Section/Item Number	Page Number	Question	MDH Response
Reference: 5.2.4	3 and page 115	The *Key Information Sheet* states that proposals should be sent to the attention of Queen Davis. However, *Section 5.2.4* (page 115) states that all proposal materials should be sent to the Procurement Officer, Mr. Dana Dembrow. Please clarify to whom the RFP should be sent.	The proposal materials should be sent to the Attention of Queen Davis.
General Question		Would MDH consider execution of a risk arrangement in addition to the requested administrative services arrangement outlined in the request for proposals?	This contract is for an Administrative Service Organization and is not a risk contract. For Part 4: Management of Provider Quality Incentive Proposal, a risk model could be proposed in the *technical* section as long as for Attachment B a flat "management of these services" fee is also included.
General Question		Based on the new programs and requirements in this RFP that are not part of the current or historical ASO contracts, will the State modify the budget for the new contract to accommodate these new expectations? If so, can the State provide the estimated new budget?	Final year of the current contract is estimated $20,330,965 (see https://bpw.maryland.gov/MeetingDocs/2018-Dec-19-Summary.pdf Item 13S-Mod). On Attachment B the current services translate to Parts 1, 2, and 3. For Parts 4 and 5 which may be initiated during the span of the next contract period, the Contractor should offer their best price for the management of these services. The weight associated to Parts 4 and 5 would be 20% of the financial proposals given that the services are still under consideration, while Parts 1, 2 and 3 are weighted at 80% of the financial proposal. The Contract amount will be based on the successful offeror's Financial Proposal or any best and final offer.

2.3.2.1	13	Will the validation date be included in the MMIS provider file? Are providers registered with CAQH or will MDH be providing the Contractor with a provider file that includes the provider's most current validation/ re-validation date?	The validation/revalidation date is on the provider file. The Contractor would set up a registration portal which would contain the ability to upload license, certification and would then be cross referenced to the MMIS data file for discrepancies. For example, if a provider is enrolled as a provider type CC but then uploads to the Contractor's system a Social work license (provider type 94) then the discrepancy would be reported to the provider and to the Department. MDH will work with the Contractor on these critical elements and how the process would work. The Contractor is encouraged to automate as much of this process as possible as the MMIS provider of file is the system of record.
2.3.2.1.A.1	13	Will the daily data transfer include all Medicaid provider files or only the new and/or modified files (i.e., delta)?	The MMIS provider file is a full file. The Contractor could develop a system to use a daily delta but the MMIS system is the full provider file.
2.3.2.1.A.2	13	Will MDH include license and certification data in daily files supplied to the Contractor?	The MMIS file contains fields for Provider type which is an indication of the license - see Exhibit 3 Provider Matrix. The ASO will need to have the ability for providers to upload their license into their registration system then match that the Provider type to the provider's uploaded license.
2.3.2.1.A.7	14	Please clarify MDH's expectation on offering providers the ability to change the source MMIS data in the Contractor's system via the web portal. For example, which system will maintain the record of "truth," the MMIS or the Contractor's database?	MMIS files are always the record of "truth". The Contractor needs to have electronic instructions on its registration portal that includes a link to MDH's provider enrollment vendor to inform providers that their file must be changed in the MMIS database in order to be correctly registered with the Contractor. The Contractor should develop strategies that include provider indicators, prompts, for example, to ensure that providers keep their information up to date to avoid denials of authorization or claims payments.
2.3.2.1.A.8	14	Are providers who specialize in non-traditional services included in the MMIS provider data supplied by MDH? If so, are they identified by specialty code or some other unique identifier?	Yes, 1915(i) providers are enrolled through MMIS. They are enrolled as either provider type 89 or HG. See Exhibit 3: Provider Matrix. Specialty codes and Provider types are all part of the MMIS provider file.

