Attachment E

Responses to Questions from Potential Bidders on Draft RFP

Question released November 9, 2021

1. *Has there been any thought to separating out Emergency Services and Non-Emergency Transport Services? It is becoming rare for both types of service to be provided by one entity*

Careful consideration was given to multiple approaches and models. It was determined to be in the Community's interest for this to be an integrated RFP for both emergency and non-emergency ambulance services.

2. *Are the costs associated with the items listed in 1.5.E covered by or are part of the payments described in 1.5.D?*

The Contractor's costs listed in 1.5.F (section changed from 1.5.E) for First Watch and Vector/Target LMS are not included in the costs outlined in 1.5.D. However, LEMSA has negotiated enterprise level agreements that can be accessed by the Contractor that could result in reduced pricing.

3. *Section 1.5 C) references prohibition of "Stop the Clock" sub-contracts, does this include "Extend the clock" agreements as well?*

The language of section 1.5 C) has been ammended to clarify that response time extensions will not be permitted, however sub-contracts with fire departments are allowed.

4. *Section 5.3 A and D both reference ambulance configurations to be "Identically configured" with equipment stored in the "Same Location" which is not possible as unit interior design changes.*

The language of the RFP has been amended: "Ambulances shall be similarly configured with the capability to carry all supplies necessary to function in accordance with LEMSA System Policies, Protocols and Procedures.

The intent of ensuring ambulances are configured in a similar manner to the maximum extent possible considering different type units utilized. This may include stocking medical disposable supplies in cabinets, compartments, drawers, and doors, is to provide consistency in placement and location so that first responders and EMS providers can rapidly access needed supplies based on familiarity with the general placement of those supplies in the ambulances regardless of the ambulance type."

5. *Section 5.5 requires MDT be capable of transmitting ePCR. Can this be accomplished with a separate device such as an iPad?*

Section 5.4.A.v) reads *"The Contractor shall equip each ambulance, QRV, and field supervisor vehicle with a mobile computer with mobile data computer capability,*

CAD access, mapping software, and the ability to send electronic patient care records to the receiving hospital and a centralized server via wireless technology."

Multiple devices may be used to accomplish these tasks are described. iPads and other tablet computers are considered mobile computers, and as such are accepted by the LEMSA.

6. Is an annual CPI adjustment an adequate protection against increased operating costs that are outside the control of the provider? Is there a different methodology that could be used to protect both the public and provider against rising costs?
The language of the RFP has been amended. The rate increase methodology has been revised to address issues outside of the Contractor's control. Updates can be referenced in section 8.3 of the RFP.

7. What financial methodology or strategy was utilized to propose a 5% cap above current ambulance rates? Will this protect system viability or negatively impact the EMS system and its providers with uncertainties and future unanticipated changes in economic and operating conditions?
The LEMSA intends to reduce the financial burden of pre-hospital ambulance care levied on the community, while maintaining a financially viable EMS System. The LEMSA worked with Fitch & Associates to test the minimum and maximum limits of unit hours in order to meet the operational requirements as proposed in this RFP. The financial impact of these limits has guided several elements, including ambulance reimbursement rates. Fitch & Associates recommended an increase of 2.5% over the current rate would meet this goal. This did not account for the contractually allowed CPI increase which occurred in February, 2022. After additional review, the LEMSA has determined that a proposed ambulance rate will not be accepted if it is over 10% to the current rate (effective February, 2022).

Regarding future rate increases, that is addressed in Question 6 and Section 8.3.B of the RFP.

8. What is the legal basis for providing a separate (EOA) carve-out status to the County Fire Department for services provided with the UC Santa Barbara campus? Don't State facilities and properties fall under the same State statutes and regulations governing County EMS systems (excluding Federal lands)?
The language of the RFP has been amended.

LEMSA requested clarification from the California EMS Authority (CAEMSA) to determine if the UCSB Campus was considered exclusive or non-exclusive. CAEMSA stated the UCSB Campus is *non-exclusive*. CAEMSA confirmed the area could either remain non-exclusive or be made exclusive through the procurement process.

The RFP Advisory Committee recommended the area be included in the Exclusive Operating Area currently in the RFP, thus making one contiguous EOA.

