NEW YORK STATE | Corrections and Community Supervision

ANDREW M. CUOMO
Governor

ANTHONY J. ANNUCCI
Acting Commissioner

RFP #2015-03 STATEWIDE UTILIZATION MANAGEMENT PROGRAM
BID SOLICITATION ADDENDUM

Addendum #5

To: All Potential Bidders

Subject: Questions & Answers and Revision to Solicitation

Date: May 13, 2015

Proposals Due Date: May 29, 2015 by 3:00 PM (EST)

Designated Contacts:

Primary Contact	Alternate Contact
Kathleen Gallagher	Carol Turo
Contract Management Specialist 2	Contract Management Specialist 3
doccscontracts@doccs.ny.gov	doccscontracts@doccs.ny.gov

This addendum is to provide official answers to written questions submitted by prospective bidders and a revision to Section XII.B(1)(b) – Experience and References (page 36) in RFP 2015-03.

QUESTIONS AND ANSWERS

Q1) Section VI: Scope of Services, Page 11. Please provide volume of referral requests by type:

a. Emergent
b. Urgent
c. Soon
d. Routine
e. Assigned

A1) For calendar year 2014:

a. Emergent:	1,175
b. Urgent:	3,514
c. Soon:	14,350
d. Routine:	59,630
e. Assigned:	77,332

Q2) Section VI: Scope of Services, Page 11, last bullet:

a. Verify ALL inpatient and outpatient medical and oral surgery claims for payment.
    i. What does "verify" entail?
    ii. How is this different from the first bullet on page 12, conduct a ***preliminary review*** of all inpatient UB04's. What does "preliminary review" entail?
        1. What is the volume of "preliminary review" under the first bullet on Page 12.

A2) a(i). Vendor will review all claims entered on DOCCS FHS1 system to verify that the service took place. Vendor will have access to all inmate medical referrals, appointments, etc., via DOCCS FHS1 system to aid in this process. If a service cannot be verified through the FHS1 system, the vendor will contact the Health Unit or, for oral surgery claims, the Dental Department in the inmate's owning facility for verification of the service. If the facility cannot verify the service, the vendor will ask the Medical Bill Payment Unit to request the medical reports from the provider.

a(ii). The verification of claims involves a review of the inmate medical history to insure that the billed service took place. The preliminary review of all inpatient UB04's bearing any one of the top 20 most utilized DRG's involves a review of the claim for potential incorrect billing that may result in overpayments.

Vendor will review the claim based on criteria established by the vendor to determine if the potential for incorrect billing resulting in an overpayment exists. If, based on this preliminary review it is determined that the potential exists for overpayment, the vendor will request a copy of the medical records from the hospital so the vendor can perform a complete review.

a(ii)(1). That information is not available. However 425 DRG audits were performed for the period 1/1/14-12/31/14.

Q3) Section VI: Scope of Services, Page 12, second bullet:

a. Conduct a preliminary review of approximately 15% of all outpatient claims and 15% of all oral surgery claims.
    i. Is this work currently being performed?
    ii. What is the volume of this work?
    iii. What does a "preliminary review" entail?

A3) a(i). Under the current contract, 10% of all outpatient claims are reviewed.
Oral surgery claims are not being reviewed under the current contract.

a(ii). Based on the 177,108 HCFA (physician) claims verified for the period 4/1/13-3/31/14, a review of 15% would result in the preliminary review of approximately 26,566 claims.

a(iii). Vendor will review the claim based on criteria established by the vendor to determine if the potential for incorrect billing resulting in an overpayment exists. If, based on this preliminary review it is determined that the potential exists for overpayment, the vendor will request a copy of the medical records from the provider so the vendor can perform a complete review.

Q4) Section VI: Scope of Services, Page 12, third bullet:

a. Review of inpatient stays. We know there are 2502 patient days, what is the volume of inpatient admissions?

A4 For calendar year 2014 there were 3,547 inpatient admissions.

Q5) Section VI: Scope of Services, Page 13, fourth bullet:

a. Ensure the availability of appropriate personnel. Please define expected qualifications.

A5) Expected qualifications for personnel are RN reviewers.

Q6) Section VI: Scope of Services, Page 13, ninth bullet:

a. Travel to various sites for the purpose of providing training and conducting performance evaluations
    i. What does a performance evaluation entail?
    ii. How many of these visits are expected, and how many have been performed under the current contract?
    iii. Is this the same work as described on page 37, B2e Education Plan?