2.3.2.1.B	14	What data elements will the Contractor be responsible for collecting for non-Medicaid providers during enrollment? How often will enrollment/ re-enrollment occur? How many non-Medicaid providers are currently enrolled with BHA? Are there various non-Medicaid provider types and, if so, will MDH offer the various types to the Contractor?	There are currently 5 Non-Medicaid provider types and 310 Non-Medicaid providers. There's an average enrollment of 5 per month with no more than 20 per month. The non-Medicaid benefit is limited. Since all providers, Medicaid or not, would need to register with the Contractor's registration portal, there are several possibilities that could be used toward managing this small provider pool. All types will be shared with the Contractor during the implementation period for setting up the system.
2.3.2.7.B(4)	21	What types of exchanges does Medicaid/BHA envision (i.e., paper, electronic) to ensure the provider directory is up-to-date? What data elements would be included in this exchange?	The primary driver for the provider directory would be the manner in which the Contractor's Registration System is set up. Since providers must separately register with the Contractor and their information verified based on existing databases we envision the directory could include categories beyond the standard MMIS fields which may include: Practice name, location (if not protected) Website links, email, office hours, foreign languages spoken, practice specialty, disability access, accepting new patients. This data capture should feed into an accessible public facing provider directory. Although MMIS data is the system of record, building a functional provider driven database with additional routine update requirements, is a goal for MDH under this RFP.
2.3.4.D	23	What format (HL7 CCA, HL7 FHIR, or X12 278) would be used to integrate data elements? Are there any non-standard data requirements associated with this data sharing? What is the expectation of responses/workflows once the data is imported/exported?	The format can be determined by the contractor as long as it is compliant with the Health IT standards. The primary objective is to prevent duplicate data entry. Required PBHS data elements will be part of the data sharing. Providers without EHR, will utilize the contractor's system to enter data. Data from the EHRs as well as data entered through the contractor's system must be co-located and be available for reporting and operational purposes.

2.3.4.1 J – amended to: 2.3.5.1	24	Would MDH consider the following modification to correspond to industry standards? 80% of member calls answered live within 30 seconds, 80% of provider calls answered live within 60 seconds"? Would MDH consider amending the call abandonment rate to 4% as the minimum?	Call responsiveness is a critical component to the contract. We encourage Contractors to offer robust use of electronic communications in addition to use of call center in their proposals as appropriate. In consideration of feedback MDH has made the following changes: 1) Reference to the Chart 2 System measures is incorrect. The reference should be to the Call Center metrics, not specifically to Authorization. 2) We concur with the recommendation to the definition of member (recipient) calls within 30 seconds and provider calls within 60 seconds. Operate a toll free call center that providers and participants can access 8am to 6pm during which time: 90% of Member Calls answered live within 30 seconds and 100% (excluding abandoned calls) within 60 seconds. Provider calls answered live within 60 seconds and 100% (excluding abandoned calls) within 90 seconds. Call pick up system shall have less than 4% abandonment rate MDH will amend the call abandonment rate to 4%.
2.3.4.3.F.9	28	In reference to the 350 PBHS audits, are all audits mentioned in the RFP included in this count or are there additional audit requirements (i.e., 20 ABA provider audits, SPA audits, 10 desk/five site audits for Health Homes)?	Per year total 350 which includes: 315 Audits of Behavioral Health Providers (includes 1915(i) providers) 20 Audits of ABA providers 15 Audits of Health Home providers

			Not all audits are on-site. Each year, based on approval by MDH, the Contractor will develop a proposal based on their experience with providers, complaints by consumers, other factors and drives to form their audit plan. This plan would include proposed desk versus on site audits in support of the overall goal of improving quality of care to those receiving services. Additionally the Contractor may wish to propose additional targeted audits or move audit resources depending on findings, which would all be in consultation with MDH.
2.3.9.M.18	39	Please provide the state's definition of a clean claim.	A clean claim is one that is submitted by the Provider and meets all fields required on the CMS 1500 or the UB-04, and additionally has met Maryland's combination of service rules.
2.3.9.M.37	39	What is MDH's policy on suppressing Explanation of Benefits (EOBs)? Are there specific instances when EOBs will need to be suppressed?	MDH has a policy on EOB suppression that is based on age, diagnosis, eligibility type of the individual and more. This document will be shared during the implementation period but there are instances where the EOB is required to be suppressed.
2.3.9.M.	39	The RFP says that 14.3 million claims were processed in FY2017. Please provide the actual claim count for this period and whether this number reflects full claims or claim lines. Please also confirm that these are BH specific claims and indicate if the number includes all claim types (provider claims, facility claims, and adjustments). Please also indicate the percentage of the claims that are encounter versus actual processing.	This is the number of claim lines that were processed in FY 2017 and includes all claim types. Approximately, 18% of these claims are PRP encounter claims.
2.3.10.4.A	45	Does MDH require a summary of the report findings for all reports (i.e., current and new reports) produced, or does this requirement only pertain to the new reports required in this solicitation?	All reports require a brief summary. For a standing report, the same summary with any caveats or special notations would be the same across the reports but if there is a special circumstance (i.e. shorter than normal month), the summary would capture this.

