Item	Relevant Section	Offeror Question / Comment / Suggestion	Response
1	L.9	Re: Page Limitations (Table 22, L.9.1 & L.9.4.1): Can the Government increase the 33-page limitation for the Price Volume narrative to 38-pages to allow offerors an ability to adequately explain their assumptions and logic in estimating/proposing the four (4) rates that are requested for each state, and each period of performance, under CLIN x002 as required by L.9.2.2? Prior to DRAFT Amendment 17, offerors were only required to propose a single rate (the maximum payment above or equal to the locality adjusted Medicare rate) by state and option period. However, DRAFT Amendment 17 requires offerors to propose the following four rates by state and option period: (1) Outpatient service distribution, (2) Inpatient service distribution, (3) Outpatient maximum payment above or equal to the locality adjusted Medicare rate (4) Inpatient maximum payment above or equal to the locality adjusted Medicare rate Accordingly, will the Government add pages to the Price Volume narrative page limitation to allow offerors to explain how they developed these four rates?	Response: Yes, please refer to RFP for new 38 page limitation for VOL V.
2	M.4.3.4	Re: CLINs x012: DRAFT Amendment 17 states that proposed sub-CLIN x012BA (Transition-Out) prices for each option period will be added together (i.e., a cumulative total) resulting in the offerors Total Evaluated Price (TEP) for CLIN x012. However, sub-CLIN x012BA will only be exercised once during the contract. Accordingly, will the Government consider using the average of the proposed option year prices for sub-CLIN x012BA for purposes of the TEP? Alternatively, will the Government consider only including one of the proposed sub-CLIN x012BA amounts in the TEP (as opposed to the sum of the proposed amounts for sub-CLIN x012BA for OP1-OP7)? Either approach would be more representative of the actual costs that the Government will incur during performance of the contract. In addition, using the proposed sub-CLIN x012BA rate for only a single period of performance is more consistent with how the Government is evaluating CLIN x016AA and x016BA (i.e., the Implementation for Appointment Scheduling).	Response Yes, The proposed unit price for SubCLIN CLIN X012BA for FY 27 will be the price for this SubCLIN.
3	M.4.3.4	Re: CLINs X009: Figure 5 of DRAFT Amendment 17 includes a significant number of disaster response prescriptions for OP1, OP3, OP5 and OP7 but zero (0) disaster response prescription volumes for BY, OP2, OP4, OP6 and the Extension period. The disaster response prescription volumes in Figure 5 for four (4) option periods (i.e., OP1, OP3, OP5 and OP7) are more than two times (2x) the non-disaster prescription volumes for all nine (9) periods of performance (i.e., BY-OP7 & Extension Period). As a result, approximately 81% of the Total Evaluated Price (TEP) for CLIN x009AA and x009AB is attributable to the significant volume of disaster response prescription volumes included in Figure 5. This is estimated as follows: 81% = Disaster AWP in Figure 3 x Disaster Volume in Figure 5 / ((Disaster AWP in Figure 3 x Disaster Volume in Figure 5) + (Non-Disaster AWP in Figure 3 x Non-Disaster Volume in Figure 5)) Can the Government explain why it believes it will incur disaster response prescription volumes in multiple periods of performance (e.g., 4 of the 9 performance periods) during the contract performance? The Offeror observes that: (1) the disaster response prescription volumes included in Figure 5 significantly dwarfs the non-disaster prescription volumes; and (2) it is highly unlikely that the Government and contractor will actually experience disaster response prescription volumes in multiple performance periods during this contract; Given the above observations, will the Government consider revising Figure 5 to eliminate the disaster response prescription volumes from 3 of the 4 performance periods? This would reflect a TEP for CLIN x009 that is more in-line with the prescription volumes that the offeror will actually incur during contract performance.	Response: Please refer to PWS section 15.4. Disaster response prescriptions are for all impacted eligible Veterans and includes all prescriptions (not only urgent/emergent medications). For the purposes of evaluation, the VA has assumed a disaster every year of the period of performance. Please see new CLIN X021 added for Disaster Response Pharmacy including additional data. CLIN X009 is non disaster prescriptions.