A6) a(i) Vendor will evaluate their staff's performance. Vendor will advise on what performance evaluation tools they plan to utilize and their plan to monitor their staff's performance

a(ii) Please see Section XII.B(2)(e), page 37, first sentence. Approximately 12 site visits have been performed under the current contract.

a(iii) Yes.

Q7) Please confirm the monthly rate per inmate includes:

a. Process referrals for specialty care
b. Verify all inpatient and outpatient medical and oral surgery claims for payment
c. Prior auth and concurrent review of inpatient stays
d. Training to DOCCS staff and conducting performance evaluations

A7) Yes, the monthly rate per inmate includes:

a. Process referrals for specialty care
b. Verify all inpatient and outpatient medical and oral surgery claims for payment
c. Prior auth and concurrent review of inpatient stays
d. Training to DOCCS staff and conducting performance evaluations

---

Q8) Percentage of recovery scope of services:

a. Please confirm that both the ***preliminary review*** of all inpatient UB04's bearing any one of the top 20 most utilized DRGs, and the ***retrospective review*** utilizing the corresponding medical records are to be listed separately as percent of recovery (first bullet, page 12)
b. What is the definition of recovery and what is the anticipated timeframe for recovery by DOCCS after a denial is issued. When would the vendor get credit for the recovery?
c. Is the claims data complete and accurate to allow for efficient targeting of claims?

A8) a. One recovery rate should be listed for each of the three types of claims being reviewed, and that rate includes both your preliminary and retrospective review. For example: one recovery rate should be listed for UB04 inpatient claims, which includes both the preliminary review and the retrospective review, one recovery rate should be listed for outpatient claims, which includes both the preliminary review and the retrospective review, and one recovery rate should be listed for the oral surgery claims, which includes both the preliminary review and the retrospective review.

b. Recovery is the amount of money identified as overpaid to the provider by DOCCS as a result of the vendor's findings after completion of the vendor's audit, and hospital appeal process. After the completion of a 30-day appeal process (and sometimes a second 30-day appeal if required), DOCCS will process an adjustment against future provider claims to recover the overpayment, and the vendor will submit the monthly invoice to DOCCS for their recovery fee (based on the recovery % specified in contract) to be paid to vendor by DOCCS in accordance with NY State Finance Law.

c. All data billed on the physician HCFA claim is captured on the FHS1 system record. Inpatient UB04 data on the FHS1 system will include DRG codes, and principal procedure codes. HCPCS (Healthcare Common Procedure Coding System) codes and ICD-9/ICD-10 (International Classification of Diseases) diagnosis codes will be included, but based on the number of codes billed, due to system limitations some HCPCS codes and some ICD-9/ICD-10 codes may not be captured.

Q9) Section VI Scope of Services, Page 11 indicates 207873 claims were verified

a. Please provide the total number of oral surgery claims.
b. Please provide the total value/amount of the oral surgery claims.
c. Please provide the total number of outpatient claims.
d. Please provider the total value/amount of outpatient claims.

A9) a. This is new to the contract and due to the clinic billing process that data cannot be obtained from our system.

b. $729,035.00 was reimbursed for oral surgery claims for the period of 4/1/13-3/31/14.

c. During the period 4/1/13-3/31/14, 21,655 outpatient hospital claims were paid and approximately 124,680 physician claims were paid.

d. During the period of 4/1/13-3/31/14, outpatient hospital claims were paid in the amount of $23,160,430.00 and physician claims were paid in the amount of $19,407,805.00.

Q10) Section VI Scope of Services, Page 7 inpatient admissions 2502 patient days. How many need # admissions.

A10) For calendar year 2014 there were 3,547 inpatient admissions.

Q11) Attachment C - Cost Proposal Form
What is the monthly rate per Inmate in the current contract?
Inpatient - Percentage of recovery money _____%

a. What is the inpatient percentage of recovery money in the current contract? How much was paid last year/12 month period?

b. What is the oral surgery % of recovery money in the current contract? How much was paid last year/12 month period?

A11) The monthly rate per inmate in the current contract is $2.81.

a. The inpatient percentage of recovery money in the current contract is 24%. For calendar year 2014, $125,310.00 was paid.

b. Review of oral surgery claims was not included in the current contract.

Q12) What model URAC are you looking for accreditation?

A12) Version 7-7.2.