2.3.10.4.K	45	Does MDH expect data validation processes for all reports, including fully automated reports, or just for new ad hoc reports?	Yes, initial validation for routine reports and also ongoing monitoring to ensure that there are no variances due to system changes that had an unintended consequence to a report. Although testing of all systems should include impact on existing and new reports, sometimes downstream impacts occur. The Contractor is responsible for validation to ensure data accuracy.
2.3.10.4.K	45	Are ad hoc data requests subject to a mutually agreed upon timeframe, or only the timeframe specified by MDH?	It depends. Sometimes MDH has a top priority, but when possible we try to anticipate those types of requests. Outside of emergency requests, it depends on the complexity of the request. The Contractor, in collaboration with MDH should establish a robust and complete reporting plan and capture metric requests on the front end. When launching new benefits or designing expansions to services, the Contractor would be a full partner in designing the expectations of the reports.
2.3.10.4.L	45	Will Root Cause Analysis be limited to pure coding and data issues and not newly defined logic that arise during the review and feedback process? Newly defined logic is not necessarily an alteration to the original request but part of the overall development approach to new reports.	Yes, RCA is limited to coding and data issues that have not been resolved. When a 2nd or 3rd request for corrections occurs it could require additional resources in the development of the report. The RCA will ensure the Contractor performs its own analysis of the situation prior to it coming back to MDH for additional review.
2.3.10.4.N	46	Are data anomalies expected to be remedied prior to report submission even if the report logic is correct, or is identifying and providing next steps to remedy them sufficient?	MDH would accept identifying and providing next steps to remedy in a timely manner as sufficient.
2.3.10.4.N	46	Is it sufficient for the Contractor to identify trends and anomalies in service utilization patterns, or would a Root Cause Analysis be expected?	While not necessarily a root cause analysis, if an anomaly in service utilization occurs, the Contractor should offer to the Department observations related to the system as a whole. The ASO is a partner in managing the PBHS and should be equally invested in identifying factors that impact the system

			and collaborate with MDH to navigate the interwoven system of BH services.
2.3.10.5	46	*"The Contractor shall create an MIS that…(c) receives, uploads and trains staff on understanding data from the MMIS…"* Does this mean that the Contractor will "upload" information to MMIS?	No. The Contractor does not upload any files into MMIS. The Contractor downloads from MMIS and may submit to MMIS an extract, but does not upload any material to MMIS. The wording should be interpreted as downloading from MMIS.
2.3.11.7.3	54	Are efforts such as "provide avoidable somatic complication" reports expected at go-live or through regular development cycles?	This section would not be applicable to Go-Live. The initiative and subsequent deliverables would be fully vetted prior to Go-Live but reports in this section would not occur at Go-Live.
2.3.11.8.B.9 and 10	55	Are the SPA audits included in the 350 audits mentioned in *Section 2.3.4.3.F.9*, or is this a separate requirement?	This refers to the 1915(i) program. These would be included under the 350. This activity is performed in conjunction with BHA teams focused on the child population.
2.3.11.9	56	Will DME be included as part of the Health Home services the Contractor will be billed for?	No. The Chronic Health Home program does not use DME.
2.3.11.9.B.9.a	57	Please clarify as to what level of detail the State is requesting the ASO to provide for a site audit of a Health Home provider. Is "chart and care management record review" separate from a normal audit?	The HH audits are based primarily on record review, with potential for site visits. The current structure under MDH for this service is front end payment with back end reporting. The Contractor would develop a system that requires front end reporting tied to payment and therefore much of the audit process could be automated. The audit process specific to the HH program is slightly varied from other types of audits which would be more formally defined during the Contract development period prior to Go-Live.

