These questions represent a portion of the questions that have been submitted regarding the RFP. These answers will **not** be posted in the Q and A section of eMaryland Marketplace.

**125.** Section 3.69.4 of the RFP requires that the Contractor’s UM Manual include a monthly quality audit of the infirmary RN care (Item 8). We are familiar with reviewing infirmary RN care from a CQI standpoint, but this is not a traditional UM function. • What is the expectation of this requirement from a UM standpoint, and what information would you expect to see.

*Section 3.55.1 of the RFP explains the Department’s view that utilization review is a part of CQI. The specified audits are quality audits and would assess the quality of care based on patient outcomes in areas specified by the Department Director of Nursing. Offerors should use their expertise in describing how the Offeror will meet this requirement.*

**126.** RFP Subsection 3.69.2, at Item 25, requires that the Contractor’s UM Manual include a monthly quality audit on inpatient RN care. Inpatient care will be provided in independent hospitals with which the Contractor contracts for appropriate inpatient care. Contractors are unlikely to know all of the different inpatient RNs who care for DPSCS patients when the patient is hospitalized. • Please indicate how you envision the monthly quality audit of inpatient RN care being conducted. • Please indicate what type of information you would expect to see in this audit.

*Section 3.55.1 of the RFP explains the Department’s view that utilization review is a part of CQI. The audits are quality audits and would assess the quality of care based on patient outcomes at various facilities. The Department would not expect individual assessments of RNs providing Off-site care but an assessment of the overall quality of nursing care at hospitals providing Inpatient care. Quality of nursing care could be assessed by decubitus ulcer development, wound care, falls, patient safety, medication*
errors, complications occurring during hospital stays associated with failure to follow
treatment plans, orders resulting in longer stays, or additional therapy. Offerors should
use their expertise in describing how the Offeror will meet this requirement.

127. Section 3.69.5 of the RFP requires that the Contractor’s UM manual include a monthly
quality audit of the outpatient RN care (Item 11). We are familiar with reviewing
outpatient RN care from a CQI standpoint, but this is not a traditional UM function, and it
is not immediately clear which RNs you would identify for review within the outpatient
UM review process. • Because outpatient referrals are generated from a physician exam
conducted on site and are not generated by an RN, what is the expectation of this
requirement from a UM standpoint? What information would you expect to see?

Section 3.55.1 of the RFP explains the Department’s view that utilization review is a part
of CQI. The audits are quality audits relating to specialty care and telemedicine, both on
and off site. Examples of the information that might be included in an audit is vital signs
documented, documented follow up with treatment plans, wound care, and medication
care plans etc. Offerors should use their expertise in describing how the Offeror will
meet this requirement.

128. RFP Subsection 3.69.2, at Item 26, requires that the Contractor’s UM Manual include
“diagnostic grouping of all inpatient admissions with an extensive EPHR review on each
case.” • Please clarify this requirement. What information would you expect to see?

The Department expects that all inpatient admissions would be grouped by Hospital
Diagnostic Related Groups and International Classification of Disease categories by
patient by facility. A sample of what might be provided:

<table>
<thead>
<tr>
<th>Category</th>
<th>No. of cases</th>
<th>ICU/CCU/Telemetry Bed Days</th>
<th>ALOS</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma</td>
<td>11</td>
<td>20</td>
<td>1.81</td>
<td>Seven (7) cases in this group were assault-related, 2- were SIB related, and 1- was a MVA involving a patient who is in work release</td>
</tr>
<tr>
<td>Neurology</td>
<td>5</td>
<td>19</td>
<td>3.80</td>
<td>Two (2) cases were Seizure –related (1 possibly Status Epilepticus, the other developed ARF due to Rhabdomyolysis), 1-AMS due to severe Hypercalcemia from Hyperparathyroidism, 1- possible CVA.</td>
</tr>
<tr>
<td>GI</td>
<td>4</td>
<td>11</td>
<td>2.75</td>
<td>There were 3 surgical cases ,and 1 hemodynamically compromised GI bleeder who had IBD and was being treated for DVT with Coumadin-this patient had hematochezia with an initial INR of 9</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>9</td>
<td>1.80</td>
<td>There were three(3) patients who had chief complaints of “chest pain”; all 3 had major CAD risk factors</td>
</tr>
<tr>
<td>------------------</td>
<td>-----</td>
<td>------</td>
<td>------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Oncology</td>
<td>1</td>
<td>8</td>
<td>8.0</td>
<td>Only one (1) case of a patient with severe respiratory compromise due to a new dx of extensive Lung cancer( <strong>this patient expired in the hospital</strong></td>
</tr>
<tr>
<td>ID</td>
<td>2</td>
<td>6</td>
<td>3.0</td>
<td>Both were Sepsis cases.</td>
</tr>
</tbody>
</table>