Section V, Minimum Bidder Qualifications, has been amended to revise the requirement regarding program accreditation by URAC. Please review RFP 2015-03 – Addendum #4 Revisions to Solicitation. The addendum is available for download from the following websites: DOCCS (Community Supervision) at https://www.parole.ny.gov/rfps.html[parole.ny.gov] and NYS Contract Reporter at https://nyscr.ny.gov/[nyscr.ny.gov].

Q13) Is there any liquidated damages in this proposal for failure to execute anything?

A13) The contract will not contain a clause concerning liquidated damages. However, there will be a clause in the contract that will allow DOCCS to seek all available legal remedies.

Q14) Section XIV, Part A, Phase 4 – Part III Cost Proposal Submittal, Proposal Evaluation Criteria and Selection Process, page 43 and Attachment C, Cost Proposal Form, page 57. The evaluation criteria state that this Phase will consist of an evaluation of the overall cost of each proposal, with the information contained on Attachment C. We understand the directions on page 39, Section XII.C, indicating that Bidders may not deviate from the Cost Proposal. As currently structured, Attachment C seems inconsistent with the evaluation criteria as it (a) combines two different forms of pricing (a per covered life per month) and proposed percentages of recovery money for three different categories of services (inpatient claims, outpatient claims, and oral surgery claims) and (b) does not include a way to propose or calculate a total cost for comparison purposes. Please clarify the evaluation criteria and Attachment C format so that Bidders can understand how Attachment C should be completed and will be evaluated.

A14) Section XIV.A, Proposal Evaluation and Scoring (page 43, Phase 4 – Part III Cost Proposal Submittal), and Attachment C - Cost Proposal Form have been amended to revise the evaluation criteria for cost proposals. Please review RFP 2015-03 – Addendum #3 Revisions to Solicitation. The addendum is available for download from the following websites: DOCCS (Community Supervision) at https://www.parole.ny.gov/rfps.html[parole.ny.gov] and NYS Contract Reporter at https://nyscr.ny.gov/[nyscr.ny.gov].

Q15) We also request that the Department provide a listing of claims costs for inpatient UB04s by DRG; a listing of outpatient claims costs by CPT4; and a listing of oral surgery claims costs by procedure code for services paid in calendar year 2014.

A15) Our system is not capable of listing UB04's by DRG. However, approximately 2,700 inpatient UB04 claims were processed for fiscal year 2013-14 in the amount of $40,308,025.00.

Our system is not capable of listing outpatient claims by CPT 4. However, approximately 124,680 physician HCFA claims were processed for fiscal year 2013-14 in the amount of $19,407,805.00.

The addition of the oral surgery claims review is new to the contract and we are unable to breakout the number of claims. However, oral surgery claims processed for fiscal year 2013-14 totaled $729,035.00.

Q16) In the Bidders Conference Transcript you broke down the volume for UM/UR for last year as the following:

2014
Emergent 1,175
urgent 3,514
soon 14,350
routine 59,630
assigned 77,332

Could we please get this data broken out by month?

A16) This data is not available by month. It is prepared annually.

Q17) Could you please verify if you require an onsite RN?

A17) An onsite RN is not required.

Q18) On page 13, 9th bullet it states "Travel to various sites within NY state". The transcripts question is asking "What is meant by performance evaluations when traveling out for training, what is the expectation?" I understand from the transcript that you are working on a response but I would just like to clarify our question:

Please advise as to how much travel is involved? More specifically, what sites in NY will vendor need to travel to and how many times per month or year?

A18) Please see Section XII.B(2)(e), page 37, first sentence. Approximately 12 site visits have been performed under the current contract. Upon contract award, the number of visits and sites will be negotiated as it will depend on the needs identified by the contract vendor as to areas that need corrective action or additional attention/training.

Q19) Section VI, Scope of Services, page 12 (first bullet). If the Offeror suggests alternatives to review of the 20 most utilized DRGs, should these assumptions be used to propose the percentage of recovery in the Cost Proposal or should the Offeror base assumptions on the 20 most utilized DRGs?

A19) Recovery percentage (%) is based on amount ($) recovered regardless if the recovery was based on the 20 most utilized DRG's or other criteria.

Q20) Section VI, Scope of Services, page 12 (first bullet). Please confirm or correct that by "preliminary review" DOCCS means a screening review to identify candidates for medical record review.