2.3.11.9.B.9.a	57	As MDH requires submission for review/ approval in Section 2.4.4, would the state please consider removing the minimum audits for health homes at section 2.3.11.9, B, 9(a) for desk and site audits such that the Contractor would detail the methodology for audit process and provider selection within the Comprehensive Audit Plan?	Yes but to clarify, the Health Home audits (10 desk, 5 site) are included in the total number of all audits of 350. See response above related to audits. We believe this clarifies this question. Not all health home providers would receive an audit every year and all audits should be developed based on needs identified within the PBHS, and the plan is ultimately approved by MDH (Collaborative process).
2.3.11.14	61	For the program under the Brain Injury Trust Fund, would these services need to be clinically reviewed? What is the scope of these services (e.g., how many individuals are using them, what varieties of services are offered, what is the number of providers)?	MDH will clinically review and authorize these services. These are support services and the expectation is to use the existing BI waiver workflow, to the extent possible. The Contractor will flag the individuals eligible for the BI trust fund services based on BHA's eligible list of individuals and track the amount spent on these services, to keep expenditures within the budget allocated.
2.3.11.16.B	62	What incentives would the Contractor be responsible for providing? (e.g., financial)?	The RFP reads that the Contractor will work with MDH in the process of facilitating and providing incentives for the utilization of EHRs. The contractor will not be responsible for financial incentives but will collaborate with MDH on this.
2.4.4	64	The Provider Survey is associated with the requirement in *Section 2.3.7.2.B.*; however, this survey seems to be associated with *Section 2.3.7.2.C.* If so, would the provider survey be required biennially (every other year) as stated on page 34 (*2.3.7.2.C.1*) or annually as stated in the table on page 64?	Thank you for the correction, the reference should have been associated with 2.3.7.2 C. and is required every other year. **See Addendum # 3 for official reference correction**.

2.5	65	Is pricing for this section mandatory? It is hard to predict pricing for models that have not been previously approved by MDH.	Yes with the caveat that the pricing is for "management of" these services as well as the time/staffing investment needed to plan and develop the services in collaboration with MDH.
2.5.1.1	65	If MDH is interested in providing financial incentives to providers and/or creating value-based payment methodologies, will additional funding be available to cover these costs?	Yes, any funding for incentives would be separate from this Contract. It is the management of those funds, and implementation of a project that the Contractor would be pricing in this section. Actual incentives would be a separate budget apart from this Contract.
2.6.7	68	*Chart 1 Outcome measures* – Is MDH expecting the Contractor to respond to the "Experience with this measure" column? If so, please clarify what level of detail MDH is expecting the Contractor to provide in response to this column.	MDH is looking to review types of experience in other markets that a Contractor may have for each particular measure. In the absence of actual experience, MDH would like to review suggestions from the Contractor that captures the of each measure.
2.6.7	68	*Measure No. 1* – Please clarify for Follow-up Appointment After Behavioral Health Hospitalization, what specific "SUD residential" levels of care will be reported separately? How does reporting "SUD residential" separately impact participants that are discharged from an inpatient hospitalization? Please describe the impact, if any, of "SUD residential shall be reported separately" on potential liquidated damages for Follow-up Appointment After Behavioral Health Hospitalization. For example, will this mean different targets?	Chart 1 has been updated to reflect that while the measures listed are of interest to the State for data collection and performance standards, there will not be service credits associated with the performance of the Contractor in "moving the needle" on these measurements. During the first year, these measures will be tracked for evaluation and the Contractor will, in collaboration with the Department review targets and strategies to achieve targets**. There will be no associated credits for failure to meet any targets.** This process is to be collaborative with the intent to impact the PBHS as a whole and improve outcomes for individuals in