129. Subsection 3.70.4 of the RFP states that a written plan will be submitted within 60 days to identify the types of patients who will be reviewed on site at the hospitals in Baltimore. Subsection 3.68.4 requires daily in person UM hospital rounds for all patients at Bon Secours, the University of Maryland Medical System, and any Baltimore area hospital in which inmates are in the intensive care unit. The requirements of 3.70.4 appear to be a very reasonable way to maximize staff and the efficiency and efficacy of the UM process. 

- Please confirm that RFP subsection 3.70.4 permits bidders to develop a written plan that identifies select types of patients who will be reviewed on-site in the hospitals at Baltimore.

"**Section 3.68.4 was amended by Amendment No. 1 to change the required off-site patient reviews. Section 3.70.4 requires an additional program to be recommended by the Offeror to minimize length of stay.**"

130. Attachment R Staffing Matrix indicates that the UM Hospital RN must be Masters Level. 

- Please clarify how the expectation for a masters prepared UM Nurse in the UM process would be different than a standard program UM Nurse.

"**The masters prepared UM nurse will supervise the 2 UM RNs and is expected to have more knowledge and experience related to UM.**"

131. Please provide the volume of x-rays and ultrasounds services provided at each location in FY 16.

"**Attachment QA – 8 contains x-ray data but not ultrasounds for which the Department has no data.**"

132. Please clarify if the Medical Contractor or the Pharmacy is responsible for the cost of required dietary supplements.

"**Required dietary supplements are the responsibility of the Pharmacy Contractor.**"

133. Of the 250 EPHR Provider licenses owned by DPSCS, how many are in use?
The Department has 275 licenses (correction to answer to question 32) of which 268 are in use.

134. Please provide the # of out of state inmates housed in Maryland facilities for FY15 and FY16, by Facility/SDA.

Due to Inmate movement, the Department is able to provide only system wide data. The total number of out of state Inmates housed in Maryland facilities was 75 for FY 16 and 68 for FY 15.

135. Would the State consider providing all bidders a copy of Attachment R in excel to facilitate the recording of hourly rates as required in the RFP response?

See Amendment No. 3.

136. Does the State have minimum educational/licensure requirements for the Internal Auditor/Health Care Analyst position? Please provide the education background/licensure of the current incumbent, if the position currently exists.

The Health Care Analyst/Internal Auditor should possess a bachelor’s degree in business administration, finance or accounting from an accredited college or university with at least one year experience in health care administration, project management, audits, conducting administrative medical compliance analysis, online document management, developing procedural manuals, preparing statistical and organizational charts and presentations.

137. Jessup MCIW: The night shift subtotal of 280 hours and 6.00 FTEs does not agree to the detail for the shift, which sums to 296 hours and 7.4 FTEs. Likewise the grand total for MCIW of 1,728 hours and 42.2 FTEs does not agree to the detail. Please advise if the subtotals are incorrect, or a change to an individual line on the night shift is needed.

See Amendment No. 3.

138. Attachment T. Please clarify that the Inpatient Cost on page 11 is the fully loaded cost to include professional as well as facility component.

The cost includes all provider and hospital facility costs associated with the hospitalization.

139. In reference to attachment AA please provide the current database format for each database listed and confirm these databases will be made available to the medical vendor.

All databases are in Excel format and will be made available to the Contractor.