A20) Yes, the preliminary review is a screening review to identify candidates for medical record review.

Q21) Section VI, Scope of Services, page 12 (second bullet). Please provide additional information about the review of oral surgery claims. Is this review for coding/billing or medical necessity?

A21) The review is to determine that the service was provided based on the referral and properly billed based on the services that were performed.

Q22) Section XII.B.e, Proposal Content, page 37. Please clarify the meaning of "on-site." In the Bidder's Conference we asked about the location of training sessions, which we understood to include hospital sites. This section seems to suggest that on-site training sessions would be held at a correctional facility.

A22) On-site training may take place either in a correctional facility or at a correctional facility's Quality of Work Life (QWL) building.

Q23) Section XII.B.e, Proposal Content, page 37. Given the three months requirement for submission of the training agenda, the first training sessions could begin in February at the earliest, with 18 total sessions to be conducted in 2016. Would DOCCS consider allowing submission of the training agendas 45-60 days in advance during the first year of the contract so that the total number of on-site sessions can be delivered?

A23) Yes.

Q24) Page 7 – Section I. Overview "In 12-month period, over 122,731 specialty care appointments were completed by contracted physicians and 2,502 acute care admission days were accessed…." Per Bidder's Conference transcript, lines 19 and 20, "…156,001 referrals were processed for the calendar year 2014."

a. Please clarify the difference in the volumes provided.
b. Can you confirm that all 156,001 referrals in calendar year 2014 were clinically prior authorized for specialty care and acute admissions by the current vendor?

A24) a. The larger number, 156,001, represents the number of referrals entered into FHS1 for review. The difference between the two numbers is a result of multiple factors including, but not limited to, denied referrals, no shows to appointments, patient refusal, appointment cancelations, service no longer deemed medically necessary by primary care provider, and the service/need was met at another appointment, ER trip or admission.

b. No, not all were authorized by the vendor.

Q25) Page 11 – Section VI. Scope of Services – General

a. Is the current vendor reviewing each referral manually, utilizing RNs or other clinical staff, or are auto-authorization tools being utilized? Is an automated authorization using clinical criteria an acceptable option?
b. Does the FHS1 system enable referral data to be extracted by the vendor in order to perform workload analysis, quality analysis, and trend analysis?
c. Does the claims data in the FHS1 system contain primary data elements diagnosis to allow for adequate targeting for retrospective review and all diagnosis and procedures codes are being captured.

A25) a. The current vendor is utilizing RN reviewers who manually review each referral using clinical criteria and enters data as needed manually.

With respect to the use of an automated authorization tool as an acceptable option, it depends on the specifics of the automated review tool. This question cannot be answered without knowing what mechanisms such a tool would employ to produce automatic reviews.

If such an automated tool cannot provide an interface to read data from and enter data into the FHS1 mainframe system through existing input screens, then it is highly doubtful that such a tool would be compatible with FHS1.

b. The only way to "extract" referral data is through physical reports. Based on information supplied by the Office of Information Technology Services, I do not believe that data downloads are available to the current vendor.

c. All data billed on the physician HCFA claim is captured on the FHS1 system record. Inpatient UB04 data on the FHS1 system will include DRG codes, and principal procedure codes. HCPCS codes and ICD-9/ICD-10 diagnosis codes will be included, but based on the number of codes billed, due to the system limitations some HCPCS codes and some ICD-9/ICD-10 codes may not be captured.

Q26) Page 11 – Section VI. Scope of Services - Bullet One – "Process referrals for specialty care…."

a. Please confirm the vendor will receive referrals via the FHS-1 system. If not, how are the referrals submitted to the vendor?

b. If referrals are sent outside of the FHS1 system, what was the percentage of claims not shown in FHS1 in the 4/1/13 to 3/31/14 time period?

A26) a. The vendor will receive referrals via the FHS1 system.

b. Referrals are not sent outside of FHS1 system. However, through error some referrals may not be entered on the FHS1 system. Claims created under this scenario would be minimal but would still need to be verified by the vendor. Please see answer provided in response to question #29(c) for verification process to follow in this case.

