5. PROJECT NUMBER (if applicable)

CODE

7. ADMINISTERED BY

2. AMENDMENT/MODIFICATION NUMBER

CODE

6. ISSUED BY

8. NAME AND ADDRESS OF CONTRACTOR

4. REQUISITION/PURCHASE REQ. NUMBER

3. EFFECTIVE DATE

9A. AMENDMENT OF SOLICITATION NUMBER

9B. DATED

PAGE

OF PAGES

10A. MODIFICATION OF CONTRACT/ORDER NUMBER

10B. DATED

BPA NO.

1. CONTRACT ID CODE

FACILITY CODE

CODE

Offers must acknowledge receipt of this amendment prior to the hour and date specified in the solicitation or as amended, by one of the following methods:

The above numbered solicitation is amended as set forth in Item 14. The hour and date specified for receipt of Offers

**E. IMPORTANT:**

is extended,

(a) By completing Items 8 and 15, and returning \_\_\_\_\_\_\_\_\_\_ copies of the amendment; (b) By acknowledging receipt of this amendment on each copy of the

offer submitted; or (c) By separate letter or electronic communication which includes a reference to the solicitation and amendment numbers. FAILURE OF YOUR

ACKNOWLEDGMENT TO BE RECEIVED AT THE PLACE DESIGNATED FOR THE RECEIPT OF OFFERS PRIOR TO THE HOUR AND DATE SPECIFIED MAY

is not extended.

12. ACCOUNTING AND APPROPRIATION DATA

(REV. 11/2016)

is required to sign this document and return \_\_\_\_\_\_\_\_\_\_\_ copies to the issuing office.

is not,

A. THIS CHANGE ORDER IS ISSUED PURSUANT TO: (Specify authority) THE CHANGES SET FORTH IN ITEM 14 ARE MADE IN THE CONTRACT ORDER NO. IN ITEM 10A.

15C. DATE SIGNED

B. THE ABOVE NUMBERED CONTRACT/ORDER IS MODIFIED TO REFLECT THE ADMINISTRATIVE CHANGES

SET FORTH IN ITEM 14, PURSUANT TO THE AUTHORITY OF FAR 43.103(b).

RESULT IN REJECTION OF YOUR OFFER. If by virtue of this amendment you desire to change an offer already submitted, such change may be made

by letter or electronic communication, provided each letter or electronic communication makes reference to the solicitation and this amendment, and is received

prior to the opening hour and date specified.

C. THIS SUPPLEMENTAL AGREEMENT IS ENTERED INTO PURSUANT TO AUTHORITY OF:

D. OTHER

BY

Contractor

16C. DATE SIGNED

14. DESCRIPTION OF AMENDMENT/MODIFICATION

16B. UNITED STATES OF AMERICA

Except as provided herein, all terms and conditions of the document referenced in Item 9A or 10A, as heretofore changed, remains unchanged and in full force and effect.

15A. NAME AND TITLE OF SIGNER

16A. NAME AND TITLE OF CONTRACTING OFFICER

15B. CONTRACTOR/OFFEROR

STANDARD FORM 30

PREVIOUS EDITION NOT USABLE

Prescribed by GSA - FAR (48 CFR) 53.243

(Type or print)

(Type or print)

(Organized by UCF section headings, including solicitation/contract subject matter where feasible.)

(Number, street, county, State and ZIP Code)

(If other than Item 6)

(Specify type of modification and authority)

(such as changes in paying office, appropriation date, etc.)

(If required)

(SEE ITEM 11)

(SEE ITEM 13)

(X)

CHECK

ONE

**13. THIS ITEM APPLIES ONLY TO MODIFICATIONS OF CONTRACTS/ORDERS,**

**IT MODIFIES THE CONTRACT/ORDER NO. AS DESCRIBED IN ITEM 14.**

**11. THIS ITEM ONLY APPLIES TO AMENDMENTS OF SOLICITATIONS**

**AMENDMENT OF SOLICITATION/MODIFICATION OF CONTRACT**

(Signature of person authorized to sign)

(Signature of Contracting Officer)

1

16

A00003

09-18-2017

None

00244

Department of Veterans Affairs

Network Contracting Office 4

00244

Department of Veterans Affairs

Network Contracting Office 4

To all Offerors/Bidders

VA244-17-R-0822

X

X

X

1

10/10/2017 @ 4:00 PM EST

X

1

1. Issuance of Amendment A00003 See Continuation Page for complete details on Clarification to Questions and Answers.

2. See Continuation Page for PWS chages due to responses provided from Questions and Answers.

3. All other terms and conditions remain unchanged.

SHAWN SMITH

Contracting Officer

CONTINUATION PAGE

**Question 2**. Paragraphs 2.3.2-2.3.4 indicate that “Current standards are 1200 active patients per full time” RN/Clinical Associate/Clerical Associate. Does this mean that for Providers that have less than 1200 patients allowed on the panel (such as mid-level providers or part-time providers) the RN, Clinical Associate, and Clerical Associate can be shared as long as they are not assigned to over 1200 patients?

A. Yes

Clarify: Based on conversation in the pre-proposal conference, It was our understanding that each PACT team would need its own team member and that positions could not be “shared” across PACT teams. We believe this would highly affect the team aspect. We ask that VA reconsider this response.

1. Each PACT serves ~1200 patients.  Each PACT will have 1 Provider, 1 RN, 1 LPN and 1 clerk.  The philosophy is that these 4 work closely together and are focused on their 1200 patients.  Aside from short duration coverage or other time-limited needs, each PACT will support the needs of their own patients.  In other words, the PACT disciplines  (RNs for example) should not be interchangeable or pooled to serve the needs of any CBOC patient.