140. Attachment R says methadone supervisor who is an Addictions Specialist, a Substance Abuse Program Manager, two methadone counselors, and a 0.4 Addiction Specialist RN
at BCBIC. It also lists 1.0 Addiction Specialist RN at MCIW. The RFP requires methadone services in four locations. Additionally, we understand that female detainees from BCBIC are transferred to MCIW for treatment. We want to make sure we understand the staffing allocations and facility assignments. Please clarify whether the addictions treatment staff included in Attachment R and assigned to BCBIC currently also serve MCIW, MTC, and JI. If so, please indicate how much time of their time is devoted to MCIW, MTC, and JI.

The treatment staff in Attachment R assigned to BCBIC serves MTC and JI. The Addictions Specialist MD, RN Substance Abuse Program Manager and the Methadone Counselor supervisor – LCADC support all programs in Baltimore and MCIW. It is not possible to anticipate how much time is required for each facility because time required varies with patient population.

Female inmates are not transferred to MCIW for the purpose of methadone maintenance or detox. Female Inmates are transferred from BCBIC to MCIW for treatment when they are required to be in an Infirmary or require segregation beds. If the Inmate is on methadone maintenance, the Inmate may be detoxed while there or maintained. The numbers of transfers has been between 5 and 10 per month.

141. The RFP requires the Contractor to operate a methadone detox and maintenance program with services at BCBIC, JI, MCI-W, and MTC Infirmary. Attachment R includes staff allocations for substance use disorder treatment at BCBIC, including 1.0 FTE Addiction Specialist (Methadone Supervisor), 1.0 FTE Substance Abuse Program Manager, 2.0 FTE Addiction Specialist (Methadone Counselors), and 1.0 FTE Addiction Specialist RN. No staff allocations for a methadone detox and maintenance program are shown in Attachment R for MCI-W. Does the Department wish for the Contractor to provide staffing allocated specifically for a methadone detox and maintenance program at MCI-W.

The Department believes that the one RN Addictions Specialist and a methadone counselor (that has been added in revised Attachment R) with support via telemedicine from the Addiction Specialist and the Substance Abuse Program Manager are sufficient to support the program in MCIW. See Amendment 3.

142. Please provide the certifications/licenses and experience requirements for Substance Abuse Program Manager and Methadone Supervisor.

The RN Substance Abuse Program Manager should be a Certified Addictions Registered Nurse with at least 2 years’ experience in providing addictions care as an RN.

The Addiction Specialist - Methadone Supervisor - LCADC (Licensed Certified Alcohol and Drug Counselor), supervises the methadone counselors. Qualifications for LCDAC can be found here: http://dhmh.maryland.gov/bopc/Pages/ac_newrequirements.aspx. This supervisor should have a minimum of three years’ experience as an LCADC.
143. Attachment R indicates there are six full-time State-wide Administrators in the State-wide Office staff. Please:

a. Describe, per Administrator, which facilities each of these Administrators oversee.

The Administrators will be assigned as follows: Administrators shall be assigned to SDAs as follows: Baltimore SDA sentenced population, Baltimore SDA pre-trial, East SDA, Jessup SDA, West –Hagerstown and West NBCI/WCI.

b. Describe the desired credentials for these staff.

Regional Administrators should possess a bachelor’s degree with experience in health care administration and management or an advanced degree in health care administration and should have extensive supervision experience including correctional supervision or project management experience, and health care administration experience.

c. Describe the job role/duties of each of these staff.

The Administrators will have primary responsibility for Contractor operations and contract compliance at all facilities in the SDA. They provide oversight of facility administrators, collaborate with the Other Healthcare Contractors and State staff including Regional DONs to resolve problems and assure quality medical care, facilitate communications with the DPSCS Wardens, Commissioners, ACOM, DPSCS DON and DPSCS Chief Medical Director, attend required meetings and generally assure that quality medical care and utilization services are effectively and efficiently delivered in accordance with the Contract.

d. Describe the reporting roles these staff have.

Section 3.6.3 requires Offerors to provide an organizational chart and describe the management structure they recommend in their Technical Proposals.

e. Do the site Administrators report to the State-wide Administrators?

Yes.

144. There are no Administrators identified in Attachment R for the East SDA. Does the DPSCS require an Administrator in the East SDA?

An Administrator has been added in revised Attachment R.

145. The staffing plan for the Statewide Office shows six full-time Administrators. Please describe the regions/SDAs each Administrator will manage.