Q27) Page 11 – Section VI. Scope of Services - Bullet Two – …"emergent" and/or "urgent" referrals

a. Approve: Call the appropriate nurse scheduler.
    i. Would the Department consider alternate communication methods such as email, fax, web portal?

b. Preliminarily Deny –
    i. What percent of referrals had a preliminary denial?
    ii. What percent of the referrals had a final denial?
    iii. Please confirm that if the vendor cannot approve the referral it should be forwarded to the RMD or RDD for review. Does the vendor have any responsibility for the referral once it is forwarded on to the RMD/RDD? If so, please describe.
    iv. Is the RMD/RDD responsible making the final determination? How is the determination of the RMD/RDD entered into the FHS1 Clinic Scheduling System?

A27) a. No, for emergent and urgent referrals we require a phone call to ensure a scheduler is aware of it and the approved referral can be scheduled immediately.

b(i). 7.53% were preliminarily denied in calendar year 2014.
7.43% were preliminarily denied in calendar year 2013.
9.22% were preliminarily denied in calendar year 2012.

b(ii). 3.26% of all referrals had a final denial in calendar year 2014.
2.34% of all referrals had a final denial in calendar year 2013.
4.00% of all referrals had a final denial in calendar year 2012.

b(iii). When preliminarily denied by the vendor, the referral goes to the RMD or RDD. The RMD or RDD may need more information as to why it was preliminarily denied; however, the determination of that referral is now the RMD or RDD's responsibility.

b(iv). Yes, the RMD or RDD is responsible for making the final determination. There is a field for the RMD or RDD's approval or denial and their comments.

Q28) Page 11 – Section VI. Scope of Services - Bullet Three – "Render an electronic decision…for all "soon"…"routine"…and "assigned" referrals.

a. Please describe the process if a referral cannot be approved. Is it forwarded to RMD/RDD?

A28) If a referral cannot be approved with the information given, the referral can be pended back to the facility's primary care provider for additional information, or if further information is not needed to support request or would not be helpful, the referral is to be preliminarily denied to the RMD/RDD.

Q29) Page 11 – Section VI. Scope of Services - Bullet Four – "Verify ALL inpatient and outpatient medical and oral surgery claims…."

a. Please confirm that the verification process does not require any clinical or coding review.
b. What percent of services were not able to be verified in the 4/1/13 to 3/31/14 time period?
c. What is the process if a claim cannot be verified?
d. Can an extract file be created from FHS1?

A29) a. Vendor should have basic coding knowledge. The vendor will confirm that the service billed is consistent with the FHS1 referral. The FHS1 system claim verification process provides the user the option to display the descriptions for each of the CPT and diagnosis codes listed on the claim to aid in the review.

b. System is not able to track that information.

c. If a claim cannot be verified via the FHS1 system referral history, the vendor will contact the Health Unit in the inmate's owning facility for verification of the service. If the facility cannot verify the service, the vendor will ask the Medical Bill Payment Unit to request the medical records from the provider. Receipt of the medical records by the Medical Bill Payment Unit will serve as justification that the service took place. The Medical Bill Payment Unit will re-enter the claim on the FHS1 system with comments to the vendor indicating reports have been received. Vendor will verify the claim based on the fact that the medical records have been received.

d. Question is not clear as to what information would need to be extracted.

Q30) Page 12, Bullet One Preliminary Review

a. Can the retrospective reviews only be completed on claims in which a preliminary review was conducted? Can the vendor select claims from the entire population of claims to select for retrospective review?

A30) We feel it is necessary to do a preliminary review to determine if a claim is a candidate for a retrospective review in order to avoid unnecessary retrospective reviews. The retrospective reviews are more labor intensive as they require review of the complete medical records. The medical record copies also come at a cost to DOCCS.

Please see the second paragraph under the first bullet on page 12 "As knowledgeable and experienced coding specialists, the UR vendor may be able to identify DRG's other than the top 20 most utilized, in order to generate the most health care cost recovery. Therefore, suggested alternatives to the above reviews will be given consideration". To clarify further, the vendor may select claims other than those falling within the top 20 for a preliminary review to determine if it is a candidate for a retrospective review.

Q31) Page 12, Bullet One – DRG Review

a. Please describe the vendors responsibility related to appeals for each of the following?
   - Referrals
   - Verifications
   - Retrospective Review

b. Please provide the number of appeals for each for calendar year 2014.

A31) a. Referrals - Not part of DRG review.

Verifications - Not part of DRG review.

Retrospective Review - Vendor will be responsible for reviewing the appeals submitted by the hospitals and making a determination as to whether their original findings stand or the claim was correct as originally billed by the hospital. The vendor will provide a response supporting their findings. In some cases a second appeal may be received in which case the vendor would also be responsible for reviewing and responding.

b. There were 44 DRG appeals for calendar year 2014.