			care. Each of these measures will be more fully developed with the selected Contractor. There are different requirements related to SUD residential which are part of our agreement under the Waiver. This portion related to SUD residential has now been excluded from this Measure and will be re-visited post award, without damages associated to it.
2.6.7	68-69	Will MDH require inpatient facilities to enter discharge dates and information into the ASO platform so that measure No. 1 Follow-up After Behavioral Health Hospitalization and No. 2 MH Readmission can be calculated using exact dates?	This measure no longer has service credits. MDH is considering making discharge data entry mandatory but in the meantime, the Contractor will use proxy dates to work these metrics. This will be more developed post-award during the implementation planning process.
2.6.7	68-69	*Measure No.1 and 3* – These measures may be hard to impact without somatic data. Will the Contractor be receiving somatic data from MDH? For example, a participant who is included in the denominator for these metrics, but who has their follow-up, initiation, and/or engagement with a Primary Care Physician will not be identified as meeting this metric with the ASO's behavioral health data only. In addition, how will the new diagnosis be defined?	Measure 1, that now has no service credits, would be based solely on ASO claims data, however this remains under consideration. Measure 3, also with no service credits, is defined as new diagnosis is no claim at least in the past six months with the specified diagnosis.
2.6.7	70	*"Calls answered live within 3 rings and 15 seconds ."* Please verify if "answered live" means after the caller makes their initial selection via the auto attendant.	This metric has been updated please refer to the response listed earlier in this document.

2.6.7	70	*"Calls answered live within 3 rings and 15 seconds ."* Could MDH clarify how three rings correlates to 15 seconds? Would MDH be amenable to measuring this requirement using 15 seconds as the standard regardless of the number of rings?	This metric has been updated please refer to the response listed earlier in this document.
2.6.7	70	*"Call pick up system shall have less than 3% abandonment rate and hold time of less than 2 minutes."* In calculating the abandonment rate, are calls that are abandoned in the first 15 seconds excluded from the measurement? This exclusion would be in keeping with call center industry standards.	This metric has been updated please refer to the response listed earlier in this document.
2.6.7 Chart 2	70	Would MDH consider revising the SLA language regarding call center service requirement 2.3.4.1.J to read "80% of member calls answered live within 30 seconds, 80% of provider calls answered live within 60 seconds"? Would the state also consider revising the abandonment rate metric from 3% or less to 4% or less? Additionally, would the state consider removing references to "recorded messages" and "hold time" as part of the SLA language?	This metric has been updated please refer to the response listed earlier in this document.
3.1.D	73	Please define the new credentialing process. What data elements need to be collected by the Contractor for enrollment? What data elements will be transferred via the MMIS? Which system will be the record of truth (e.g., the provider file)?	This is an oversight and is updated to mean streamlined *Registration* process. This Contract does not have credentialing as part of the core functions with the exception of any project specific requirements (i.e. 1915i).

3.3.5	77	Please clarify what types of travel will not be reimbursed under this RFP.	MDH does not reimburse the Contractor for travel.
3.4.2.C.1.a	80	Please clarify the CAP turnaround requirement. The RFP states that a CAP should be delivered to the Contract Monitor within three business days; however, later in the section, it states that if the CAP is not delivered in five days, then liquidated damages will be incurred. Does this mean that even though the Contractor is required to deliver a CAP within three days, the Contractor will only incur liquidated damages if the Contractor does not deliver the CAP within five days?	The CAP requirement is 5 business days.
3.7.2	83	The RFP delineates CJIS background checks. If the Contractor has an existing background check with the same components, will this suffice?	A background check must contain all CJIS components. 3.7.2 A states that this check may be performed by a public or private entity.
3.7.5.C	87	What is the FIPS Categorization for this Certification and Accreditation (C&A), now known as Assessment and Authorization (A&A), effort (i.e., Low, Moderate, High)?	Moderate.
3.7.5.C	87	Who is the Authorizing Officer (AO) for the A&A effort? Given the complexity and time requirements for this undertaking, is there a State security office that Contactors should begin to work with, or does MDH envision that sufficient time will be allotted after award notification to ensure this requirement is met January 1, 2020?	Proposals should include an assessment of the A&A as the system currently (or would exist) and a plan for those items that may not currently exist in the Contractor's system. Include with the assessment an implementation plan that lists an estimated time frame for implementation of items not current in the system. The Authorizing Officer at MDH will review all plans submitted. Additional note: for proposals, you need only include ONE original and ONE copy of these plans. In order to save