4	M.4.3.4	Re: CLINs x016, x017, x018, x019: The term "Optional" within the context of this RFP is confounding. Almost all CLINs, at the discretion of the VA, have the potential to be exercised or not depending on VA or VAMC decisions to make referrals or place orders. As such, will the Government please remove the term “Optional” from the CLIN x016, x017, x018 and x019 descriptions throughout the Solicitation (i.e., Schedule B, Section B.1, PWS, G.14, G.15, L.9.2.5, Pricing Template, etc.)? *Alternatively,* if the Government's intent to is to make clear that Non-Optional CLINs (i.e., x002, x005, x008, x009, x010, x011, x012, x014, and x020) are more certain to be exercised by the Government than Optional CLINs (i.e., x016, x017, x018, and x019), it seems inappropriate that, in calculating the TEP, Optional CLINs would be included at 100% of the offeror's proposed price. Using the volumes provided in M.4.3.4 of the Draft Amendment 17, the Optional CLINs would represent a material percentage of the Total Evaluated Price (TEP) across all CLINs. The result is that the Optional CLINs, which have an uncertain likelihood of being exercised, represent a disproportionate percentage of the TEP (when compared to the Non-Optional costs that the Government expects to incur). If the Government persists in using the term "Optional," the Government should adjust for the disproportionate impact that Optional CLINs (i.e. x016, x017, x018, and x019), have on the TEP by including them at a rate that is significantly less than 100% (e.g., computed at 10-20% of the Offeror’s Proposed Price).	Response: The Government is retaining the usage of "Optional" as prescribed. The Government has eliminated CLIN weighting and has identified the need to exercise these CLINs which requires them to be priced and evaluated.

5	M.4.3.4	Re: Completeness: Draft Amendment 17 added the following language: "Completeness: The Government will review the Pricing submissions for completeness. The completeness review will focus on whether the offeror used the Government-developed Excel file as required and whether the pricing tables included blanks, or unreadable files, or incomplete data were received. Incomplete price submissions may not be evaluated, and the proposal may be eliminated from the competition." Please confirm that the RFP (especially, this new language) does not prohibit pricing a line item on the Pricing Template at $0.00 or 0.00% for any of the CLINs or Sub-CLINs.	Response: Correct, the VA will allow for prices or percents to be included in the Pricing Volume that equal either $0.00 or 0.00% with an exception for CLIN 2, in which Offerors may propose 100% Medicare which would make their prices proposed equal to $0.00 above the set rate under Medicare. Note that if the offer proposes 100% for CLIN X002 then the offeror will be paid by invoicing CLIN X001 under the contract.
6	M.4.3.4	Re: Total Evaluated Price (TEP): DRAFT Amendment 17 has explained how the TEP will be calculated for each individual CLIN in CLIN Group C. Is it the Government's intent to only evaluate the CLIN Group C TEP in aggregate? Could the Government clarify/confirm that the aggregate CLIN Group C TEP is simply the sum of the individual TEP for each CLIN as described in M.4.3.4? If the Government is not evaluating the CLIN Group C TEP in aggregate, what weighting or importance is the Government placing on the individual CLIN TEPs? The Offeror notes that DRAFT Amendment 17 states that the weighting of CLIN pricing are no longer part of the evaluation process. Accordingly, we request that the Government clarifies its evaluation methodology.	No, The Government's intent is to evaluate the CLIN Group C TEP in aggregate by determining proposed prices Fair and Reasonable based on the final evaluated contract price IAW FAR SubPart 15.404-1(a) (See solicitation at M.4). The individual line items total evaluated prices are evaluated as expressed in the RFP section M.4.3.4. and make up the total evaluated price. CLIN weighting has been removed and all line items are equally considered.
