that can be provided by only a handful of specialty pharmacies, IV medications, TPN preparations, and non-sterile compounded medications:
How are pharmacies to invoice the DPSCS for those medications? How are bidders to submit those items in their financial proposals? Will the dispensing pharmacy be required to have the capability to compound sterile and non-sterile compounds, IVs, TPNs, etc. so these items do not need to be subcontracted out at a higher expense to the DPSCS?

RESPONSE: See Revised Attachment F – Financial Proposal Form, Instructions Tab and Amendment 5.

180. Item 1.4.1 on page 12 of the RFP states, "The Contract that results from this solicitation shall commence as of the date the Contract is signed by DPSCS following any

required approvals of the Contract, including approval by the BPW, if such approval is required."
Is BPW approval required?

RESPONSE: Yes, BPW approval is required for this contract.

181. Section 1.33.1 on page 22 of the RFP states, "An overall MBE subcontractor participation goal of 12% of the total value of the Annual Management Fee portion only…"
(A) Please confirm that bidders are permitted to utilize any service or product specific to this solicitation from MBE suppliers to qualify for MBE participation.

(B) Is the 12% MBE subcontractor participation goal the maximum? Or, can bidders score additional points over other bidders for MBE subcontractor participation over 12%? If so, how are the evaluation points structured regarding MBE subcontractor participation?

RESPONSE: (A) See Q&A 1, Question 2. (B) The 12% goal is not a maximum. Offerors will be evaluated using the criteria listed in RFP Section 5.2.

182. Regarding MBE participation, since this is a pharmacy agreement and not a wholesaling agreement, please confirm that an MBE Prime registered with the Maryland Office of Minority Business Enterprise under NAICS code 424210 – Drugs and Druggists' Sundries Merchant Wholesalers, would be ineligible to apply any pharmacy-related work toward fulfilling up to fifty-percent (50%) of the MBE participation goal (overall), as the proper NAICS code for a pharmacy vendor capable of fulfilling the requirements of this RFP would be 446110 – Pharmacies and Drug Stores.

RESPONSE: See Q&A 1, Question 2.

183. Item 3.1.3 on page 29 of the RFP states, "During CY16 the total number of fills for the Department was approximately 1,015,942." Attachment Q indicates that the ADP is approximately 23,055. Using these statistics, the DPSCS averages 3.67 prescriptions per inmate per month, which is approximately 70% higher than the average number of prescriptions per inmate per month we see in other state departments of corrections.

(A) Please confirm that the numbers we quoted here are correct.

(B) Please confirm that the clinical pharmacists currently provide medication management and routine poly-pharmacy reviews.

(C) Are maintenance medications routinely dispensed in a 30-day supply?

(D) With clinical pharmacists responsible for medication management and cost control, would the DPSCS reconsider the need for five clinical pharmacists if the return on investment is not realized in relationship to the high cost for these current positions, based on the information noted herein regarding the current number of prescriptions per inmate per month?

RESPONSE: (A) Confirmed. (B) Confirmed. (C) Chronic care medications are provided in a 30 day supply with three refills. (D) No.

184. Item 3.2.2.1 on page 28 of the RFP states, "The State anticipates allowing for a four (4) month transition-in period." With a projected contract start date of July 2018, will the transition period begin in March 2018? Or, will a pharmacy be permitted to begin sooner if they display to the CM that they can begin services at an earlier date?

RESPONSE: The Department does not anticipate an earlier start date for this contract.

185. Item 3.2.5.2 on page 30 of the RFP indicates that the NextGen "bi-directional data feed or interface shall include but not be limited to licenses, interfaces, implementation, on-going troubleshooting, and 24x7 helpdesk and support."

(A) Please indicate any and all charges currently paid by the incumbent pharmacy per year regarding the NextGen interface to meet the requirements of item 3.2.5.2 so other bidders may also account for accurate costs in their proposals.

(B) Does the DPSCS bear any costs related to the NextGen interface? Will a bidder be expected to bear any future costs related to NextGen that are not outlined in the RFP or known at the time of a bidder's proposal submittal?

(C) Are orders transmitted by NextGen through a switch company such as Surescripts? If so, what is the cost per transaction and who is responsible for those costs?

RESPONSE: (A) The Department does not have this information. (B) Yes, the Pharmacy Contractor must pay for access to the current NextGen interface as well as any future interface to any eMAR system used by DPSCS. DPSCS does not have information about the cost related to the NextGen Interface allocated solely to the Pharmacy Services contract. (C) DPSCS does not have information about how orders are transmitted or what the cost per transaction would be.

186. Item 3.2.8 on page 30 of the RFP states, "The Contractor shall have a reliable mechanism, to include a written process, approved by the P&T Committee for reporting drug interactions or other ordering errors back to the ordering Clinician within 24 hours." Electronic order entry programs in the industry typically have a DUR process built in to the front end of the order entry module so prescribers are alerted of drug interactions and allergies at the point of order entry. Please indicate if the NextGen platform has this capability. If so, does the DPSCS currently take advantage of this capability?

RESPONSE: No, NextGen does not have this capability.

187. Item 3.2.13 on page 30 of the RFP states, "The Contractor shall provide pre-printed MARs for all medications and patient information sheets in English and other foreign languages, as directed by the CM, and submit the pre-printed MARs and patient information sheets to the Other Healthcare Contractors on a monthly basis by the 20th day

of the subsequent month."

(A) Besides English, what other foreign languages currently are required to be provided on patient MARs?

(B) For a system as large as the DPSCS, would you be interested in a vendor that can provide an eMAR solution that would eliminate the need for a manual, and very time-consuming, medication pass process?

(C) Is the version of NextGen currently in use capable of providing electronic medication pass?

RESPONSE: (A) Primarily, Spanish is the only language other than English that is requested. (B) See Q&A #1 response to question 6. (C) NextGen is not capable of providing electronic medication pass.

188. Section 3.2.17.1 on page 31 of the RFP states, "The Contractor shall provide five (5) full-time equivalent (FTE) Clinical Pharm.D.s, licensed by the Maryland Board of Pharmacy, during the term of the Contract." Clinical knowledge is not state-specific in terms of state board of pharmacy licensure. In other words, a clinical pharmacist licensed by the Maryland Board of Pharmacy would not be clinically superior to a pharmacist licensed by any other state board of pharmacy in terms of clinical knowledge.