See answer to Question 143 (a).
146. The response to Question 85 indicates that the Statewide Director position on page 21 of Attachment R is the Statewide Contract Manager. Please clarify the following:

a. If the Statewide Director is the Statewide Contract Manager, what is the role of the Statewide VP on page 22 of Attachment R?

_The Statewide VP has been changed to Assistant Contract Manager in revised Attachment R. This position assists the Contract Manager in contract compliance and delivery of medical care and utilization services under the Contract. The Assistant Contract Manager should have contract and project management experience, and experience in managing medical care in a correctional system that has at least four facilities._

b. There are 6.0 Statewide Administrators listed on page 21 of Attachment R. Is the following oversight area for each correct: Cumberland, Hagerstown, Baltimore Pre-Trial, Baltimore Sentenced, Jessup, Eastern?

See the answer to Question 143 (a).

c. Is the Statewide Medical Assistant Coordinator the Third Party Reimbursement Coordinator?

No.

147. The RFP requires Infection Control Coordinators for each SDA, yet none are listed on Attachment R. Are the Infection Control RNs listed on Attachment R considered the “Infection Control Coordinators” for each SDA?

See revised Attachment R.

148. The RFP requires onsite OB/Gyn services, yet Attachment R shows no onsite OB/Gyn services at MCIW. Please append Attachment R to indicate desired OB/Gyn service.

See revised Attachment R.

149. The RFP requires a Report Coordinator. Attachment R shows a “Data Specialist/Report Analyst” and a “UM Report Coordinator”. Is one of these two positions in Attachment R the same as the Report Coordinator in 3.18.1?

No. The Data Specialist/Report Analyst works directly with the DPSCS Inmate Health fiscal auditors in providing all fiscal reports, participating in audits of the Contract, resolving audit issues, resolving and calculating liquidated damages, coordinating equipment purchases, etc. The UM Report Coordinator is responsible for assuring all UM Reports are complete, accurate, consistent with State requirements, and delivered on time. The Report Coordinator is responsible for assuring that all other reports required
under the RFP are complete, accurate, consistent with State requirements, and delivered on time.

150. The RFP indicates contractor is responsible for 1 FTE Certified Health Educator (CHE) at MCIW. Attachment R indicates an additional CHE at BCBIC. Is the CHE at BCBIC required to solely provide women’s services or can this employee serve the male population as well?

This position is primarily for women’s health for the female population. The position may but is not required to provide health education services to the male population. The position at BCBIC – Women has been reduced to 20 hours per week at BCBIC. See revised Attachment R.

151. Section 3.38.8 requires the contractor to provide a comprehensive women’s health education program at MCI-W and a FT equivalent certified health educator. Education sessions are to occur no less than three days per week for four hours each and may be increased to five days per week. Please clarify the following:

a. At what stage of the female offender’s sentence are health education sessions to be conducted?

Beginning after the 7 Day Intake Physical and continuing throughout the period of incarceration.

b. Education sessions will run between 12-20 hours per week. What will the certified health educator do when not conducting education sessions?

The health educators will be expected to conduct one on one follow-up and provide support to individual Inmates, work with care coordinators regarding re-entry and update materials for the education sessions.

c. A full time certified health educator is also required at BCBIC-WDC. Is the same program developed for MCI-W to be provided at WDC?

The program at BCBIC – Women will be more concentrated and expedited because of the rapid population changes. The program should address the same health issues as the program at MCIW. The certified health educator position at BCBIC - Women has been adjusted to 20 hours per week by revised Attachment R.

152. RFP requires onsite podiatry. Please provide volume of onsite podiatry clinics and name of podiatrist/podiatry services in each SDA.

The RFP does not require on-site podiatry. Currently podiatry clinics are held at Bon Secours Hospital. Outpatient podiatry office visits and Outpatient podiatry surgeries for FY 14 through 16 were as follows:
The RFP requires use of onsite opticians. In most cases, onsite optometrists are able to perform all services that opticians perform. Is it acceptable to use optometrists to perform optician services?

See Amendment 3.

The RFP requires Designated Regional CQI Nurses, yet Attachment R does not list Regional CQI Nurses. Please append Attachment R to include Regional CQI Nurses, or acknowledge that four RNs listed in the SDAs can be tasked with the Regional CQI RN roles.