**Question 3.** Paragraph 2.3.3 provides four options for Clinical Associates: LPN, LVN, MA, or HCT. Our understanding is that Pittsburgh VA policy does not allow for MA or HCTs to perform the functions required of the Clinical Associate. Could the VA confirm that MAs or HCTs are acceptable Clinical Associates? If so, what is the clinical scope that MAs or HCTs will be allowed to provide as Clinical Associates?

A. MAs and HCTs cannot perform clinical work beyond blood pressure checks and.

Clarify: It appears the person answering the question did not finish answering. Please clarify.

A. MAs and HCTs cannot perform clinical work beyond blood pressure checks.

Clarify: The answer ends with “and”. What is the rest of the sentence? Would MA’s and HCT’s be allowed to do phlebotomy, testing and specimen processing? Why are MA’s and HCT’s included as options for the Clinical Associate position if they cannot do all the tasks?

A. MAs and HCTs cannot perform clinical work beyond blood pressure checks.

**Question 4.** Paragraph 2.5.1 indicates the following requirement for podiatrists “1.0 FTE per 950 active patients and only a single room available for services or 1 FTE per 1300 active patients with two rooms and clinical support (such as a nail technician)” Does the reference to “active patients” refer to Primary Care active patients or number of patients needing podiatry services at the CBOC?

A. Refers to the number of patients needing podiatry services at the CBOC (podiatrists panel size)

Clarify: Regarding podiatry utilization for staffing and space planning, the first question in the Additional Pre-Proposal shows a wide range between sites that is inversely proportional to the number of veterans using the site. Do you have any explanation for that?

1. The data was for one month snapshot, for the actual contract we will use one year historical data. Washington currently employs 0.7 podiatry FTE; Fayette employs 0.5 podiatry FTE.

**Question 5.** Paragraph 2.6 requires 2.0 Telehealth Clinical Technicians. What level of discipline

is required for these positions (e.g. LPN/ LVN and CMA/RMA)?

A. Certified Medical Assistant, Health Technician, LPN or higher level provider; LPN is Preferred.

Clarify: Based on conversation in the pre-proposal conference, it was our understanding that the backup was also preferred to be an LPN. Could you please clarify?

1. LPN is preferred although others are acceptable.

**Question 10.** Will the VA be providing any staff members to the CBOC? Will the Contractor need to plan for space for any VA providers?

A. VA requires office space for psychiatrist and audiologist and lab space for the audiologist.

Clarify: We assume the VA meant psychologist instead of psychiatrist. Please clarify.

A. Psychologist

Clarify: Can the Audiology Exam or Hearing Aid Lab also be the office for the Audiologist?

1. Yes

**Question 21.** 1.1.1 – “A Primary care CBOC often provides home-based primary care (HBPC) and home telehealth to the population it serves to meet the primary care and mental health needs of Veterans who have difficulty accessing clinic-based care.” – Can you please estimate how many home based primary care and home telehealth encounters are anticipated monthly?

1. N/A, current CBOC does not offer HBPC services. Home telehealth services are offered but fall under another service line’s purview and not the contracted CBOC’s. So the CBOC is not responsible for these encounters/visits and will not be reimbursed for them.

Clarify: Can the VA please remove the section in 1.1.1 that indicates contractor is responsible for HBPC?

1. Section 1.1.1 will be reworded from:
   * 1. Primary Care CBOC: offer both medical (physically on site) and mental health care (either physically on site or by telehealth) and may offer support services such as pharmacy, laboratory, and x-ray. Primary Care CBOCs are required to provide both primary care and mental health services. Sites that do not provide both primary care and mental health services are classified as Other Outpatient Services. Access to specialty care is not provided on site, but may be available through referral or telehealth. A Primary care CBOC often provides home-based primary care (HBPC) and home telehealth to the population it serves to meet the primary care and mental health needs of Veterans who have difficulty accessing clinic-based care. Primary care in VA includes both medical and mental health care services, as they are inseparable in providing personalized, proactive, patient-centered health care. **Primary Care Requirements.** A point of service is said to provide primary care services if the site registers more than 500 primary care encounters within the primary care stop class within a given fiscal year. **Mental Health Requirements.** A point of service is said to provide mental health services if the site registers more than 500 mental health encounters within a single mental health clinic stop class within a given fiscal year. Mental health services may be provided using telehealth, if the workload at the point of service would not otherwise justify the presence of mental health providers.

To:

* + 1. Primary Care CBOC: offer both medical (physically on site) and mental health care (either physically on site or by telehealth) and may offer support services such as pharmacy, laboratory, and x-ray. Primary Care CBOCs are required to provide both primary care and mental health services. Sites that do not provide both primary care and mental health services are classified as Other Outpatient Services. Access to specialty care is not provided on site, but may be available through referral or telehealth. A Primary care CBOC often provides home telehealth to the population it serves to meet the primary care and mental health needs of Veterans who have difficulty accessing clinic-based care. Primary care in VA includes both medical and mental health care services, as they are inseparable in providing personalized, proactive, patient-centered health care. **Primary Care Requirements.** A point of service is said to provide primary care services if the site registers more than 500 primary care encounters within the primary care stop class within a given fiscal year. **Mental Health Requirements.** A point of service is said to provide mental health services if the site registers more than 500 mental health encounters within a single mental health clinic stop class within a given fiscal year. Mental health services may be provided using telehealth, if the workload at the point of service would not otherwise justify the presence of mental health providers.