Please clarify if this is a requirement? If so, why would the clinical pharmacists be required to be licensed by the Maryland Board of Pharmacy?

Most pharmacies with the capacity to meet the clinical requirements of the RFP are domiciled outside of Maryland, and the requirement for Maryland-licensed clinical pharmacists will provide a competitive advantage to the incumbent that is located in Maryland.

To ensure a balanced procurement, will the DPSCS consider removing the requirement of Maryland licensure for the clinical pharmacists?

RESPONSE: Clinical Pharm.D.s must be licensed in Maryland. See RFP Section 3.2.17 and Amendment 5, Item 9.

189. Section 3.2.19.7 on page 34 of the RFP states, "The monthly Regional P&T Committee meetings may be conducted at the Department's option by video or teleconferencing." Could you provide a list of specific monthly P&T meetings held during the past 18 months using videoconference or teleconference and indicate which meetings were conducted in the region so bidders can properly assess the costs of providing personnel for these meetings?

RESPONSE: Yes, the Department at its discretion, will grant the opportunity to do a video conference or a teleconference. The monthly Regional P&T Committee meetings are

chaired and must be attended by that region's Clinical Pharm.D. Only the quarterly meetings which are held in Baltimore must be attended by all five Clinical Pharm.D.s, the Contractor's Clinical Liaison, and the Program Manager.

190. Regarding item 3.2.21.2 on page 35 of the RFP, specifically the capability to electronically reconcile medication orders:

(A) Does each barcoded label currently contain both a prescription number and a unique identifier that permits reconciliation of orders to the exact piece?

(B) If not, will this be required at the time of proposal submittal so the DPSCS can reconcile every order to the exact piece instead of merely the prescription number?

(C) Does each facility currently process medication returns through the current reconciliation program? If not, will this be required at the time of proposal submittal, as electronic medication return reconciliation is equally important so the State is ensured of receiving full credit on all returned medications?

(D) If not, does the DPSCS have a reason they do not wish to have accountability of all medications returned using an electronic process?

RESPONSE: (A) Yes, a barcode label contains the prescription number and a unique identifier. (B) N/A (C) Currently, each facility processes medications that way. The Department does not anticipate changing this process. (D) N/A.

191. Item 3.2.22.1 on page 36 of the RFP states, "…a limited stock supply of medication maintained at the correctional facilities," which was seen during the provided facility tours. Although bidders' compliance with federal and state regulations regarding stock distribution is anticipated and should be expected, compliance cannot be fully assured unless written documentation is provided to your office at the time of proposal submittal. Often overlooked is that a pharmacy provider cannot dispense more than 5% of their overall company-wide sales as stock without being registered as a wholesaler to distribute wholesale quantities of stock medications. A fair assumption is that the percentage of stock dispensed by various correctional pharmacies is similar. Therefore, most pharmacies working in the correctional industry, and likely responding to your RFP, provide at least 5% of their overall correctional sales as stock. Thus, our interpretation of federal regulations and Maryland law is that bidders would need to comply with the federal and state rules and regulations regarding stock distribution.

(A) Will you require bidders to provide written documentation or a copy of their Maryland wholesale license, along with a copy of their wholesale license from their home state, at the time of proposal submittal to show whether they are licensed as a wholesaler or whether they use the services of a Maryland-licensed wholesaler?

(B) Will a bidder's failure to provide proof of compliance with federal regulations, specifically this requirement, at the time of proposal submittal, deem a pharmacy bidder

non-responsive and therefore ineligible for an award (based on RFP item 1.27 that states, "By submitting a Proposal in response to this RFP, the Offeror, if selected for award, agrees that it will comply with all Federal, State, and local laws applicable to its activities and obligations under the Contract"?

(C) If not, what process will the DPSCS follow prior to awarding a contract to ensure compliance with federal and state laws regarding stock distribution so that a contract is not awarded is to a bidder that is later discovered unable to comply, which would place the DPSCS at risk for possible fines and/or disciplinary actions when inspected?

RESPONSE: (A) No. (B) No. (C) See RFP Section 1.27 and Amendment 5, Item 22.

192. Item 3.2.22.6 on page 36 of the RFP states, "Any Legend and Non-legend stock medication ordered for Starter Medication Kits shall be dispensed in 3 to 7 day amounts as unit dose packaging." As questions were not permitted during facility tours, potential bidders could not ask to see the contents of the Starter Medication Kits. Thus, we have the following questions:

(A) Could you provide a list of all medications in all starter kits for each facility of the DPSCS for bidders to review?
(B) Are the contents of the starter medication kits paid for and owned by the State, which appears to be the case based on RFP item 3.2.23.2?
(C) Or, are the contents of the starter emergency kits owned by the pharmacy and provided as contingency stock?

RESPONSE: (A) No, there is no designated list of Starter Medication Kits. The medication starter kits vary by facility. See RFP Sections 1.2.62 and 1.2.26. (B) Yes. (C) No.

193. Although bidders' compliance with federal and state regulations is anticipated and should be expected, compliance cannot be fully assured unless written documentation is provided to your office at the time of proposal submittal. During the facility tours, each facility had interim stock provided in 30-count blister cards. Item 3.2.22.6 on page 36 of the RFP indicates that each facility has starter medication kits with the medications provided in 3- to 7-day amounts. As the DPSCS currently receives stock in blister cards, a pharmacy or a wholesaler cannot simply put those medications in a card and label them as stock and still be in full regulatory compliance. Our understanding of federal regulations is that a company must be an FDA-registered repackager or use the services of an FDA-registered repackager to legally repackage stock medications into blister cards or any other packaging that results in a change to the original manufacturer's packaging.

(A) Will you mandate that bidders comply with these regulations and use an FDA-registered repackager if stock is provided in packaging (such as blister cards) other than the original manufacturer's packaging?
(B) Will DPSCS legal counsel state for the record that their understanding of repackaging laws and regulations is that an FDA-registered repackager is required for DPSCS facilities to receive stock medications in blister card packaging, so any confusion on this matter is transparent and documented as part of the procurement record?