			resources, only one original and one copy is needed (in addition to the electronic file).
3.7.5.C	87	Will MDH require the Contractor to hire an independent organization to create the SAR or will MDH provide State resources to conduct the Security Assessment and produce the SAR and POA&M?	MDH will not provide State resources for this effort. The requirements under this RFP are true for the handling of all Medicaid data. Any Contractor if handling Medicaid data would need to have their system evaluated and updated to meet these requirements. The requirements are not specific to Maryland.
3.7.5.C	87	Will MDH pay the Contractor for the associated cost for the A&A as a separate billable item, or should the Contractor factor the associated costs into the pricing proposal?	Same as the previous answer. Because this is not Maryland specific and is a requirement for handling any/all Medicaid data, the Contractor should assume these types of costs as part of doing business with a Medicaid agency (see CMS 2015 memo).
3.7.5.C	87	Will MDH accept an A&A package already approved by a Federal agency (e.g., Department of Defense; Department of Health and Human Services, Federal Occupational Health) in lieu of completing another full A&A package for Maryland?	If the components of this package is the same as that requested under this RFP then that would be sufficient as long as for items that are not yet implemented, a time line is included for implementation.
3.7.5.C	87	Will MDH require the use of a special tool to develop the SSP package (e.g., RSA Archer, Emass, CSAM)?	No, there is no requirement of a specific tool in the development of this package. Please refer to the 2015 NIST / MARS-E Version 2.0 memo from CMS.
3.7.5.C	87	Will MDH require Contractors to use a State mandated template for all A&A deliverables associated with the ATO?	No. Whatever tool is used will need to pass an audit under the Office of Legislative Auditors but compliance with the NIST / MARS-E Version 2.0 would meet that requirement.

4.26	107	Does the Contractor have to contract directly with the MBE or can this be a subcontracting arrangement?	The contract must be between the prime contractor and the MBE subcontractor.
5.2.9.F.9	117	Is MDH requesting Contractors provide new/additional Service Level Agreements within this section or are Contractors just responding to Section 2.6 here?	Same or similar measures as identified in Section 2.6.
6.2	124	Please describe how the technical section will be evaluated. Will a score be awarded? If so, please provide this information.	The technical proposals will be evaluated in accordance with COMAR 21.05.03 by a committee established specifically for the purpose of this Contract based on the evaluation criteria set forth in Section 6.2 of the RFP.
6.3	124	Please describe how the financial section will be evaluated. Will a score be awarded? If so, please provide this information.	All qualified offerors will be ranked from the lowest to the highest price based on the Total Proposal Price set forth on Attachment B -Financial Proposal Form.
7	126	*Section 5. Proposal Format, 5.2.5.A.* (page 114) requests one original executed Technical Proposal and all supporting material. *Section 7. RFP Attachments and Appendices, Instruction Page* (page 126) states to submit two copies of each attachment or appendix with original signatures. Please clarify if only one original should be provided as part of the proposal submission.	For the proposal submission, one original and **4 copies** of the technical and financial proposals are required. NOTE the *reduction* in the copies from 6 to 4 copies. One Original Signature is needed for all the affidavits (attachments) prior to Contract award. Documents submitted after award will require three original signature submissions (Section 7, page 126).
Attachment B	N/A	Please confirm the components included in the Cost Based Pool service.	The Cost Based Pool could include system design for new provider types, new services, reports designed for initial implementation of new provider types; reports designed for new services and associated initiatives. This fund supports system design, builds, improvements that may not have been