**Question 29**. 4.6.7 – Radiology Service Links do not work

A.

<http://vaww.oed.portal.va.gov/applications/VistAImaging/Lists/VistA%20Imaging%20Approved%20Equipment%20List/AllItems.aspx> and <http://vaww.oed.portal.va.gov/applications/VistAImaging/Lists/Device%20Validation%20Database%20%20SharePoint%202003%20Archiv/User%20View.aspx> and HL7 communications: <http://vaww.oed.portal.va.gov/applications/VistAImaging/Lists/Approved%20Devices/Approved%20HL7%20Interfaces.aspx>.

Clarify: These links still do not work. They appear to be intranet links. Could the VA either provide Internet links or documents as amendments?

1. Added as attachment D.29 DICOM and D.30 hL7 in section D.



**Question 30.** 4.6.7 – Please provide specific requirements for rad room equipment including generator kilowattage and whether desires single phase/three phase equipment. Please also provide direction on whether the VA requires CR or DR for image digital processing and transmission.

1. Three phase. DR required, CR allowed. The rad room has to be shielded. For any x-ray room, they need a shielding calculation from a qualified medical physicist. Of course, the room has to be large enough to house the equipment. The equipment should be a fully mobile x-ray tube / detector to be able to perform studies requiring cross table lateral approach. Also, the big push is dose reduction and this should be seriously considered when purchasing.

Clarify: If a DR is required, how is a CR allowed? Please clarify.

1. DR required.

Clarify: The space requirements require an exam table in each of the telehealth rooms. Does that also apply to the telehealth room for Mental Health? Our experience has been to have a desk with desktop video conferencing unit.

1. Yes

**Question 41.** 4.7.16 – “Doors for each PACT Patient Care Room should be sliding and follow the design standards outlined in the PACT Design Guide.” In our experience the “barn doors” cause an issue with auditory privacy as they are not as sound proof as traditional doors. Has this been taken into account with other VA clinics? If so, what has been the solution? Is this the only type of room in which a sliding door is needed? Please clarify?

1. Sliding barn doors within pact exam rooms on both sides of room.

Clarify: “Sliding barn doors within PACT exam rooms”. The design guide advises having the doors on the outside of the exam room for multiple reasons. Is mounting outside the room okay?

1. Yes

**Question 46.** 4.7.31 – “In accordance with VA and VHA directives, policies, and handbooks, all equipment attaching to a VA network will be owned by the VA and controlled by the VA.” Does this imply that the VA will provide the Codex for the rad room? Please clarify.

1. It is preferred the vendor provides, maintains, and owns the equipment in the rad room.

Clarify: if connecting contractor owned equipment to the VA network will be permitted, we ask that the VA remove this language from the proposal.

1. Section 4.7.31 will be re worded from:

**Equipment, Office Supplies and Technical Support**: In accordance with VA and VHA directives, policies, and handbooks, all equipment attaching to a VA network will be owned by the VA and controlled by the VA. No other equipment will be connected to this network. The use of the equipment will be for the benefit of the Government in providing care to our veterans. The equipment will only be used by those expressly authorized in support of the VAPHS. All users must comply with and adhere to VA Directives and VA Cyber Security policies.

To State:

**Equipment, Office Supplies and Technical Support**: In accordance with VA and VHA directives, policies, and handbooks, all equipment attaching to a VA network will be owned by the VA and controlled by the VA. The following exception shall apply to VA approved Contractor supplied equipment, such as FDA approved equipment that conforms to the Vista Imaging listing for Digital Image and Communication in Medicine (DICOM) (3.0)DICOM and hL7 communications for Radiology Services. The use of the equipment will be for the benefit of the Government in providing care to our veterans. The equipment will only be used by those expressly authorized in support of the VAPHS. All users must comply with and adhere to VA Directives and VA Cyber Security policies.

**Question 54.** 4.8.6 – Link does not work.

1. Attachment D. 14 Directors Performance Measures

Clarify: Attachment 14 is cited in the evaluation criteria for both Washington and Fayette County RFPs in as Subfactor 3.I. This attachment appears to be a document that is intended *primarily for VA management*, and presents high-level measures to evaluate overall performance of senior management, rather thana CBOC contractor.

The attachment does not directly address most of the measures cited in the evaluation subfactor (e.g., primary care, mental health, documentation, etc.), includes a number of acronyms that are not defined in section 1.1 of the RFP (e.g., ELC, QSV,SPARQ, EHCPM, AES, VERC/PENTA, ADLTCI, CBI, FBCS, etc.) or cited anywhere else in the RFP, and the general measure of "Access" in the attachment cites a performance target that references a question that is not even identified.

I understand that this was provided to you by a colleague. I would ask if they can review this to see if this is in fact, the document intended, as it is not at all clear how the attachment relates to the evaluation subfactors specified in 3.I.

A. Section 4.8.6 will be re worded from:

The VA is committed to providing high quality primary care. The VA measures quality in primary care through its performance measurement system. Several "process" and "outcome" measures are extracted by external reviewers from random samples of records of veterans who visited VA primary care providers at the Contractor’s Outpatient Site of Care. These measures change from year to year. The current performance measures and method of extraction are available at http://vaww.oqp.med.va.gov. The Contractor is responsible for achieving levels of performance on these measures that meet or exceed the annual expectations for performance of VAPHS as outlined in the Network Performance Plan and Network Technical Manual. Revisions/updates to the Network Performance Plan and Network Technical Manual may be obtained from the above website. The Contractor is required to utilize the VISTA CPRS clinical reminder system as a means of both ensuring high performance on these measures and to facilitate monitoring of performance at the site independent of external reviewers. Levels of performance on the quality measures in primary care will be used as a factor in decisions about renewal of the contract.