7A	B	Re: CLINs x002: Assuming that after contract award, an individual provider is needed to maintain the network adequacy standard in a highly-rural area, it is possible that the provider may be unwilling to accept the specific rate that the Offeror proposed under CLIN x002. The revised language in DRAFT Amendment 17 Section B.1 is unclear and potentially contradicting on how an Offeror could address this situation. The language in DRAFT Amendment 17 suggests that all highly-rural providers within a given state must be paid the same rate above Medicare that was proposed by the Offeror (even if the offeror's proposed CLIN x002 rate is higher than the offeror needs to offer the provider). However, other language in DRAFT Amendment 17 suggest that the highly-rural providers within a state may be paid at different rates, as approved by the Contracting Officer. Below is the RFP language that is causing this confusion: *Draft Amendment 17 RFP pg. 50* *"VA's payment to the Contractor for CLINs X001, X002, X003, X004AA, X004AB, X006, and X007 (for services with available Medicare pricing), and X015 shall be the rate identified in the applicable CLIN. The CLINs listed in the paragraph are fixed price. Contractor's payment to its CCN provider shall be the rate identified in the applicable CLIN." (Emphasis Added)* *Draft Amendment 17 RFP pg. 50-51* *"CLIN X002 is for Reimbursement for Highly Rural Care Areas and/or Scarce Medical Services. This CLIN only applies if the Contractor must execute a specific agreement in a Highly Rural Care Area or provide Scarce Medical Services at a rate that is equal to or greater than the Medicare rate as required to maintain Network Adequacy. When the Contracting Officer has approved rates for a certain provider in CLIN X002, Reimbursement for Highly Rural Care Areas, the Contractor must always reimburse those approved providers using CLIN X002 in lieu of CLIN X001." (Emphasis Added)*	Response: 7A) No, offerors shall not negotiate with individual network providers for rates below those that are proposed for CLIN X002. The individual provider will be paid the contract rate. The VA is not intending for the contractor to renegotiate for lower rates than those applied at time of contract award. Response: 7B) No, If a network provider is unwilling to accept the Offeror's proposed rate for CLIN X002 the Offeror may still allow for care, however, the VA will only reimburse the contractor the established FFP contractual rate.
7B	B (Continued)	(Continued from 7A above Re: CLINs x002) Accordingly, please confirm the following: (A)Are offerors are free to negotiate with individual network providers for rates below those that are proposed for CLIN x002? For example, if an Offeror bid 115% and was able to negotiate 107% with a provider, what rate is the Offeror obligated to reimburse the provider at? (B)If a network provider is unwilling to accept the Offeror's proposed rate for CLIN X002, is the offeror allowed to pay the provider a rate above the proposed CLIN x002 rate in order to meet adequacy and access standards? (C)If the Offeror is allowed to pay the provider a rate above the proposed CLIN x002 rate and the Contracting Officer approves the agreement, will the Government reimburse the Offeror at the higher negotiated rate under CLIN x002 OR does the difference between the Offeror's proposed CLIN x002 rate and the higher rate (as negotiated between the Provider and the Offeror) become the responsibility of the Offeror? (D)If the Offeror is responsible for the dollar amount that exceeds the proposed CLIN x002 rate, why does the Contracting Officer need to approve the agreement between the Provider and Offeror?	Response 7C) The Contracing Officer will not approve rates other than the contract rate. If a network provider is unwilling to accept the Offeror's proposed rate for CLIN X002 the Offeror may still allow for care, however, the VA will only reimburse the contractor the established FFP contractual rate. Resposne 7D) The purpose for pre-authorization is not to renegotiate or approve proposed differences in pricing, it is to ensure that providers pricing is integrated into the healthcare invoicing system to ensure prompt payments at the CLIN 2 pre-priced percent/rate.
8	B	Re: CLINs x002: DRAFT Amendment 17 states that CLIN x002 only applies "if the Contractor must execute a specific agreement in a Highly Rural Care Area or provide Scarce Medical Services at a rate that ***is equal to*** or greater than the Medicare rate..." (Emphasis Added) – DRAFT Amendment 17 pg. 51. This contradicts the Order of Precedence listed in Section B, where all reimbursements at 100% of Medicare are to be reimbursed under CLIN x001. Can the Government correct the RFP to eliminate the "equal to" language in CLIN x002? The corrected language should be as follows: "if the Contractor must execute a specific agreement in a Highly Rural Care Area or provide Scarce Medical Services at a rate ***that is greater*** than the Medicare rate."	No the RFP is correct. For CLIN X002, Offerors may propose equal to or greater than 100% Medicare. Pricing CLIN X002 at 100% Medicare will result in all invoicing against CLIN X001 during contract administration Pricing at greater than 100% Medicare Please refer to Section M.4.3.4 CLIN X002 for how this will be evaluated.