9. Can you define the steps between the Draft RFP going to the State and subsequently to the Board of Supervisors? It is our understanding the Draft RFP will go to the State for their review, and once their edits have been incorporated the LEMSA would take the RFP to the Board for their approval. Is that an accurate assessment of the process?
The LEMSA is presenting a final version of the RFP to the Board of Supervisors and requesting approval to release for public procurement.

10. Will there be an opportunity for Public Comment on the RFP after it returns from the State Review Process if it does not go before the Board of Supervisors?
A bidder's conference will be held to answer questions and receive comment, but once approved for Procurement, the RFP will not be released for an additional comment period.

11. When does the LEMSA anticipate posting responses to bidders' questions associated with the Draft RFP?
Responses are posted with the public presentation of this RFP.

12. Page 8, item 1.5B - We are not able to determine where the sub-response time zones are specifically located or the associated response time requirements for these zones.
The LEMSA understands that data is vital to any proposer to be able to prepare a realistic proposal.

Upon release for Public Procurement LEMSA will provide maps and shapefiles/polygons of the five ambulance zones so that Proposers can analyze the zones to understand and develop proposed coverage levels. See Appendix 2 for reference.

13. Page 8, item 1.5.C - Local fire departments should not be prohibited from sub-contracting. Currently, local fire departments provide more service than is reimbursed; we are concerned that removing these sub-contracts would potentially create a system with longer response times. The community that supports the fire department funds these resources, not the Ground Ambulance provider. Additionally, the Draft RFP indicates that funds from the selected ground ambulance provider for this taxpayer funded service are deposited into an account managed by the LEMSA. Please more clearly articulate how the LEMSA proposes to reimburse the taxpayer funded first responder agencies for this service.
The comment/question is unclear.

The language of the RFP has been ammended within section 1.5.C

The LEMSA is not aware of the legal or contractual requirements to reimburse the first responder agencies for this service. The ambulance provider is fee-for-service based with no subsidy from the county, therefore, any services provided within subcontracts wouldn't be taxed based.

It is unclear on how the removal of "Extend the Clock" agreements will create longer response times for either the ambulance provider or the fire agencies. Under the current agreement with American Medical Response (AMR), each fire agency receives financial support from AMR in exchange for these agencies arriving on-scene first and extending AMR's response time requirement by two (2) minutes. If these agreements were to continue, the result would be an additional two minutes to the response time requirement of the provider, netting a four (4) minute addition to the current response time standard.

Recognizing that EMS System enhancements are often unplanned and unfunded, the LEMSA has developed an EMS Clinical & Technical Enhancement Fund. The Fund may be accessible to EMS System participants for EMS initiatives, as well as the LEMSA for EMS System enhancements. Once established the LEMSA will meet with EMS system partners to develop the disbursement process.

14. Can you define the steps between the Draft RFP going to the State and subsequently to the Board of Supervisors? It is our understanding the Draft RFP will go to the State for their review, and once their edits have been incorporated the LEMSA would take the RFP to the Board for their approval. Is that accurate?
Please see the response to Question #9.

15. We are pleased to see that progressive KPIs and quality measures are included in the draft RFP. We would like to clarify if those metrics included in Appendix 9 are the actual performance measures that would be implemented, or are these examples? We appreciate the emphasis in Appendix 9 that this may be a difficult process and that the LEMSA is willing to work with the provider to develop KPIs. We feel that a collaborative effort between the LEMSA, provider, and greater EMS system will ensure that all tracked measures for compliance have qualifiers clearly defined for inclusion and exclusion. We do have some reservations about the assessment of penalties for missing CQI targets. Many medical providers are shifting to Just Culture, non-penalty approach to quality improvement because they feel that introducing monetary penalties could result in under or non-reporting of error due to fear of financial retribution, thus inhibiting concerted efforts toward improvement. The District would like to acknowledge that tools (ImageTrend and FirstWatch) for clinical data collection are being put into place, however, we feel that further testing and implementation will be required to establish reliability, and baseline metrics for the system.
The language of the RFP and Appendix 9 have been amended.

The Centers for Medicare & Medicaid Services (CMS) and private health insurance companies within California have implemented value-based programs that adjust payment to health care providers based on the quality of care they give to people. These programs are part of the larger quality strategy to reform how health care is delivered and paid for. This RFP is in-line with existing elements of state and national healthcare programs.