Q32) Page 12, Bullet Three - Inpatient stays

a. "Commence initial review…"
   i. Please confirm this review is to assess medical necessity. If not please describe what the review should entail.

b. "…Continue concurrent review"…"and provide a written report…"
   i. Please describe what type of written report is required.
   ii. Is there any responsibility beyond confirming the ongoing medical necessity for the inpatient stay?

A32) a. Yes, this review is to assess medical necessity and appropriateness of setting.

b(i). The review that is obtained from the hospital is entered into our FHS1 system.

b(ii). Yes, we want concurrent review and anticipated discharge needs and estimated length of stay.

Q33) Page 13, Bullet One – Quarterly Reports "…DOCCS must be in receipt of reports that reflect workload, program success, and opportunities for improvement."

a. Please verify whether queries can be performed within the FHS1 system for reporting?

b. Are complete extracts of selected data fields available?

c. Does the FHS1 system allow data to be extracted by the vendor for workload and quality analysis, trend analysis, and reporting?

A33) a. FHS1 has various reports that can be printed from within the system and others that are available as periodic prints. There are three (3) screens full of report menus that are accessible on demand which include reports for Clinic Scheduling, appointments and some for referrals. Queries can be performed within these on demand reports. The reports are located in FHS1 on the option 4.9, 4.9.1 and 4.9.2. These reports query the underlying database. However, these are preprogrammed queries and do not allow the end user a tremendous degree of flexibility.

b. Based on information supplied by the Office of Information Technology Services, currently complete extracts of selected data fields are not available to our vendor.

c. Based on information supplied by the Office of Information Technology Services, currently extracts of selected data fields are not available to our vendor.

Q34) Section V. Minimum Bidder Qualifications page 11 states

The State considers the following qualifications to be pre-requisites in order to be considered as a qualified Bidder for purposes of this solicitation. Any bidder who cannot provide evidence of meeting these requirements will be considered nonresponsive and that bidder's proposal will be immediately rejected, prior to the scoring process.

- Evidence of.....registration as a UR agent under Article 49 of the NYS Public Health Law. (To review Article 49, please visit the following website: http://public.leginfo.state.ny.us.)

Our organization is currently not registered as a UR Agent in New York. Upon contacting the Department of Health to request an application, we were informed that 1) they were unsure which URA application was required for the Department of Corrections and Community Supervision, and 2) regardless of which application, the application and approval process could not be completed by May 29, 2015 when the proposals are due.

1. Given that the contract start date is not until December 1, 2015, would evidence that an application has been submitted and approval pending satisfy the requirement?

2. Would the Department publish the appropriate/specific URA application for potential vendors in the same predicament?

A34) Section V, Minimum Bidder Qualifications, has been amended to revise the requirement regarding registration as a UR agent. Please review RFP 2015-03 – Addendum #2. The addendum is available for download from the following websites: DOCCS (Community Supervision) at https://www.parole.ny.gov/rfps.html[parole.ny.gov] and NYS Contract Reporter at https://nyscr.ny.gov/[nyscr.ny.gov].

Q35) Page 9 – Section III. Key Events/Dates

a. Given the Responses to Questions are estimated to be posted May 13, 2015, would the Department consider an extension to the Proposal Due date of May 29, 2015?

A35) We believe issuing responses on May 13, 2015, provides bidders with sufficient time to complete and submit their proposals by the proposal due date of May 29, 2015. Therefore, we will not consider an extension of the proposal due date.

REVISION TO SOLICITATION

Section XII.B(1)(b) – Experience and References (page 36) in RFP 2015-03 is amended as shown below:

a. Written letters of recommendation from two (3) to six (6) professional references, outlining past work performance. The documentation must be on official letterhead and should include a contact name, address, phone number, and email address for inquiries. DOCCS reserves the right to contact references for clarification and/or verification of information provided. We will make no more than three attempts to contact any one reference. (8%)

All other terms and conditions remain unchanged.

If submitting a proposal, this Addendum #5 for RFP #2015-03 is required to be returned with your proposal and must contain an original signature, be dated, attached to, and made a part of your proposal.

Company Name: _____

Address: _____
(include Street, City, State, Zip) _____

Bidder's Name: _____
(please print):

Title: _____

Signature: _____

Date: _____