9	B	Re: CLINs x001 and x002 Order of Precedence: Please confirm that if a highly-rural Veteran travels within the applicable drive time standards to an urban area, the care received will be reimbursed at an urban rate, not at the highly rural rate? Explained another way, please confirm that care is reimbursed based on the location of care delivery, not the geography of the Veteran's residence.	Response: Reimbursement is based upon the location of healthcare delivery.

10	L.3	General: DRAFT Amendment 17 states that "Offeror questions related to changes established in Amendment A0017 are due by 16:00 PM, EDT on 21 May 2019." The Offeror presumes that, upon issuance of the FINAL Amendment 17, this is the date that questions regarding that FINAL Amendment 17 will be due. VA has requested that the offeror provide written questions regarding DRAFT Amendment 17 by close of business on Friday, May 17th. Those questions are reflected in this question set. Please confirm that, upon issuance of the FINAL Amendment 17, there will be another opportunity to submit questions to VA.	Response: Confirmed, please refer to Section L.3.1.1.
11	L.4	Re: Table 21: DRAFT Amendment 17 was issued with a revised SF33 cover sheet. Please provide instructions for submission of the executed SF33. Please confirm that the updated SF33 may be submitted as a standalone document or within the Pricing Volume, and does not need to be submitted within a revised Offer Volume as provided in Table 21.	Response: Please See Section L.2.7 The signed SF 33 cover sheet for Amendment A0017 will be included in the sealed envelope or box that enclose the CDs.
12		First, the current incumbent is in a favored position to know historic demand for care in highly rural areas as a basis for making such projections, placing all other offerors at an unfair competitive disadvantage.	Response: Concern is noted.Please see next question below.
13		Second, this new approach invites price "gaming" by encouraging offerors to project a very low volume of highly rural demand under CLIN 2 (in order to reduce total evaluated price artificially), because the selected contractor will not be limited to recovering only that proposed proportion through the highly rural rates.	Response: Concern is noted. Please see next question below.
14		Third, the invitation to propose very different assumptions about highly rural patient demand will result in very different total evaluated prices that will not be suitably comparable for purposes of competitive comparison.	Response: Concern is noted.Please see next question below.
15		Near the top of page 239 of the draft RFP, the first full paragraph instructs that "Offerors shall submit a complete pricing template (reflecting the revised prices) in the pricing template, 'CCN Reg4 Pricing Template v8 04032019.'" Will the file name (which is highlighted in the draft) be replaced by the Pricing Template v9_051419 Excel file?	Response: Yes, a revised pricing template, with a new version number, will be provided with the Final amendment.
16		In Section M.4.3.4, under CLIN X0008, the draft RFP language provides: "The Offerors proposed Percentage of Billed charges will be multiplied by the billed charges provided in Figure 3 (for evaluation purposes only) for each year of the PoP. The sum of these calculations will result in the Offeror's Total Evaluated Price for CLIN X008." Please confirm that VA intends for this statement to refer to Figure 2, rather than Figure 3.	Response: Figure 2 is the correct reference. Please see updated Section M.4.3.4
17		Attachment L_CLIN X002 Volume and Price Projections includes a file header that states "CLIN X002 Volume and Price Projections," but the data in the attachment appears to include total statewide projected service volumes. Please clarify whether the data in Attachment L is total statewide service volume projections, or if it only represents volumes in Highly Rural or medically scarce areas. Please clarify whether the data in Attachment L is total statewide service volume projections, or if it only represents volumes in Highly Rural or medically scarce areas.	Response: The data in Attachment L are statewide projected service volumes.
18		Attachment L_CLIN X002 Volume and Price Projections lists the Medicare allowable unit cost for inpatient and outpatient medical services, but only at the state level. Because it appears that Attachment L is an average for the entire state of all Medicare localities, projections for Highly Rural utilization cannot be accounted for correctly. We therefore urge VA to consider providing the Attachment L volume and price projections data at either the county level or the VAMC level.	Response: The CLIN X002 Pricing Template includes all data previously in Attachment L. The CLIN X002 Pricing Template reflects state-wide information (aggregated at the state level) ; this is intended to aid offerors in developing their price proposals, as deemed necessary by the Offerors. These volumes, combined with the proposed service distribution, will be used in evaluation. To further inform the highly rural utilization, enrollment/patient summary data has been added to the CLIN X002 Pricing Template (i.e., unique enrollment, highly rural enrollment, and unique community care patients). The CLIN X002 Pricing Template includes all data previously in Attachment L.