It is the intent of the LEMSA for the Clinical Metrics in Appendix 9 to be implemented as written. It is unclear how the liquidated damages and the financial discount process impacts the bidder's ability to implement a "Just Culture" approach. The Just Culture approach focuses on managing behavioral choices, implementing safe systems, and is focused on a teaching/learning environment. The financial aspects of the Contractor's overall performance are indicative of their ability to create Just Culture within their organization.

It is unclear what the potential bidder means regarding further testing being required to establish reliability.

16. Is it the LEMSA's intent to maintain these KPIs and policies and procedures to current clinical standards, as determined by the local EMS and medical community?
Please refer to Section 4.2.

17. The RFP states a deadline of 10 days from the date of incident for clinical exemption requests, but 10 days from the end of each month for response times exemption requests. 10 days is very quick turnaround for analyzing the need for clinical exemptions. We feel that it would be more appropriate if the same standard was applied to both types of exemption requests.
LEMSA is committed to ensuring a clinically sophisticated and engaged EMS system. LEMSA's goal is to have the ability to rapidly identify and address systemic clinical performance as they occur. Additionally, the 10-business day turnaround time ensures that information from individual care providers or clinical data from equipment will be more readily available.

18. P. 5, items 1.2 and 1.3. Please clarify how the LEMSA defines clinical proficiency
In short, clinical proficiency is generally defined as excellence in patient care. One mechanism of determining clinical proficiency is an organization's ability to successfully deploy a clinical performance monitoring and improvement program. Please refer to Section 4 and Appendix 9 of this RFP for additional information, background and, resources.

19. P. 8, item 1.5B - We support reducing complexity, however, we are concerned that maps of sub-response time zones are not included. Adding the maps will provide more clarity

The LEMSA understands that data is vital to any proposer to be able to prepare a realistic proposal.

Upon release for Public Procurement LEMSA will provide maps and shapefiles/polygons of the five ambulance zones so that Proposers can analyze the zones to understand and develop proposed coverage levels.

20. P. 8, item 1.5.C - We have concerns about the prohibition of fire department sub-contracts. Currently, local fire departments provide more service than is reimbursed. These funds have historically been provided directly to the Fire departments by the vendor to help offset fire agency costs and provide opportunity to improve their EMS services. What will be the new protocol and procedures for distribution of these EMS System Enhancement funds to the fire departments? In addition, what would qualify as an eligible reimbursable cost?

Please see question #13

21. P. 9, item 1.5 F) - Please clarify what Mental Health Patient Support is currently provided by the existing provider, and what the minimum requirement is so that we can better identify improvements.

Mental Health patient transport from the scene and to licensed psychiatric facilities is provided by American Medical Response and the County Fire Department. For additional information on the current Mental Health patient framework please review to the Fitch & Associates EMS System Review Phase 1. The LEMSA is seeking innovation from Proposers (Section 1.5.G) in navigating these challenging patient scenarios, therefore no minimum requirements have been established.

22. P. 14, item 2.5 - Is the False or Misleading Statements section necessary? What is the intent of calling this out separately?

This is standard RFP language.

California law establishes that it is unlawful for a person, contractor, subcontractor, supplier, subsidiary, or affiliate thereof to knowingly and with intent to defraud, fraudulently obtain, attempt to obtain, or aid another person in fraudulently obtaining or attempting to obtain, public moneys, contracts, or funds expended under a contract.

23. P. 18, item 2.8 A) - It appears that the LEMSA is seeking proposal responses divided into three files or sections: 1) A Program Proposal; 2) A Financial Proposal; and 3) Reference Document. Which portions count towards the 100-page limit, excluding title pages and dividers?
The narrative portion of the Proposal shall be limited to one hundred (100) pages, excluding title pages and dividers. The financial documents and proposed ambulance rates required to be submitted in a separately titled file do not count towards the (100) pages.

24. The RFP p. 18 indicates that the proposal submission should have double-sided printing; however, on p. 17 it says that hard copy submissions will not be accepted. Is the intent for us to save printing preferences in the file for double-sided printing?
Proposers are not required to save printing preferences to double-sided for proposals. Standard single-sided PDF format is acceptable.