(C) Will you require bidders to provide at the time of proposal submittal evidence such as the repackager's FDA Drug Establishment Registration Facility Establishment Identifier as proof of FDA registration, or a letter from the repackager on their letterhead, to show that they actually use an FDA-registered repackager?
(D) Will a pharmacy bidder's failure to provide written documentation at the time of proposal submittal, showing that they comply with FDA repackaging regulations regarding the provision of stock deem that bidder non-compliant and therefore ineligible to receive an award (based on RFP item 1.27 that states, "By submitting a Proposal in response to this RFP, the Offeror, if selected for award, agrees that it will comply with all Federal, State, and local laws applicable to its activities and obligations under the Contract"?
(E) If not, what process will the DPSCS follow prior awarding a contract to ensure compliance with federal and state laws regarding stock repackaging so that a contract is not awarded to a bidder that is later discovered unable to comply, which would place the DPSCS at risk for possible fines and/or disciplinary actions when inspected?

RESPONSE: (A) DPSCS requires that the Contractor comply with all federal and state law and regulations. Offerors should consult their legal counsel to determine whether they must use a repackager, or are exempt. (B) Offerors should consult their legal counsel. (C) No. (D) No. (E) See RFP Section 1.27 and Amendment 5, Item 22.

194. Item 3.2.22.9 on page 36 of the RFP states, "The Contractor shall account for and dispose of all controlled substances within the guidelines of all federal and State laws." As the use of a reverse distributor is reserved for the disposition of controlled substance medications from a DEA registrant, this source of disposition is typically not used for discontinued or unused controlled substance medications dispensed as a patient-specific order since the patient is not a DEA registrant.
How are controlled substance medications currently destroyed in compliance with the Secure and Responsible Drug Disposal Act of 2010?

RESPONSE: Medications are currently destroyed in compliance with all federal and State requirements.

195. (Hazardous Waste) During the facility tour at MCI-W, a very large sharps container was observed filled nearly to the top with individual doses of medications. As questions were not permitted during the facility tours, please address the following:

(A) Can you confirm that pharmaceutical waste is currently destroyed using a sharps container at all DPSCS facilities, as this practice would be in violation of the EPA Management Standards for Hazardous Waste Pharmaceuticals, especially if any of those medications were hazardous substances, such as warfarin, which would subject the DPSCS to a possible fine of up to $37,000 per tablet if the items were not properly identified and disposed of as hazardous waste?
(B) If not, how are unused or dropped medications classified in accordance with the EPA Standards and properly destroyed?

(C) If a hazardous waste company is used, as required, can you provide the name and contact of the current provider so bidders can reach out to them and ask if they would be willing to continue in that capacity?

RESPONSE: Pharmaceutical waste is not destroyed using a sharps container, and disposing of pharmaceuticals in a sharps container is not in compliance with the Department's policies and guidelines. No subcontractor is used for this service as there is an onsite medication disposal process. Use of a hazardous waste company is not required.

196. (Deliveries) As questions were not permitted during facility tours, for each facility code listed in Attachment AA please answer the following:

Please list the number of routine deliveries, Monday through Saturday, received per facility in Attachment AA along with the average delivery time per day to each facility.
Please detail per facility in Attachment AA the number of routine deliveries received each Sunday for the past 180 days, along with the average delivery time per day.

RESPONSE: Deliveries take place based on the requirements of security for each facility and the delivery times required under the contract.

197. Section 3.2.26.3 on page 37 of the RFP states, "The Contractor shall supply prescription medications in unit dose blister packs and nonprescription medications and supplies as applicable to each facility using Contractor supplied transportation/courier services." Unless each individual bubble of the blister card is labeled with the medication's name, strength, manufacturer, lot number, and expiration date a blister card would be considered unit of use and not unit dose.

(A) Please confirm that the DPSCS requires medications to be dispensed in unit-dose blister cards and not unit-of-use blister cards to ensure the safety of those patients entrusted to your care.
(B) Please confirm that a courier service or common carrier utilized by a vendor would be defined as vendor-supplied transportation.

RESPONSE: (A) The Department requires the use of unit dose blister packs but does not require unit-of-use blister cards. The OTC or Starter Medication Kits are composed of medications in unit dose blister packs. They are not packaged as unit-of-use blister cards.
(B) Courier services must be approved for delivery of Pharmaceuticals and Supplies by DPSCS. See Amendment 6, Item 1. See also RFP Section 3.2.26.4.

198. Item 3.2.27.4 on page 38 of the RFP states, "For medications obtained through local pharmacies the Contractor shall not charge DPSCS more than 10% above what the Contractor would have charged for the medication (i.e., AAC less any proposed discount) if it had been provided through the Contractor's primary pharmaceutical supplier."
Throughout the industry, typical practice is for Agencies to pay the local emergency backup pharmacy invoice as a pass-through charge (of the actual charges) since the vendor pharmacy does not have any control over the costs established by local pharmacies

providing emergency services.

(A) Would the DPSCS consider permitting the contractor to invoice backup pharmacy costs as a pass-through charge?
If not:
(B) Can DPSCS share how the reimbursement structure in item 3.2.27.4 was derived?
(C) Can the Pharmacy Contractor intervene to decide whether an item would be considered an emergency backup need?
(D) If an emergency medication is ordered multiple times, will the Pharmacy Contractor have the right to mandate this item be stocked at the facility to decrease future emergencies and subsequent cost to DPSCS?
(E) What remedies would the Pharmacy Contractor have regarding refusing a non-emergency medication a facility requests from the local backup pharmacy?
(F) Can the Pharmacy Contractor invoice the DPSCS for their invoiced amount and delivery charge from the backup pharmacy if an item is not deemed an emergency?
(G) What obligation will a prescriber have to determine if an order is considered an emergency?
(H) Would the DPSCS consider making the charges for backup medication costs and delivery the responsibility of the medical, dental, and/or psych provider, as they would be the source for any medication requested from a backup?
(I) What limitations and guidance does the DPSCS have in place to prevent excessive use of the local backup pharmacies, especially for nurses not reordering medications when they are due, as the actions of the other vendors could have a negative impact on the pharmacy contractor, as the pharmacy is permitted to invoice the DPSCS only at the contractor's Acquisition Cost, whereas the local backup pharmacy charges would be at a higher rate?
(J) Can the cost of the local backup medications be billed as a pass-through charge, especially for expensive medications such as those for HIV?