See Amendment 3.

Attachment R – Staffing Matrix consistently reflects variations in nursing services staffing across days of the week. Specifically, staffing variations for RN, LPN, CNA positions at dispensaries and/or infirmaries routinely reflect more hours on shifts Monday – Friday, with small to significant decreases in hours for same position on Saturday and Sunday. Please explain how the decrease in nursing hours on the weekend impacts the services that are required/provided on the weekends versus the weekdays in the dispensaries and infirmaries where relatively lower weekend staffing is indicated in Attachment R.

There is no significant difference in infirmary staffing on weekdays compared to weekends but the differences in dispensary staffing is related to decreased activities on the weekends. Chronic care clinics, sick call clinics and specialty clinics are not conducted on the weekends. Inmate transfers, releases, and intakes do not occur on weekends.

Page 8 - 9 of Attachment R lists positions under “Jessup - JCI” assigned to the infirmary, that only include a 1.4 FTE CNA on days, evenings and nights. Our understanding per RFP Subsection 3.24 Infirmary beds is that JCI has a 6 bed infirmary. Per review of Chapter 3 Medical Management of Infirmary Patients - Acute Care Patients Section A, II C. under Procedures “All DPSCS infirmaries shall have twenty-four (24) hour on-site nursing coverage daily by a registered nurse within the infirmary area. . . “. It is noted that there is no designate RN – Infirmary staff for any of the shifts • Please confirm that our understanding is correct that these are identified by DPSCS and per NCCHC standards to be defined as infirmary care beds. • Please define if the current RN staff on Day, Evening and Nights includes a designated RN for the Infirmary? If yes, please...
define by Day, Evening and Night Shift the amount of RN hours designated per day and per shift?

The 6 beds identified as infirmary at JCI are respiratory isolation beds which are used as additional infirmary beds when not in use as isolation cells. The primary infirmary beds at Jessup are the 21 beds at JRI. The RN and LPN hours for JCI in the staffing matrix cover the 6 isolation beds when occupied. See Amendment 3 to the RFP.

157. The RFP requires the Contractor to refer patients to the Department’s Mental Health Contractor immediately upon detecting a possible mental health need during the delivery of medical services. Our understanding is that the current practice does not always involve a direct referral from medical staff to the Mental Health Contractor. Instead, we are aware that medical staff refer many such patients to DPSCS behavioral health staff rather than the Mental Health Contractor, and that DPSCS behavioral health staff then determine whether the patient’s mental health needs require psychiatric evaluation or services. • Please confirm that the DPSCS desires the mental health referral from medical staff to be made exclusively and directly to the Department’s Mental Health Contractor, and not to the DPSCS behavioral health staff. See Amendment 3.

158. RFP Amendment 1 states that the “Contractor shall be responsible for gender reassignment surgery if there is a clinically approved indication for reassignment based on an external review and a recommendation from the gender dysphoria committee.” RFP Subsection 3.32.6 indicates that, for any Episode, the Department will pay 50% of the costs that exceed $25,000 and the Contractor will pay the other 50%. • Please confirm that the cost-sharing arrangements under 3.32.6 apply to gender re-assignment surgery. • The RFP definition of “Episode” as a single admission to an off-site medical facility is noted. Gender reassignment surgery involves multiple surgical procedures that are not completed at the same time. Each of these surgeries, by itself, may fall below the $25,000 threshold for cost sharing, but in aggregate the series of medical procedures required for successful gender re-assignment add to far more than $25,000. Is the DPSCS willing to apply the 50% cost sharing provision to the entire set of required gender re-assignment surgeries as whole? • Are there currently any DPSCS patients for whom gender re-assignment surgery is under consideration? If so, please indicate how many patients are involved, with a break down indicating the number of male-to-female and female-to-male patients involved. • Are there currently any DPSCS patients for whom gender re-assignment surgery has been recommended after external review and determination by the gender dysphoria committee? If so, please indicate how many patients are involved, with a break down indicating the number of male-to-female and female-to-male patients involved.