			anticipated under the original bid solicitation. These funds are not guaranteed.
Attachment B	N/A	Please describe the services to be included for the Management of Provider Quality Incentive Proposal.	The proposal would come from the Contractor and is based on 2.5.1.1 under the Technical section based on the Contractor's experience in other markets. As explained in pre-bid, Maryland is interested in developing a quality incentive project and any proposal would be budget dependent. The Contractor should share publicly available information that shares their experience managing a similar program in other markets.
Attachment B	N/A	Please confirm what services or optional features would be of interest to the State and that should be included in order to develop a rate for other optional features or services.	This RFP is a solicitation for companies with national expertise as an ASO, MCO, ACO, or other health management related services. The State has shared within the RFP the general idea of the direction in which Maryland may be interested in pursuing based on national and local articles, research and studies. However, the State does not have a pre-conceived idea of how to implement such services in Maryland. Part 4 Services (at State's Option) is a flat rate proposal for the management of the incentive program. This would be inclusive of all administrative and staffing associated to the cost of the program. Contractors should propose models with which they have had experience under the technical section and then propose the cost to the State for the Contractor to manage such an effort. For Part 5 we are requesting that the Contractor propose effective strategies they've had experience with in other markets that is publicly sharable and how initiatives were implemented. This description belongs under the Technical proposal.

			The corresponding Financial proposal would then include the project costs (1000, or 10,000 hours) related to program design and operational implementation that could also include stakeholder engagement (all planning activities). The PMPM costs would assume ongoing increased staff needs to successfully manage the implementation and ongoing management of the project. The Contractor would add the amount necessary to the PMPM Example: $ 1.00 PMPM = about 12 million per year to cover Parts 1,2, and 3, or 1 million / month in staffing/management of the system. To add optional project 1: 1000 Hours X $ 100 per hour = $10,000 for design/implementation PMPM add .02 (cents) equating to an additional $ 20,000 per month. The PMPM would be added to the monthly total and included from the point of implementation to end of the contract. Due to the nature of these being proposed, but not solidified, the financial component of those services will be given a reduced weight within the context of the overall financial proposal.
Attachment B	N/A	Please confirm if only *Part 5* is weighted at 20 percent of the evaluation or if another area is weighted at 20 percent. If so, please list the specific area that carries the 20 percent weight.	Parts 4 and 5 combined will be weighted at 20% of the total weight factors given to the Financial Section. Parts 1, 2, and 3, which are the essential components of an ASO contract, will be given 80% consideration.

			Each optional service is dependent on the MDH budget and may or may not launch during the Contract period. A successful Contractor will share their national experience with the measures or programs that are under consideration to bring new ideas and initiatives into the Maryland market. This would be considered as part of an ASO's standard performance under the contract. The proposal shall include the Contractor's cost associated with operations and programming under the Rate section and staffing and management under the PMPM for each of these initiatives. MDH may launch planning for these projects without implementation at its option.
Attachment B	N/A	Please confirm that all parts of *Attachment B (Parts 1-5)* will be considered in order to evaluate the overall total program cost. Are all mandatory? Additionally, will a vendor who responds to the optional portion of the bid be favored over a vendor who does not respond to the optional parts?	All parts of the RFP must be responded to and all parts are considered in order to evaluate the overall total program cost. All sections are mandatory. If a Contractor does not complete all 5 parts the proposal will be considered non-responsive.
Addendum 2; item 2	1	Please clarify how MDH interprets this requirement and applies the requirement to the ASO Contractor. What would potential Contractors have to do in order to satisfy this requirement (e.g., sign a statement stating that they meet NIST 800-53 Rev 4 requirements)? Currently, there is no formal authorization and accreditation process for MARS-E.	An ASO is the designee of the State and, for Maryland, specifically manages claims data which requires specific data protection. We interpret the CMS Memorandum to mean that the ASO must meet the stated criteria. This requirement has now been updated please see Addendum.

Page 15 Second Attachment B: Not sure I understand the sentence starting with "The Costs ... through end of next sentence ending with ”PMPM." I thought staffing, etc. was on an hourly basis, but implementation on PMPM. See, First Attachment B on page 16.