RESPONSE: (A) Pass-through of invoice backup pharmacy costs is not permitted. Any concerns regarding whether an item would be considered an emergency backup need may be appealed to the Statewide Medical Director and the DPSCS CMO. Final determination of whether an item would be considered an emergency backup need is the purview of the CMO. See RFP Section 3.2.27.4.

(B) This information will not be provided.

(C) & (D) There are regional Pharmacy and Therapeutic committees that articulate stock medication inventory lists and that is the conduit the Pharmacy Contractor shall use regarding emergency medication supplies.

(E) Regarding refusing a non-emergency medication a facility requests from the local backup pharmacy, any such issues shall be brought to the attention of the Medical Contractor's Statewide Medical Director for determination. Appeals may be made to the CMO.

(F) & (G) No, delivery charges shall not be invoiced to the Department. The Pharmacy

Contractor is not the final determinant of whether an item is not deemed an emergency. In the event that an emergency medication is required and the Pharmacy Contractor disagrees, then the issue shall be brought to the attention of the Statewide Medical Director immediately with any appeals brought to the CMO.

(H) No, DPSCS will not make the charges for backup medication costs and delivery the responsibility of the medical, dental, and/or psych provider.

(I) Regarding the limitations and guidance DPSCS has in place to prevent excessive use of the local backup pharmacies, the Department encourages all healthcare contractors to participate in the Regional P&T Committee reviews at which emergency medication reviews are conducted. Abuses are tracked and monitored with corrective action plans.

(J) No, cost of the local backup medications shall not be billed as a pass-through charge.

199. Item 3.2.27.5 on page 38 of the RFP states< "All delivery and courier fees associated with use of local pharmacies are the responsibility of the Contractor including any fuel surcharges or additional shipping costs." To prevent a distinct advantage to the incumbent services provider, all bidders will need to know the exact number of emergency deliveries provided to all DPSCS facilities (from both local pharmacies and your incumbent provider for the sites in which they are serving as the backup) for calendar year 2016, so that bidders can calculate those costs into their bid rates, as a pharmacy provider has no control, yet is responsible for the costs associated with the delivery of emergency medication written for and requested by the medical, dental, and psych providers.

(A) Would the DPSCS consider permitting the contractor to invoice delivery and courier fees as a pass-through charge?

If not:

(B) Could you please provide the exact number of emergency deliveries provided to each DPSCS facility for calendar year 2016?

(C) If current usage is unknown or not tracked, please project usage, as this figure will be extremely critical to providing an accurate delivery cost for these services.

(D) If actual usage exceeds DPSCS projected usage as documented by an Offeror, will DPSCS allow for an increase in this rate to be payable to Offeror, as this will be the information a bidder will have in determining cost?

(E) Would the DPSCS consider allowing these charges as a pass-through cost if a bidder maintains monthly reporting of backup requests and delivery costs as part of their quality improvement initiatives?

RESPONSE: (A) No. (B) The Department had 1,256 emergency deliveries during calendar year 2016. The specific number of STAT orders is not tracked in the current contract as we are not reimbursed per STAT delivery; it is a portion of our monthly service fee. However, for the purposes of this RFP, the definition of RFP Section 1.2.67 Urgent Medication Delivery applies. (C) No, DPSCS will not permit the contractor to invoice delivery and courier fees as a pass-through charge.

200. Item 3.2.30.1 on page 39 of the RFP states, "The Contractor shall provide a method for return and credit for all medications." Regarding credit on returned medications and decreasing overall costs, not all pharmacies apply the same safeguards in terms of your patients' safety once medications are returned to their pharmacies. If each individual bubble of their blister pack for medications eligible for reclamation is not labeled with the medication's lot number and expiration date, tracking this information for a medication returned and subsequently redispensed to your patients would be difficult. During facility tours, none of the medications dispensed for stock or as patient-specific orders in blister cards appeared to be dispensed in unit-dose blister cards, but rather they were in unit-of-use blister cards.

Do you currently receive credit for returned medications in full and partial blister cards?
If so, are you charged a processing fee?
If so, is there a card value minimum in place for a return to be eligible for credit?

RESPONSE: Returns only apply to full blister cards. No processing fee is charged. There is no card value minimum in place. See response to question 197(A).

201. Regarding Section 3.2.31 Federal 340B Pricing Program on page 40 of the RFP:

What is the name of the current EHR utilized by Bon Secours Hospital that electronically transmits orders to the pharmacy?
Can you provide a contact person at Bon Secours that is familiar with the 340B program and can be contacted by bidders to get a comprehensive understanding of the current model?
Can you also provide a contact person regarding their EHR program?

RESPONSE: The State's current pharmacy contract does not include a 340B component. DPSCS does not have an EHR contact person at Bon Secours Hospital.

202. Item 3.11.1 on page 55 of the RFP states, "The contractor shall provide reasonable access for the successor contractor to the Contractor Clinical PharmDs no later than 60 days prior to the Contract end date."

Is this requirement currently applicable, should vendors change resulting from this solicitation?
Or, will an incoming vendor be required to establish all new personnel for clinical pharmacy services?

RESPONSE: The current Pharmacy Services contract contains transition-out requirements requiring the cooperation of the current pharmacy contractor in the transition-out process as follows. "Near the end of the contract (either the base contract term without any renewal options being exercised, or for any renewal option period if exercised), at a time requested by the State, the Contractor shall support end-of-contract transition efforts with technical, business, and project support."