To State:

The Contractor is required to utilize the VISTA CPRS clinical reminder system as a means of both ensuring high performance on these measures and to facilitate monitoring of performance at the site independent of external reviewers. Levels of performance on the quality measures in primary care will be used as a factor in decisions about renewal of the contract.

**Question 60.** Attachment 8 – T21 Implementation - Links in sections 7, 18, 22, 23(under note), 70, 71 and 88 do not work.

1. 7 -- Will be answered in a separate Amendment/ upon further clarification from end user.
2. 18 <http://vaww.prevention.va.gov/VHEI/NPO_Toolkit.asp>
3. 22 <http://vaww.prevention.va.gov/CPS/Guidance_on_Clinical_Preventive_Services.asp>
4. 23 <http://vaww.prevention.va.gov/CPS/Guidance_on_Clinical_Preventive_Services.asp>
5. 70 <https://vssc.med.va.gov/CallCenter/>
6. 71 -- Will be answered in a separate Amendment/ upon further clarification from end user.
7. 88 <http://reports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fMentalHealth%2fMHSurveyStruct_Summary&rs:Command=Render>

Clarify: These are intranet links and cannot be accessed by anyone who does not have VA access. Please provide publically accessible links or documents.

1. Some links no longer work, sites are VA Intranet, asking Subject Matter Experts if this Documentation can be removed from SOLICITATION.

**Question 61.** Attachment 9 – Government Furnished Equipment – Lab Equipment - How much feet of counter space is needed for equipment? How much other space is needed for floor mounted equipment such as refrigerators? How many electrical outlets and data jacks?

1. No specific requirement; contractor can coordinate with their staff to determine individual staff needs and suggestions. Lab square footage requirements listed in PACT Design Guide specifications.

Clarify: We ask the VA at the very least to provide the make and model of each piece of government furnished equipment so it can effectively plan for enough counterspace and data drops in the proposed floor plan.

1. Lab specifics are in the design guide, please refer to design guide.

**Question 84.** Will the VA be providing equipment such as an ENT chair and cerumen removal equipment?

1. Contractor will provide furniture, VA will provide equipment.

Clarify: Do you define the ENT chair as furnishing or equipment?

1. All ENT services are referred to Pittsburgh.

**Questions from PRE PROPOSAL**

**Question 1.** Will VA provide Podiatrist? What is the anticipated number of patients needing podiatry appointments? How many patients currently enrolled for podiatry?

1. Contractor will provide the Podiatrist. Fayette treated 256 unique patients in July, Washington treated 54 in July, Belmont treated 22 unique patients in July

Clarify: It seems peculiar that the smallest clinic in terms of enrollment treated the most podiatry unique patients. To take into account scheduled and unscheduled leave, please provide a year worth of data so that offerors can provide a more accurate FTE count for the proposals. We also ask that the VA provide the number of patients that are currently waiting to make a podiatry appointment in each location.

1. We can pull the data but it will not be available until after contract award. Washington currently employs 0.7 podiatry FTE; Fayette employs 0.5 podiatry FTE.

**Questions unanswered from Amendment A00002**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 73. | | 31 | 4.6.2.1 | Testing | Preceding sections specify VA is providing testing supplies but not indicated for Women Veterans testing. Can you please clarify?   1. No supplies provided for Women Veteran testing | |
| 88. | | Attach 9 | |  | VA provided equipment | 26 workstations seem low considering that there will be 24 just for the Patient Care Rooms and workstations for the Teamlet members.  Printers, phone system and phones are not listed.   1. Based on staffing we will provide the corresponding computers. Contractor will provide appropriate number of workstations |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 89. |  |  | Wireless | Will the VA provide access points and wireless devices for use by the PACT staff?  A. VA will provide laptops, contractor will provide mobile carts. |

**PRE PROPOSAL Questions unanswered from Amendment A00002**

**Question 10.** Would VA consider providing women’s health thin prep test kits?  Minimum order is 500 and they are not widely used.  Costly to dispose of unused ones.

1. No supplies provided for Women Veteran testing

**Additional Questions continuing with number scheme from Amendment A00002:**

98. When does the VA expect to release the amendment clarifying other items in amendment 2 that indicate “will be answered in a separate amendment”?

1. They are provided in this amendment.

99. This question is in response to the answer to question number 20 posted in Amendment 2 of solicitation number VA244-17-R-0720.

* Price/Cost Schedule. We see that the annual increase of estimated enrollees is over one (1) percent. However, VA’s most recent study on Veteran population completed in 2014 indicates a 2% decrease in population each year through the base and option years of this contract. Can the VA please provide their justification for enrollment increases when Veteran population actually decreases throughout the life of this contract?
* 1% increase based on historical performance of the contract. This includes increases to CBOC enrollees as well as increases to the PMPM rate.

After reviewing the solicitation VA244-10-0060 (The previous Washington and Fayette County solicitation) and the amendments, we found that the VA reported the following in Amendment 2:

* The clinical member numbers: Washington 4,850 overall PCNM, Fayette 2,677 PCNM. 4,562 (Washington) and 2,534 (Fayette) have had 12 month visits.

In amendment 2 of the current solicitation (VA244-17-R-0720), the VA reports the following in question 3 of the pre-proposal conference questions:

* What is the current enrollment at the clinics based on the last invoice?