19		In light of the lack of granularity in the Attachment L data, Offerors could conceivably use data from Attachments A and E to make assumptions. Therefore, data is not presented in a comparable manner. Offerors would have to know, for each VA Referral Category of Care listed in Attachment E, which procedure codes and/or CMS groupers VA is including in each. For example, Attachment L lists Maternity, Delivery and Non-delivery for inpatient and Maternity for outpatient, while Attachment E lists a single group of Obstetrics. We further note that, should VA not provide distinct and specific instructions that all Offerors are to use only data supplied in the RFP, incumbent contractors will have an unfair advantage due to access to referral and claims history.	Response: Offerors should use data from all attachments, as they see fit, to inform their price proposals. As noted above, enrollment/patient summary data has been added to the CLIN X002 Pricing Template (i.e., unique enrollment, highly rural enrollment, and unique community care patients). VA provided updated FY 18 information in Attachment E Summary Demand data: the data includes: FY18 Referrals by state, total unique and total unique Veterans who received care by VA station and category of care, FY18 Referrals by VISN total authorization, and total unique Veterans. VA provided Attachment A VA Medical Center Catchment Area, which includes total enrollees by State and county; Attachment AA is updated with FY18 unique patients by Rurality who received Non VA Care .
20		We note that Attachment A includes data based upon FY17Q4 enrollment, Attachment E includes data based upon FY15-FY17, and Attachment L begins with data from FY19. We respectfully request that VA provide updated Attachments A and E, and that each contain data from FY15 to the present, including FY19 information. We respectfully request that VA provide updated Attachments A and E, and that each contain data from FY15 to the present, including FY19 information	Response: Enrollment/patient summary data has been added to the CLIN X002 Pricing Template (i.e., unique enrollment, highly rural enrollment, and unique community care patients). Attachment A - VA Medical Center Catchment Area, which includes total enrollees by State and county; Data is provided for FY 18Q4 Attachment AA is updated with FY18 unique patients by Rurality who received Non VA Care for FY15-18. Attachment E Summary Demand data: the data includes: FY18 Referrals by State, total unique and total unique Veterans who received care by VA station and category of care, and FY18 Referrals by VISN total authorization and total unique Veterans.

21		In addition to misaligned periods of performance across the various RFP Attachments, the data provided in Attachment L calls into question data previously provided in Attachment E. If the Attachment L data is specific to Highly Rural Veterans then it appears that VA is projecting approximately 13 cardiovascular procedures, per month, per Highly Rural Veteran based on the Attachment E data that indicates there are 1,641 Highly Rural Veterans in California.	Response: The CLIN X002 Pricing Template includes all data previously in Attachment L. The CLIN X002 Pricing Template data is not specific to highly rural Veterans. As previously noted, enrollment/patient summary data has been added to the CLIN X002 Pricing Template.
22		Per the Rural Health Information Hub, there are a vast number of designated and recognized Health Physician Shortage Areas for medical, behavioral, and dental providers throughout all of Region 4. Moreover, services vary greatly by VAMC. Should a VAMC not provide specialties such as dermatology, rheumatology, endocrinology, orthopedics, or cardiology, such specialties could be considered “scarce medical services,” given the multiple designated HPSAs throughout Region 4. Please provide a listing of what VA deems to be “scarce medical services.”	Response: VA provided a definition in PWS Attachment 1 "Terms and Definitions" A scarce medical resource is defined as any health care examination or treatment that has significantly reduced access due to geographic location, lack of providers to support patient demand, lack of equipment or technology to provide necessary services, or any other factors negatively impacting access regardless of geographic designation, i.e., urban, rural, or highly rural. What is deemed a scarce medical resource is Offeror Network dependent. When proposing a percentage of Medicare for CLIN X002, each Offeror, should assess its network against the definition of scarce medical resources.