203. Section 4.4.2.7 Experience and Qualifications of Proposed Staff on pages 60-61 of the RFP requests resumes for key personnel. However, bidders that currently do not require the

services of Maryland-licensed clinical pharmacists cannot provide resumes for Clinical PharmDs that are not currently employed by them.
To prevent any advantages to the incumbent services provider, who at the time of proposal submittal would be the only bidder required to have Maryland-licensed PharmDs on staff, would the DPSCS modify this requirement to exempt resumes for Clinical PharmDs and the Project Manager (that you require to live in Maryland) and instead allow bidders to submit a job description with requirements in lieu of an actual resume?

RESPONSE: The Program Manager is not required to be a Maryland resident. No, the Department will not allow Offerors to submit a job description with requirements in lieu of an actual resume. See response to question 176. See also Amendment 5, Item 6 and Amendment 6, Item 2.

204. Section 4.4.2.9 References on page 61 of the RFP states, "DPSCS reserves the right to request additional references or utilize references not provided by an Offeror."

For the procurement record, please disclose the process and selection criteria for soliciting a reference from a source not provided by a bidder.

If for some reason the reference chosen by DPSCS provides an unexpected negative reference, how will the evaluation commit contact the bidder to provide a written response that will be made part of the procurement record before a contract is awarded?

Please confirm that DPSCS will give any bidder that receives a negative reference (from a source not provided by the bidder) the opportunity to respond to that reference prior to an award being granted.

RESPONSE: Additional references will be sought at the discretion of the Procurement Officer. Any further information requested will be at the discretion of the Procurement Officer.

205. For bidders to ensure the smoothest transition of services and continuity of care, please provide a list of all current subcontractors (including PharmDs) as this is reportable and non-proprietary information, so potential bidders can reach out and negotiate terms for continuation of their services in the same or similar capacity.

RESPONSE: This information will not be provided.

206. Section 5.1Evaluation Committee on page 66 of the RFP states, "DPSCS reserves the right to utilize the services of individuals outside of the established Evaluation Committee for advice and assistance, as deemed appropriate."

(A) For procurement transparency, if and when the evaluation committee goes outside the evaluation committee, will DPSCS provide an addendum that indicates who was contacted and the nature of those discussions?

(B) For procurement transparency, can the names and/or positions of members of the evaluation committee be shared with all bidders at this time?

RESPONSE: No addendum will be provided indicating who has assisted the evaluation

committee nor will the names and/or positions of the evaluation committee be shared at this time.

207. Section 4.4.2.11 Financial Capability on page 62 of the RFP requests bidders to provide a significant amount of very sensitive and confidential financial information.

Will this information be excluded from release as public information and be protected as confidential information, as the disclosure of this information would be very detrimental to a bidder should it be made public?

RESPONSE: See RFP Sections 1.14 and 4.4.2.2.

208. (Current Costs) In most, if not all public procurements, cost is not considered proprietary and would be readily available without the need to submit a public records request.

(A) Please provide the annual management fee paid by the taxpayers of Maryland for the period of July 1, 2016, through June 30, 2017.

(B) Please provide the annual management fee paid by the taxpayers of Maryland for the period of July 1, 2015, through June 30, 2016.

(C) So bidders can obtain a copy of the current contract in place between the DPSCS and the incumbent services provider, can you please provide the current contract number that governs the current agreement and the date on which the contact took effect so bidders can be sure they are requesting the proper document?

RESPONSE: (A) - (C)The Department will not provide this information.

209. (DPSCS Inmates Housed at Other Facilities) (A) Does the DPSCS house inmates at any county facilities or out-of-state facilities?
(B) If so, please provide those facility names and addresses, along with monthly volume so that shipping costs can be projected.
(C) If so, will those costs for shipping be a pass-through cost to the DPSCS or the responsibility of the vendor?

RESPONSE: (A) DPSCS does house inmates at county facilities for court related activities. However, the Pharmacy Contractor does not deliver or prepackage medications for prisoners in county facilities. Medications for prisoners traveling to county facilities are sent with the inmate to the county facility. (B) & (C) N/A.

DPSCS does house inmates at out-of-state facilities (under interstate compacts). The Pharmacy Contractor is not responsible for providing medications to inmates in out-of-state facilities.

210. (Financial Proposal Form) In the Financial Proposal Form, on the Pharmaceuticals & Supplies tab, in column B (Unit of Measure), many items are designated as EACH, BOTTLE, CAN, INJ, SYR, AMP, KIT, GEL, CREAM, INH, VIAL, PADS, BAG, LOTION, SYRUP, and SPRY. Differences in interpreting the unit of measure would cause different bidders to submit significantly different prices. Please clarify how the DPSCS

wishes bidders to price out these particular items in column F (AAC per Unit of Measure).

We provide the following three examples.

(1) Line 5 lists ProAir 8.5gm INH and has a designation of EACH in column B. Are bidders to provide the price of one 8.5gm inhaler or 1 gram of the inhaler?
(2) Line 24 Ensure Vanilla 24/Case Liquid has a designation of EACH in column B. Are bidders to provide the price of one case, one can, or 1 mL?
(3) Line 62 Dove Body Wash has a designation of BOTTLE in column B. Are bidders to provide the price of a 354mL bottle or 1 mL?

RESPONSE: See Amendment 5, Item 30 and Revised Attachment F.

211. (Attachment 2) For 340B medications, specialty and limited distribution medications, sterile and non-sterile compounds, TPNs, and IV medications, how are those items to be priced out and invoiced to the state, as these are not traditional prescriptions and Attachment 2 does not appear to provide a mechanism to account for these costs?

RESPONSE: Please clarify this question. The Pharmacy Services RFP Solicitation No. Q0016025 does not include an Attachment 2. Otherwise, provide AAC pricing for all Pharmaceuticals and Supplies listed in Attachment F.

212. (Barcode Scanners) Are the barcode scanners currently in place capable of reading 2-D barcodes, linear barcodes, or both?

RESPONSE: The DPSCS barcode scanners read linear and 2-D. The Department does not use 2-D barcodes.

213. (Attachment Y Formulary Report) Several medications listed in Attachment Y Formulary Report typically are not seen on correctional formularies, and they are misrepresented in terms of their prices and the safety concerns posed in correctional settings. What is the current frequency of the formulary review? Are the current clinical pharmacists active members in the routine review of the formulary medications listed in the provided formulary?