1. Fayette July invoice – 2,968
2. Washington July invoice – 4,299
3. Belmont – 4,761

The answer to question 20 indicates that the increase of one percent of estimated enrollment is based on “historical performance”, however, review of actual enrollment numbers from the previous solicitation to the current solicitation indicate a drop in enrollment of over six percent.

In an effort to obtain the most accurate pricing from all offerors, we ask that the VA revise its numbers for the estimated enrollment in the price/cost schedule to reflect the actual historical trends indicated above. If actual enrollment in the future is greater than what is reflected in the price schedule, such increases can be accommodated without the same kind of negative financial impact as would occur if actual enrollment in the future is significantly less than is priced in the schedule.

1. Estimate is just that, actual enrollees and PMPM rate can fluctuate.

100. If an organization has multiple CBOC contracts, does the past performance evaluation consider past performance information on *all* similar contracts within the last three years?

A. The Past performance evaluation will consider past performance information on similar contracts within the last 5 years. Either provided or found through Past Performance Information Retrieval System (PPIRS).

101. If our active SAM registration doesn’t expire until months after the due date for bids, are we required to update the registration if any information has changed by the deadline for proposal submission, or can the updates be made when the registration is renewed?

A. Update can be completed when SAM renewal is due as long as the information such as Contractor name or address hasn't changed. This information would need to be updated prior to award, as our Contract writing system pulls the information from SAM into the 1449 Award Documentation.

102. Does *any* settlement for contract deficiencies associated with a federal contract within the past three years constitute a civil judgement under FAR 52.209-5, even if it’s not for a related type of contract, or only if it’s over a certain amount? Please specify the minimum amount, if applicable?

A. 52.209-5 applies to all settlements for contract deficiencies associated with any federal contract.  52.209-5 is a check the box clause, there is no dollar thresholds unless specifically stated (for example sub section (D) Have □ , have not □ ,within a three-year period preceding this offer, been notified of any delinquent Federal [taxes](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=e7c3de2c69ecf724736be4cfdf5433ce&term_occur=1&term_src=Title:48:Chapter:1:Subchapter:H:Part:52:Subpart:52.2:52.209-5) in an amount that exceeds $3,500 for which the liability remains unsatisfied.)  52.209-7 on the other hand requires the vendor to report specific detailed information as stated below.

Reporting Requirements

Agencies must insert FAR clause 52.209-7, “Information Regarding Responsibility Matters,” in all solicitations issued after April 22, 2010. The clause requires vendors who are submitting proposals for government contracts with an expected value of over $500,000 and having more than $10 million in active contracts and grants at the time of proposal submission to report information relating civil, criminal, and administrative proceedings.

Government contractors must report and maintain accurate information on FAPIIS concerning occurrences “within the last five years” relating to the following categories:

* Criminal Convictions: An offeror must provide information concerning whether the offeror and/or its principals has, in connection with the award or performance of a federal contract or grant, been subject to a federal or state criminal proceeding that resulted in a criminal conviction. The clause also requires the contractor to write a narrative description for all reported actions. 75 Fed. Reg. 14067 (Mar. 23, 2010).
* Civil Proceedings: An offeror must provide information concerning whether the offeror and/or its principals has, in connection with the award or performance of a federal contract or grant, been subject to a federal or state civil proceeding that resulted in a finding of fault and liability and required the payment of a monetary fine or penalty, reimbursement, restitution or damages of $5000 or more.
* Administrative Proceedings: The new rule defines an “administrative proceeding” as a “non-judicial process that is adjudicatory in nature in order to make a determination of fault or liability.” The rule provides the following examples of what is considered an administrative proceeding: (1) Securities and Exchange Commission proceedings; (2) Civilian Board of Contract Appeals proceedings; and (3) Armed Services Board of Contract Appeals proceedings. The rule also states that the definition does not include agency actions such as contract audits, site visits, correction plans, or inspection of deliverables.

An offeror must provide information concerning whether the offeror and/or its principals has, in connection with the award or performance of a federal contract or grant, been subject to a state or federal administrative proceeding that resulted in a finding of fault and liability that required the payment of a monetary fine or penalty of $5,000 or more, or the payment for any reimbursement, restitution, or damages in excess of $100,000.

Settlements: An offeror also must provide information relating to the award or performance of a government contract or grant where a federal or state administrative proceeding was disposed of by consent or settlement with an acknowledgment of fault by the contractor.

Contractor Certification

Additionally, a government contractor must certify that the information provided is “current, accurate, and complete as of the date of the submission.” Therefore, in order to ensure that the information provided is “current, accurate, and complete,” many contractors will find it necessary to amend their internal procedures and processes because the information required goes above and beyond the pre-FAPIIS requirements set forth in FAR 52.209-5, “Certification Regarding Responsibility Matters.” The increased reporting obligation is readily apparent from a comparison of the existing requirements of FAR 52.209-5 with the additional requirements of FAR 52.209-7, “Information Regarding Responsibility Matters.” Examples include:

* FAR 52.209-5 only requires the government contractor to check a box if a contractor has or has not been criminally convicted. In contrast, FAR 52.209-7, requires the contractor to draft a narrative commenting on the activity;
* FAR 52.209-5 requires offerors to look back three years while the new FAR 52.209-7 requires a five year look-back.