25. P. 20, item 2.9 - What do you mean by experience managing a clinically sophisticated program? How will this be measured?
Operating an emergency ambulance service in compliance with established clinical protocols, with well-defined quality improvement processes, engagement in/support for clinical improvements and other activities generally associated with improving the patient experience of care as outlined in the Tipple Aim and as described in the 2018 Fitch Report. This will be measured by reviewing compliance metrics and other information provided by the proposer.

26. P. 36, item 4.3. - Please clarify how the LEMSA would define severe or chronic deviations from clinical performance standards. Does the LEMSA intend to define this in the contract?
Generally, an individual deviation of clinical performance standards would not be considered severe or constitute a breach of the Agreement. Should the deviation be happening over long periods, existing frequently or not be remediated could constitute a breach. This will be more clearly defined within the contract.

27. " P. 44, item 5.3 A) ii - The RFP indicates that equipment and supplies need to be stored in the same location in all ambulances. This requirement may be difficult to achieve if we have different types of ambulances deployed. The reasoning for deploying a mixture of type II and III is as follows:
a. Due to the varying geography and unique community needs, a different configuration of units may be needed in different deployment locations.
b. Current supply chain issues may affect the availability of new ambulances, necessitating a mixture of ambulance types to meet needs.
c. Not allowing for a mixture of ambulance types could be restricting competition of ambulance suppliers."
The language of the RFP has been amended.

Ambulances may be standard Type I, Type II, or Type III.

Ambulances shall be similarly configured with the capability to carry all supplies necessary to function in accordance with LEMSA System Policies, Protocols and Procedures.

The intent of ensuring ambulances are configured in a similar manner to include stocking medical disposable supplies in cabinets, compartments, drawers, and doors, is to provide consistency in placement and location so that regardless of the ambulance type, first responders and EMS providers can rapidly access needed supplies based on familiarity with the general placement of those supplies in the ambulances.

28. P. 44, item 5.3 A) v - The RFP requires a driver video surveillance system - can the LEMSA provide further clarification as to what this is?
Driver monitoring and video surveillance systems are used throughout the EMS industry to protect employees, identify coaching opportunities, fight against false claims, and improve vehicle operations safety.

These systems provide prescriptive monitoring of driver behavior by using forward facing cameras and monitoring devices that recognize when the vehicle experiences rapid acceleration and deceleration, significant g force, collisions, high speeds, and seatbelt use.

These instances are then reviewed by designated individuals to determine whether the driver operated the vehicle in an appropriate or inappropriate manner based on the event and Just Culture principles.

Commercially available products are offered by Samsara, Lytx, Digital Ally and SambaSafety.

Companies listed are for illustrative purposes only, LEMSA does not own stock or have any financial interest in any of these products or organizations.

29. P. 46, 5.5 B) - With the language, "the LEMSA approved patient care report" it is unclear if the LEMSA dictates which ePCR is approved, or just approves the ePCR choice of the ambulance provider? We agree with B and currently have ImageTrend, however, if the LEMSA ever wanted to change it, we would expect them to bear the burden of the cost of switching.
The LEMSA does not intend to approve another ePCR system for use within the County.

30. Page 54, section 6.2 - Response times - why was semi-rural eliminated and wilderness added? What was the justification for deviating from the historical response time standards and terminology?
The most recent U.S. Census bureau population density definitions outline 2 primary categories: Urban and Rural. Anything that does not meet the criteria of these definitions are classified as wilderness.

It is the LEMSA's intent to align with the most current standards

31. On page 29, "Participation in System development and Future System Enhancements" is listed as 7.8 in the TOC, but as 7.9 in the Evaluation Criteria and the narrative p. 66
This was a typo and has been corrected.

32. On page 28, "Continuing Education Program Requirements" is 4.6, but labeled as 4.7 on page 38 of the narrative. The following sections in 4 also differ due to this.
This was a typo and has been corrected.

33. On page 29, Emergency Takeover is 9.5 in the TOC, but 9.4 in the narrative on p. 76.
This was a typo and has been corrected.

34. P. 26 there is a hanging H)
This was a typo and has been corrected.

35. On page 33, 4.1, there is a referral to Appendix 11 - Clinical Scorecard. The Clinical Scorecard is actually Appendix 9.
This was a typo and has been corrected.