RESPONSE: The formulary review is done quarterly. Yes, the current clinical pharmacists are active participants in the routine review of formulary medications.

214. (Additional Questions) In the event that any responses to questions are unclear, will there be an opportunity to ask additional questions for clarification purposes?

RESPONSE: Generally, there is an opportunity for a subsequent round of questions if any answers in the prior round of questions need clarification.

215. Please confirm if subsection 3.2.32.9 was inadvertently removed from the section or if the subsections should be renumbered accordingly.

RESPONSE: RFP Section 3.2.32 has been renumbered. See Amendment 6, Item 3.

216. (Amendment 3, Items 2 & 3) As many vendors have already collected and organized the invoices for July 2017 for the more than 2,000 line items required for the Financial Proposal Form in anticipation of the prior due date that was a week away, would you please reconsider changing the requirement back from June 2017 invoices to July 2017 invoices? If not, could you please explain why the invoice date was changed?

RESPONSE: No. See Amendment 5, Item 31.

217. (340B) The current 340 B guidelines and program are under scrutiny and pressure from the Executive and Legislative Branches of Federal Government. The most recent 2015 guidelines were withdrawn in June and there are ongoing congressional hearings focused on the program's transparency, compliance and audit enforcement.

The consequences for failure to comply with guidelines by the covered entity or contracted pharmacy are significant.

Given this, would the Department consider the following questions as it relates to the 340 B program as outlined in the RFP, Exhibit Z and Exhibit Z1:

Attachment F of the RFP instructs vendors to include all management fees including those related to 340B (e.g., drugs, interfacing with the EMR and the covered entities Macrohelix tracking and management software) in the overall Management Fee for all pharmacy services covered under this contract. Further, there is a column provided to allow Offerors to propose a percentage reduction in the management fee in the event that the 340B program is terminated for any reason. As the costs associated with the 340B program are directly tied to the number of patients and orders, how will the Department assess the reasonableness and legality of the percentage discount offered for 340B services given the expectation of HHS/HRSA compliance?

RESPONSE: The only discount associated with 340B services is represented by Attachment F, Column C which provides Offerors with an opportunity to propose a discount off of the Annual Management Fee in the event that the 340B program is discontinued.

218. (340B) Transparency of the costs and payments associated with the 340B program is a significant issue and is currently the subject of congressional hearings. How will transparency of pricing and dispensing fees be maintained in light of the requirement in the RFP that Offerors fold the dispensing fees associated with the 340B program into their Management Fee for the entire DPSCS contract?

RESPONSE: Pricing proposed via Attachment F will provide sufficient information to the Department.

219. (340B) Medications dispensed through the 340B program require additional management and oversight by the contracted pharmacy to ensure that HHS/HRSA guidelines are followed. The current HHS/HRSA framework applies the costs associated with the additional oversight to each order through a dispensing fee applied to each 340B medication dispensed by the Contract Pharmacy. In this manner, HHS/HRSA through its audit of the Federally Qualified Healthcare entity is able to track the cost associated with each order. Has Bon Secours as the Federally Qualified Healthcare Entity or the Department inquired or verified with HHS/HRSA that a flat fee reimbursement not based upon a "per prescription" dispensing fee is legal within HHS/HRSA guidelines?

RESPONSE: Bon Secours must meet all applicable federal and State regulations for the 340B program.

220. (340B) Would the Department consider amending the RFP to require proposals to apply a negotiated dispensing fee to each 340B medication rather than a flat rate to be included in the administrative fee?

RESPONSE: No.

221. (340B) Has the Department verified with Bon Secours and HHS/HRSA that the inclusion of fees associated with the 340B program into the pharmacy vendor's Management Fee for the entire DPSCS contract does not violate the Anti-Kickback statute 42. U.S.C. 1320a-7b(B)? For example, in exchange for offering favorable pricing to DPSCS for its non-340B services, the winning Contractor will secure the 340B contract with Bon Secours.

RESPONSE: Bon Secours must meet all applicable federal and State regulations for the 340B program.

222. (340B) HHS/HRSA guidelines instruct that the savings generated from 340B discounts on medication pricing for the Federally Qualified Healthcare Entity are to be applied back into the 340B program in order to treat a greater number of affected patients. As it is the Department's intent to increase the number of patients they are able to treat, will the Department provide quantitative data on the current number of 340B eligible patients at the start of the program and the estimated growth quarterly for each contract year so respondents are able to accurately price the cost as there is a direct correlation to the number of orders dispensed and the cost for the pharmacy to follow HHS/HRSA guidelines?

RESPONSE: The Department does not have this information.

223. (340B) HHS/HRSA regulations apply only to the Covered Entity, the Covered Patient, Contract Pharmacy and the Manufacturer. Has either the Department or Bon Secours received permission or verified with HHS/HRSA that the Department may act as the intermediary negotiator between the Covered Entity and its Contracted Pharmacy and remain compliant with HHS/HRSA guidelines?

RESPONSE: Bon Secours must meet all applicable federal and State regulations for the

340B program.

224. (340B) HHS/HRSA regulations apply only to the Covered Entity, the Covered Patient, Contract Pharmacy and the Manufacturer. Has either the Department or Bon Secours received permission or verified with HHS/HRSA that an arrangement where the covered entity delegates its responsibility to pay the Contracted Pharmacy to the Department complies with HHS/HRSA guidelines?

RESPONSE: Bon Secours must meet all applicable federal and State regulations for the 340B program.

225. (340B) HHS/HRSA regulations require the covered entity to retain complete responsibility for contract pharmacy compliance with 340B Program requirements. Under the proposed contract the covered entity has delegated dispensing fee responsibility to the Department (Attachment Z-1, Section6.1). Please describe the compliance mechanism given the delegation of responsibility to the Department for fees.

RESPONSE: Bon Secours must meet all applicable federal and State regulations for the 340B program.

226. (340B) HHS/HRSA regulations apply only to the Covered Entity, the Covered Patient, Contract Pharmacy and the Manufacturer. The Department is not covered under HHS/HRSA guidelines and is not subject to audit by HHS/HRSA. Has either the Department or Bon Secours determined how Bon Secours will comply with HHS/HRSA audit provisions pursuant to the described arrangement where the covered entity has delegated financial responsibility to the Department, but is legally responsible to conduct audits and comply with HHS/HRSA audits?