103. Since the pre-proposal conference addressed offerors questions for both Washington and Fayette County solicitations at the same time, it is unclear why offerors for Fayette County have until October 10, 2017 to submit bids, yet offerors for Washington County only have until September 26, 2017. Since the pre-proposal conference effectively established a common re-set point, we ask that VA extend the deadline for Washington County to October 10th as well.

A. Washington CBOC was posted to FBO 7/18/17 with an original response date of 9/1/18; 45 day response time. Fayette was posted to FBO 7/20/17 with an original response date of 9/8/2017; 50 day response time. FAR 5.203 Publicizing response time requires the Government to allow at least 30 days response time for receipt of proposals from date of issuance of a solicitation. Anything beyond 30 days is at the discretion of the Government. Dates were extended longer to allow a full week between the due dates for Washington CBOC, Belmont CBOC, and Fayette CBOC giving consideration to all offerors who may propose more than one offer.

104. The answer to question 12 on the last page of Amendment A00002 indicates that alternate pricing can be submitted. This answer seems to contradict page 109 of the Solicitation which deleted provision 52.212-1 "Multiple Offers."  Could the Government please clarify if Multiple Offers are allowed for the Fayette County, Washington County, and Belmont County CBOC?

A. Page 109 Addendum to 52.212-1 Continuation of Instructions to Offerors: (e) Multiple Offers is removed from this list, to allow alternate pricing.

105. Question regarding the following statement on page 110 of the Washington County RFP. "PLEASE INDICATE THE NAME OF BUSINESS ON THE FIRST PAGE ONLY OF EVERY VOLUME IN THE PROPOSAL. DO NOT PLACE BUSINESS NAME ON EVERY PAGE OF THE PROPOSAL." Does this include mentioning the name of the business anywhere in the body of the proposal or does this simply mean not mentioning the business name in the header or footer?

A. Yes, Contracting wants the business name on cover pages only. Please use "Offeror" opposed to the contractor's business name in the proposal content.

**THE FOLLOWING ARE CHANGES TO THE PWS:**

Paragraph 1.1.1 of the PWS shall change from:

* + 1. Primary Care CBOC: offer both medical (physically on site) and mental health care (either physically on site or by telehealth) and may offer support services such as pharmacy, laboratory, and x-ray. Primary Care CBOCs are required to provide both primary care and mental health services. Sites that do not provide both primary care and mental health services are classified as Other Outpatient Services. Access to specialty care is not provided on site, but may be available through referral or telehealth. A Primary care CBOC often provides home-based primary care (HBPC) and home telehealth to the population it serves to meet the primary care and mental health needs of Veterans who have difficulty accessing clinic-based care. Primary care in VA includes both medical and mental health care services, as they are inseparable in providing personalized, proactive, patient-centered health care. **Primary Care Requirements.** A point of service is said to provide primary care services if the site registers more than 500 primary care encounters within the primary care stop class within a given fiscal year. **Mental Health Requirements.** A point of service is said to provide mental health services if the site registers more than 500 mental health encounters within a single mental health clinic stop class within a given fiscal year. Mental health services may be provided using telehealth, if the workload at the point of service would not otherwise justify the presence of mental health providers.

To:

* + 1. Primary Care CBOC: offer both medical (physically on site) and mental health care (either physically on site or by telehealth) and may offer support services such as pharmacy, laboratory, and x-ray. Primary Care CBOCs are required to provide both primary care and mental health services. Sites that do not provide both primary care and mental health services are classified as Other Outpatient Services. Access to specialty care is not provided on site, but may be available through referral or telehealth. A Primary care CBOC often provides home telehealth to the population it serves to meet the primary care and mental health needs of Veterans who have difficulty accessing clinic-based care. Primary care in VA includes both medical and mental health care services, as they are inseparable in providing personalized, proactive, patient-centered health care. **Primary Care Requirements.** A point of service is said to provide primary care services if the site registers more than 500 primary care encounters within the primary care stop class within a given fiscal year. **Mental Health Requirements.** A point of service is said to provide mental health services if the site registers more than 500 mental health encounters within a single mental health clinic stop class within a given fiscal year. Mental health services may be provided using telehealth, if the workload at the point of service would not otherwise justify the presence of mental health providers.

Paragraph 2 of PWS shall change from:

1. **Staffing and Qualifications:** **MINIMUM PACT STAFFING REQUIREMENTS:** Sufficient support staff to conduct daily business, including such functions as patient registration, financial assessments, and medical record documentation in VISTA. The Contractor shall provide personnel in numbers and qualifications capable of fulfilling the standards outlined in the resultant contract. The Contractor should give preference to hiring Veterans in positions when applicable and permissible. The Contractor shall provide a sufficient number of primary care providers so that each primary care provider has a caseload ratio to meet VA standards. Current standards for caseload ratios are based on fulltime physician care for 1200 patients, and midlevel provider care for 900 patients in accordance with PCMM. The staffing standard for support staff shall be in ratios to Primary Care Providers of at least three support staff (1 Registered Nurse, 1 Licensed Practical Nurse and 1 Medical Support Assistant/Clerk/Medical Assistant) for each full time equivalent Primary Care Provider). Clinical Pharmacy Services: The CPS shall have available the same clerical support staffing given to other providers on the team when they are working in the capacity of a mid-level provider. The support staffing mix standard includes a registered nurse care manager for every 1200 patients served by the Outpatient Site of Care. Anticoagulation clinic management and Telephone Care for the primary care patients require support staff that is in addition to the PACT staff, even if located in a separate area. Staff time dedicated to Business Office functions (means testing, registrations or billing), phlebotomy, file room activities,or supporting non-primary care clinics (e.g., podiatry, social work, and dietary) are not considered PACT support staff for the purposes of this definition. These numbers may be adjusted, upon approval by the Government, based on the availability of exam rooms and support staff (refer to VHA Handbook 1101.02) . If the number of patients reaches 90% of the maximum panel size assigned by the facility the Contractor shall communicate to the VA the Contractor’s future staffing plan to ensure VA contract staffing ratio standards remain in accordance with PCMM staffing standards. **Total Estimated Patients enrolled/assigned to site: 4600.**