36. (Appendix 3) Are the service rates representative of both 911 and non-emergency transports? If so, would the County please confirm whether hospitals are charged these totals for facility responsible transfers?
The ambulance rates refer to the maximum allowable rates and apply to both emergency and non-emergency transports.

37. (Appendix 5) The financial standards listed in Appendix 5 do not match the standards listed on page 21/22 item B. Would the County please confirm which criteria should be utilized?
This was a typo and has been corrected.

38. (p. 8, section 1.5, item A) "It is also expected that the Contractor will enter into contract negotiations with County Fire Department to manage unit deployment, 911-call prioritization & dispatch, and pre-arrival instructions." Can the County

advise whether this potential fee is in place of the $1.6M Emergency Dispatch Fee or if this is a potential added fee?
The $1.6M is the expected cost of dispatch services to be provided by the Santa Barbara County Sheriff's Office, and subsequently the Regional Fire Communications Facility.

39. p. 8, section 1.5, item A) Would the County please advise if the bidder can make the proposal based on VHF radios versus a temporary investment in UHF radios combined with new VHF radios?
Any cost associated with the delivery of service should be included in a bid. The use of VHF radios for EMS dispatching will not be available for an estimated 1.5 years into the service agreement.

40. (p. 9, Section D) It is unclear that the Contractor should be responsible for the costs to operate the LEMSA ($1,084,708 per Section 1.5(D)). We request that the County reconsider passing this cost on as it could be determined to be a violation of the Anti-Kickback Statute.
This has been reviewed and determined not to be in violation of the Anti-Kickback Statute.

41. (p. 10, Section 1.6 subsection A) Would the County confirm that the table represents transports and not responses? Can the County provide both responses and transports? (p. 43, subsection ix) Would the County advise what the current peak deployment of ambulances is?
Any potential bidder that enters into a Business Associate Agreement during the procurement process will be given historic response data. The data will not be processed or summarized by the county, and It shall be the responsibility of the bidder to analyze the information.

Current peak hour staffing reflects the service delivery of the existing contract. It is the responsibility of any potential bidder to analyze the provided data and estimate staffing needs for future services.

42. (p. 52, paragraph 2) Would the County please confirm whether response times for Priority 3 calls in Rural and Wilderness zones are both 22 minutes and 59 seconds, or if the times detailed in the table on pages 54 and 55 are correct?
This was a typo and has been corrected.

43. Section 3.2 A) 8 references sole responsibility for out of county transports and provider must accept all transports regardless of ability to pay. Would you consider added language limiting acceptance of transports to those that meet medical necessity as defined by CMS?
Please see the response to Question #1

44. (Appendix 8) Would the County confirm whether the historic data tables will include the following transport information:

a. Time of day & day of week
b. Level of service (i.e., ALS, BLS, CCT, etc.)
c. Whether the response was emergent or non-emergent
d. Pick up & drop off address, or latitude & longitude
e. Time on task

Please refer to Question #41

45. (p. 9 section D) What is the EMS System Enhancement Fund ($1,302,674.38 per Section 1.5(D)) to be used for? Is it for items that would otherwise be Contractor's responsibility?

Please refer to Question #13

46. Page 54, section 6.2 - We acknowledge that response time compliance is a key part of performance, however, because Urban, Rural, and Wilderness are not included on any of the maps, we are unable to provide comments or feedback on a provider's ability to meet these standards.

Please refer to question #22

47. Will there be an opportunity for Public Comment on the RFP before it goes to the State?

Please see the response to Question #10

48. Is the LEMSA planning to respond to bidders' questions associated with the Draft RFP? If so, when do you expect to release those responses?

Please see the response to Question #10

49. Page 5, items 1.2 and 1.3. How the LEMSA defines clinical proficiency is not clearly articulated. Please provide clarity in this area.

Please see the response to Question #18

50. Page 9, item 1.5 F - We are unclear on what Mental Health Patient Support is currently provided by the existing provider

Please refer to Question #21

51. Page 20, item 2.9 - It is unclear what you mean by experience managing a clinically sophisticated program? Please clarify how will this be measured?

Please refer to Question #18

52. Page 54, section 6.2 - We strongly agree that response time compliance is a key part of performance; however, because Urban, Rural, and Wilderness are not included on any of the maps, we are unable to determine if the times suggested are appropriate.

Please refer to Question #30