RESPONSE: Bon Secours must meet all applicable federal and State regulations for the 340B program.

227. Attachment F (340B) Attachment F instructions state:

> G) On the Annual Management Fee Tab, provide the Monthly Management Fee for Pharmacy Services. The Annual Management Fee is to include all Pharmacy Services including those related to 340B Drugs, Interfacing with the EMR, and the Covered Entity's 340B Macro Helix Tracking and Management Software. The Annual Management Fee for Pharmacy Services will then autopopulate in the Summary Tab under Column C.
>
> H) On the Annual Management Fee Tab, a column has been provided allowing the Offeror to propose a percentage reduction in the Annual Management Fee in the event that the 340B Program is terminated for any reason. The percentage reduction in the Annual Management Fee will be applied monthly to the Monthly Management Fee.

Further, Section 1.5 of the RFP states:

1.15 Award Basis
The Contract shall be awarded to the responsible Offeror submitting the Proposal that has been determined to be the most advantageous to the State, considering price and evaluation factors set forth in this RFP (see COMAR 21.05.03.03F), for providing the goods and services as specified in this RFP.

And, Section 5.3 of the RFP states:

5.3 Financial Proposal Evaluation Criteria
All Qualified Offerors (see Section 5.5.2.4) will be ranked from the lowest (most advantageous) to the highest (least advantageous) price based on the Total Financial Proposal Price within the stated guidelines set forth in this RFP and as submitted on Attachment F and F1 - Financial Proposal Form.

Please clarify how Qualified Offeror's rank will be determined from the lowest to the highest with two prices being requested one with 340 B services and one without.

RESPONSE: The Annual Management Fee for Pharmacy Services will be weighted at 75% and the Annual Management Fee for Pharmacy Services if 340B Program is Terminated will be weighted at 25%. See Amendment 6, Items 9 and 10.

228. Attachment F (340B) [Referencing question 52] Is one more important or carry higher weighting?

RESPONSE: See Response to Question 227.

229. Attachment F (340B) [Referencing question 52] How pursuant to the award basis are financial proposals evaluated with the request to provide a management fee with all services including 340B and a management fee with all services excluding 340B (i.e., What happens if there is a conflict where an Offeror is lowest or lower without 340B than with 340B or vice versa?)

RESPONSE: See response to question 227.

230. Amendment #3
2. AMEND the Attachment F–Financial Proposal Form Instructions Tab - E)
3. AMEND the Attachment F–Financial Proposal Form Instructions Tab - L)
Statement of the Facts:
On June 22, 2017, the original RFP proposal was issued including Attachment F – Financial Proposal Form which required a manufacturer/wholesaler invoice price for the month of July 2017 for each item on the attachment. In addition, the Offeror was asked to provide a copy of the invoices to substantiate the prices in the same order as listed on the Pharmaceuticals and Supplies Tab.

The stated goal of the RFP is to award the contract to the Offeror submitting the proposal that has been determined to be the most advantageous to the State with financial factors receiving greater consideration.

The change in date to June 2017 puts the State at risk of not selecting the Offeror who provides the Best Value to the State.

Given that the RFP was due on August 22nd and no Offeror could have known or counted on an extension, all Offerors would have invested significant time and resources in purchasing these items, assembling the respective invoices, negotiating more favorable pricing and completing the pricing information in Attachment F to reflect July 2017 pricing as directed in the RFP.

In addition, there may be Offerors who may not have purchased certain items on the drug list recently or ever and then specifically purchased the items in July in order to meet the RFP requirements. The RFP instructions expressly allow for Offerors to use acquisition prices prior to July 2017 in the event that they did not purchase an item in July 2017.

Since the notice of this change was not provided until August 10th then the Offerors could not have purchased the items in June 2017. Failing to ensure that the Department receives the most accurate and recent acquisition cost supported by wholesaler invoices undermines/compromises the stated goals of the RFP.

Question:
Given that July 2017 pricing information is more current and relevant, would the Department consider reversing Amendment #3 to move the date of the required invoices from June of 2017 back to July 2017 to complete Attachment F?

RESPONSE: No.

231. Amendment #3 2. AMEND the Attachment F—Financial Proposal Form Instructions Tab – E) 3. AMEND the Attachment F—Financial Proposal Form Instructions Tab – L)

Statement of the Facts and Issues to the change in the required Pricing/Invoice date from July 2017 to June 2017.
This change by the Department raises several critical issues including the following:

At no point during the Pre-Bid Conference did the Department or any potential Offeror raise an issue regarding the required Pricing/Invoice date. Nor has the Department disclosed any question it received regarding the required Pricing/Invoice date. Thus, there does not appear to be any logical or practical justification for the Department shifting the required Pricing/Invoice date from July 2017 to June 2017 while simultaneously moving the Proposal Due (Closing) date forward from August 22, 2017 to September 25, 2017. By way of comparison, the Proposal Due (Closing) date for the previous RFP for this Contract was moved on multiple occasions and on two occasions, the required Pricing/Invoice date was also moved forward to reflect more current pricing. Here, the inverse has occurred with the

Proposal Due (Closing) date being moved out a month while the Required Pricing/Invoice date was moved a month earlier with no identifiable economic benefit to the State.

Issuing the amendment just 12 days before the existing Proposal Due (Closing) date has resulted in Offerors wasting considerable hours and resources compiling pricing information and gathering invoices to provide the information requested prior to the amendment. Similarly, the effort and good will expended by Offerors to negotiate favorable terms with manufacturers and wholesalers during the month of July has likewise been for naught.