To:

1. **Staffing and Qualifications: MINIMUM PACT STAFFING REQUIREMENTS:** Sufficient support staff to conduct daily business, including such functions as patient registration, financial assessments, and medical record documentation in VISTA. The Contractor shall provide personnel in numbers and qualifications capable of fulfilling the standards outlined in the resultant contract. The Contractor should give preference to hiring Veterans in positions when applicable and permissible. The Contractor shall provide a sufficient number of primary care providers so that each primary care provider has a caseload ratio to meet VA standards. Current standards for caseload ratios are based on fulltime physician care for 1200 patients, and midlevel provider care for 900 patients in accordance with PCMM. The staffing standard for support staff shall be in ratios to Primary Care Providers of at least three support staff (1 Registered Nurse, 1 Licensed Practical Nurse and 1 Medical Support Assistant/Clerk/Medical Assistant) for each full time equivalent Primary Care Provider). Clinical Pharmacy Services: The CPS shall have available the same clerical support staffing given to other providers on the team when they are working in the capacity of a mid-level provider. The support staffing mix standard includes a registered nurse care manager for every 1200 patients served by the Outpatient Site of Care. Anticoagulation clinic management and Telephone Care for the primary care patients require support staff that is in addition to the PACT staff, even if located in a separate area. Staff time dedicated to Business Office functions (means testing, registrations or billing), phlebotomy, file room activities, or supporting non-primary care clinics (e.g., podiatry, social work, and dietary) are not considered PACT support staff for the purposes of this definition. These numbers may be adjusted, upon approval by the Government, based on the availability of exam rooms and support staff (refer to VHA Handbook 1406). If the number of patients reaches 90% of the maximum panel size assigned by the facility the Contractor shall communicate to the VA the Contractor’s future staffing plan to ensure VA contract staffing ratio standards remain in accordance with PCMM staffing standards. **Total Estimated Patients enrolled/assigned to site: 4600.**

Paragraph 4.6.13.2 of PWS shall change from:

* + - 1. Contractor shall provide administrative support for scheduling and answering telephone calls. Contractor shall provide a phone, office furniture, high stool (30”adjustable height) with armrests and back, basic administrative office and SPD supplies, and use of the CBOC’s shared office machines.

To:

* + - 1. Contractor shall provide administrative support for scheduling and answering telephone calls. Contractor shall provide office furniture, high stool (30”adjustable height) with armrests and back, basic administrative office and SPD supplies, and use of the CBOC’s shared office machines.

Paragraph 4.7.31 shall change from:

4.7.31 **Equipment, Office Supplies and Technical Support**: In accordance with VA and VHA directives, policies, and handbooks, all equipment attaching to a VA network will be owned by the VA and controlled by the VA. No other equipment will be connected to this network. The use of the equipment will be for the benefit of the Government in providing care to our veterans. The equipment will only be used by those expressly authorized in support of the VAPHS. All users must comply with and adhere to VA Directives and VA Cyber Security policies.

To:

4.7.31 **Equipment, Office Supplies and Technical Support**: In accordance with VA and VHA directives, policies, and handbooks, all equipment attaching to a VA network will be owned by the VA and controlled by the VA. The following exception shall apply to VA approved Contractor supplied equipment, such as FDA approved equipment that conforms to the Vista Imaging listing for Digital Image and Communication in Medicine (DICOM) and hL7 communications for Radiology Services. The use of the equipment will be for the benefit of the Government in providing care to our veterans. The equipment will only be used by those expressly authorized in support of the VAPHS. All users must comply with and adhere to VA Directives and VA Cyber Security policies.

Paragraph 4.8.6 Shall Change from:

4.8.6 The VA is committed to providing high quality primary care. The VA measures quality in primary care through its performance measurement system. Several "process" and "outcome" measures are extracted by external reviewers from random samples of records of veterans who visited VA primary care providers at the Contractor’s Outpatient Site of Care. These measures change from year to year. The current performance measures and method of extraction are available at http://vaww.oqp.med.va.gov. The Contractor is responsible for achieving levels of performance on these measures that meet or exceed the annual expectations for performance of VAPHS as outlined in the Network Performance Plan and Network Technical Manual. Revisions/updates to the Network Performance Plan and Network Technical Manual may be obtained from the above website. The Contractor is required to utilize the VISTA CPRS clinical reminder system as a means of both ensuring high performance on these measures and to facilitate monitoring of performance at the site independent of external reviewers. Levels of performance on the quality measures in primary care will be used as a factor in decisions about renewal of the contract.

To:

4.8.6 The Contractor is required to utilize the VISTA CPRS clinical reminder system as a means of both ensuring high performance on these measures and to facilitate monitoring of performance at the site independent of external reviewers. Levels of performance on the quality measures in primary care will be used as a factor in decisions about renewal of the contract.

Paragraph 6.1.2 of PWS shall change from:

* + 1. The Contractor shall have one hundred and twenty (120) days from contract award to commencement of the provision of medical care to local veterans. However, the Contractor must have all start-up requirements in place and ready to commence operation NLT eighty-three (113) calendar days from contract award. The final seven (7) days will be used for training and resolution of any last minute or unexpected technical or personnel related challenges. The Contractor shall comply with the following contract requirements prior to commencement of clinical operations:

To:

6.1.2 The Contractor shall have one hundred and twenty (120) days from contract award to commencement of the provision of medical care to local veterans. However, the Contractor must have all start-up requirements in place and ready to commence operation NLT one hundred and thirteen (113) calendar days from contract award. The final seven (7) days will be used for training and resolution of any last minute or unexpected technical or personnel related challenges. The Contractor shall comply with the following contract requirements prior to commencement of clinical operations:

Section E – Solicitation Provisions **Addendum to 52.212-1 Continuation of Instructions to Offerors:**

The following instruction on page 109 is revised from:

2. The following two (3) paragraphs under referenced provision 52.212-1 are hereby deleted:

(e) **MULTIPLE OFFERS**

(h) **MULTIPLE AWARDS**

(f) **LATE SUBMISSIONS, MODIFICATIONS, REVISIONS, AND WITHDRAWALS OF OFFERS**.

To:

2. The following two (2) paragraphs under referenced provision 52.212-1 are hereby deleted:

(h) **MULTIPLE AWARDS**

(f) **LATE SUBMISSIONS, MODIFICATIONS, REVISIONS, AND WITHDRAWALS OF**

**OFFERS**.

The following Evaluation Factor on page 117 is revised from:

C. Sub-factor 3. Transition/Start-Up Plan

I. Describe the methods by which Contractor will ensure that the CBOC will meet or exceed the Director’s Performance Measures (see attachment 14 in section D for current performance measures) including quality measures relevant to primary care and mental health, access measures, and measures related to timely documentation and electronic signing of progress notes and orders. Describe Contractor’s plan for ensuring providers have sufficient time to comply with administrative documentation requirements. Contractor’s proposed methods will be evaluated on completeness and feasibility.

II. Describe the methods by which Contractor will limit key staff turn-over, what incentives Contractor uses to retain staff, and contingency plan for handling any provider turnover. Describe Contractor’s capability to recruit adequate staffing to meet the needs of the contract.

III. Describe mechanism to schedule qualified physicians and staff to cover the required clinic schedule. Describe contingency plans for covering clinics due to scheduled or unscheduled leave.

IV. Describe the methods by which Contractor will ensure provider panel sizes remain within established parameters. The VHA nationally is establishing maximum panel sizes for primary care providers. Offeror shall state in the technical proposal for this Sub-factor it will adhere to this panel size requirement. Provide a detailed discussion of how the structure and/or processes of the clinic will be adjusted when/if the providers’ panel sizes exceed the established requirements.

V. Describe mechanism for maintaining continuity of care between the VA Pittsburgh Healthcare System and Contractor’s facility and continuity of care between private sector and VA care. Many patients enrolled in CBOCs also have a separate non-VA community provider. Describe the processes that will be used to ensure that all relevant medical information from the private sector is both available to the CBOC primary care provider and is available in CPRS for viewing by non-CBOC based clinicians (i.e., VAPHS-based clinicians).

VI. Describe Contractor’s Performance Improvement Program (PIP)

VII. Describe capability and/or mechanism to be used to begin contract performance within 120 calendar days after notice to proceed. Submit a chart identifying milestones and anticipated achievement dates based on an estimated contract award date of 1 December, 2017.

VIII. Describe your ADP (Automatic Data Processing) contingency plan for equipment downtime, including emergencies and limited operations.

IX. Provide evidence of a working knowledge of applicable Joint Commission regulations and describe ability to meet Joint Commission requirements. Provide evidence of Joint Commission accreditation, if applicable; and in addition, provide date of last survey, expiration date of present accreditation, and date of next survey. Indicate any conditions to the accreditation.

To:

C. Sub-factor 3. Transition/Start-Up Plan

I. Paragraph I Deleted in its entirety.

II. Describe the methods by which Contractor will limit key staff turn-over, what incentives Contractor uses to retain staff, and contingency plan for handling any provider turnover. Describe Contractor’s capability to recruit adequate staffing to meet the needs of the contract.

III. Describe mechanism to schedule qualified physicians and staff to cover the required clinic schedule. Describe contingency plans for covering clinics due to scheduled or unscheduled leave.

IV. Describe the methods by which Contractor will ensure provider panel sizes remain within established parameters. The VHA nationally is establishing maximum panel sizes for primary care providers. Offeror shall state in the technical proposal for this Sub-factor it will adhere to this panel size requirement. Provide a detailed discussion of how the structure and/or processes of the clinic will be adjusted when/if the providers’ panel sizes exceed the established requirements.

V. Describe mechanism for maintaining continuity of care between the VA Pittsburgh Healthcare System and Contractor’s facility and continuity of care between private sector and VA care. Many patients enrolled in CBOCs also have a separate non-VA community provider. Describe the processes that will be used to ensure that all relevant medical information from the private sector is both available to the CBOC primary care provider and is available in CPRS for viewing by non-CBOC based clinicians (i.e., VAPHS-based clinicians).

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IX. Provide evidence of a working knowledge of applicable Joint Commission regulations and describe ability to meet Joint Commission requirements. Provide evidence of Joint Commission accreditation, if applicable; and in addition, provide date of last survey, expiration date of present accreditation, and date of next survey. Indicate any conditions to the accreditation.

See attached document: D.29 DICOM.

See attached document: D.30 hL7.

End of Document