Amendment #3 may keep the State from receiving pricing that is most advantageous to it in contravention of the stated purpose of the RFP. First, because Amendment #3 moved the required Pricing/Invoice date to June 2017, Offerors are unable to use the more favorable pricing they were able to negotiate or medications purchased in July 2017 in an effort to comply with the original RFP instructions. Instead Offerors are locked in to providing prices and invoices from some point prior to July 1, 2017. Second, included on Attachment F are pharmaceuticals that some Offerors may not have purchased in June 2017 and potentially for several months prior. The change in the required Pricing/Invoice date will result in some Offerors including outdated pricing that does not accurately reflect the current cost of these pharmaceuticals. Not only could this result in in their bids incorrectly appearing to be more favorable, but the effect of the difference between the current accurate price and the inaccurate outdated price will be felt exponentially over the term of the Contract to the detriment of the State. The better and more advantageous approach would be for the State to require Offerors to provide the more accurate pricing from July 2017. Also, since the proposal due date is at least three months past the required Pricing/Invoice date, it would be in the State's best interest to receive an Offerors' most current and accurate pricing. Offerors should be permitted to provide pricing from more current months moving forward (e.g., August, September), so long as the Offer's prices on Attachment F are supported by a copy or copies of a manufacturer / wholesaler invoice(s) as required.

Because (1) there appears to be no justification for the change in the required Pricing/Invoice date from July 2017 to June 2107, (2) moving the required Pricing/Invoice date a month earlier while moving the Proposal Due (Closing) date back is illogical and inconsistent with prior practice, (3) the change in the required Invoice date may keep the State from receiving the most advantageous pricing and the best information upon which to base its decision, the decision to shift the required Pricing/Invoice date one month earlier without any apparent economic rationale just 12 days prior to the existing Proposal Due (Closing) date creates an appearance of impropriety and places this important RFP in a negative light.

Questions:
(A) What was the Department's basis for shifting the required Pricing/Invoice date back one month just 12 days prior to the existing Proposal Due (Closing) date especially in light of the fact that the Proposal Due (Closing) date was moved forward from August 22, 2017 to September 25, 2017?

(B) How does the Department reconcile shifting the required Pricing/Invoice date one month earlier, which may keep it from receiving the most accurate and current pricing, with the stated goal of the RFP which is to obtain the most advantageous pricing for the State?

(C) Will the Department move the required Pricing/Invoice date to July 2017 so that Offerors may provide their most current and competitive pricing?

(D) Will the Department permit Offerors to provide pricing from more current months moving forward (e.g., August, September), so long as the Offeror's prices on Attachment F are supported by a copy or copies of a manufacturer/ wholesaler invoice(s) as required?

RESPONSE: (A) – (B) The Department will not provide this information. (C) – (D) No.

232. Attachment F – Financial Proposal Form Instructions Tab (Amended 08/10/17)
Overview of concern:
The cost of pharmaceuticals and supplies account for the overwhelming majority of the Department's annual bill. The list of Pharmaceuticals and Supplies to be priced for evaluation in this RFP is based upon utilization from 2016.

This utilization is not an accurate reflection of the Department's current utilization.

This utilization is not an accurate forecast of utilization in 2018 and the next seven (7) years. For example, there are drugs that will go generic, that will cease to be produced, and that have yet to come to market.

The programs and services of your respective offerors will have a major impact on the mix and quantity of drugs utilized over the next seven (7) years. It is a false assumption that each Offeror would dispense the same mix and quantity of drugs over the course of the contract.

There is an exhaustive list of other factors that will also impact the quantity and selection of medications (e.g., prescribing habits of practitioners that are not currently employed within the Department, changes to the formulary, inmate population changes, legal issues, policy changes and new laws).

These factors are not reflected in the current pricing methodology which treats utilization as a fixed static number based on data from 2016. The inaccuracy is then compounded by extending it out for each respective year of the contract and renewal option to reach a grand total for seven (7) years. In essence, each Offeror will be evaluated on pricing that is multiplied by seven (7) and based on outdated information. Further, these figures will produce inaccurate projections of the anticipated cost of this contract for presentation to BPW.

For example, Attachment F line 282:

PEGASYS 1ML 180MCG/1ML VIAL, Syringe, Brand, 18.6/368
Pegasys was the conventional and only available treatment option for HCV for decades. Its use had been quite significant accounting for millions of dollars toward the annual medication

spend each year. Since 2015, with newer therapies available, the use of Pegasys has drastically declined and it is now obsolete. Its use is no longer recommended for HCV treatment per National Guidelines (such as AASLD) and the Department has achieved better outcomes using other, more preferred options.

> However Pegasys is an expensive drug that is included in Attachment F for all Offerors to price. While it is not current or accurate, it will have a significant impact on the pricing evaluation. Other similar examples can be found throughout Attachment F and more will naturally occur as treatment options and preferences change. It is not this one item that is the issue, but rather it is an example of the fundamental flaw in using historical data to determine the most advantageous offeror and to project future spend for the State.

Finally, Section 1.15 Award Basis states:

> The Contract shall be awarded to the responsible Offeror submitting the Proposal that has been determined to be the most advantageous to the State, considering price and evaluation factors set forth in this RFP (see COMAR 21.05.03.03F), for providing the goods and services as specified in this RFP.

The "price" factor for the pharmaceuticals and supplies is not an accurate reflection of the total yearly spend under the resulting contract, yet it is the most significant price component and will account for the large majority of the evaluated total. This fundamental flaw in the RFP will create a false narrative that will confound the selection process and subject the award to avoidable scrutiny, review or rejection.

Question:

So that the Department will be in a better position to evaluate the Best Value for the State, we respectfully ask the Department to consider using a more current drug list and to eliminate multiplying the potential error by seven. Will the Department consider altering the Pharmaceuticals and Supplies Tab to the price per pill of the Current Top 200 Drugs by price and/or volume and more importantly use the total prices of one year without multiplying by seven?

RESPONSE: Offerors shall use Attachment F – Financial Proposal Form as revised by Amendment 5 to submit the Financial Proposal.

233. Question:
I have read the Duvall Act and in section 17D, the requirement for medication delivery is within 24 hours. Duvall vs. Hogan is the reasoning behind the 12 hour delivery stipulation but is there another policy or consent decree that requires a more stringent delivery time that I am missing?

RESPONSE: The Department has determined that in order to comply with the requirement of the Duvall consent decree that detainees receive medication within 24 hours, the

pharmacy Contractor must deliver medications to the facilities within 12 hours of receipt of the order.