See Amendment 3. No inmates have been recommended for sexual reassignment surgery. One Inmate has requested gender reassignment surgery (male to female). The Gender Dysphoria Committee has recommended that a gender dysphoria consultant be retained.
to further assess the Inmate. Approximately 10 Inmates (all male) have been diagnosed with gender dysphoria.

159. Page 2 of Attachment R lists several staff positions under “BCBIC Women” assigned to the infirmary, including 1.4 FTE LPNs on days and evenings, 1.4 FTE Physician on days, and 1.4 RNs on day and evenings. Our understanding is that female detainees housed at BCBIC are transferred to the MCIW infirmary when infirmary services are needed. We also note that there are no infirmary beds listed in RFP Subsection 3.24 for BCBIC. • Please confirm that our understanding is correct, and female detainees at BCBIC receive infirmary care at MCIW rather than in an infirmary in the pre-trial facilities. • Please explain why the staff identified above are listed as assigned to an infirmary. At what infirmary/location are these staff providing services?

See Amendment 3. Female Inmates at BCBIC receive infirmary care at MCIW.

160. The RFP lists extensive Contractor responsibilities with respect to medication ordering, storage, auditing, and general medication room management. In Attachment R, no staff are listed as dedicated to the medication procurement or management responsibilities required by RFP Subsection 3.29.1. • Are there currently dedicated staff who are responsible for these duties? • If so, please identify these staff positions by facility and indicate the number of hours each day dedicated to medication procurement and management responsibilities. • Are these hours/day noted in Attachment R? • If there are not currently dedicated staff who are responsible for the duties indicated above, please identify by facility how the requirements of Subsection 3.29.1 are being completed. We are trying to understand the current level of staffing devoted to managing these duties on a day-to-day basis by facility.

See Amendment 3.

161. Has the current contractor hired its own staff to provide methadone services or do they contract with a substance abuse treatment organization?

The current contractor has hired its own staff.

162. The RFP states: “The Department has identified the recommended clinical and non-clinical staffing plan for the Contract in Attachment R…and believes that its suggested staffing plan is appropriate to perform the scope of work outlined in this RFP…” Yet Section 3.7 “Contractor’s Management” includes several inconsistencies with Attachment R. Section 3.7.2 states the Contractor shall have a “Statewide Director of Re-Entry,” yet Attachment R identifies a “Statewide Director of Telemedicine and Re-Entry.” Is this the same position? If so, shall we identify this professional as the Statewide Director of Re-Entry, or the Statewide Director of Telemedicine and Re-Entry?

There is only one position. See Amendment 3.
163. Does the DPSCS use a mobile vendor for x-ray services? If so, to which sites? Also who is the vendor?

*All X-ray services are provided by the Contractor. The Contractor may elect to use mobile x-ray services.*

164. Attachment R does not appear to include physical therapists. Please provide the number of hours or FTEs currently provided for physical therapy at each facility.

*The Contractor is required to provide physical therapy but the positions are not specifically identified. Offerors may add physical therapists to Attachment R in the Technical Proposal or may provide these services through a subcontractor without identifying a specific number of positions at each facility. Hours of PT at each facility are as follows:*

<table>
<thead>
<tr>
<th>Site</th>
<th>Hours per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baltimore</td>
<td>12</td>
</tr>
<tr>
<td>ECI</td>
<td>8</td>
</tr>
<tr>
<td>Hagerstown</td>
<td>15</td>
</tr>
<tr>
<td>Jessup</td>
<td>7</td>
</tr>
<tr>
<td>WCI</td>
<td>8.5</td>
</tr>
</tbody>
</table>

165. The RFP requires the Contractor to purchase and maintain “basic” equipment necessary for physical therapy on-site. Attachment BB includes some items identifiable as physical therapy equipment for WCI, JCI, and MTC, but does not clearly identify physical therapy equipment for ECI. In order to ensure bidders can develop responsible pricing for this area, please identify ECI equipment currently available for physical therapy. Please specify DPSCS expectations for what type of basic physical therapy equipment is expected at sites where physical therapy will be provided remotely.

*The current Contractor provides physical therapy at ECI through a subcontractor who supplies the necessary equipment. Physical therapy equipment should include but not be limited to Tens Machine, ultrasound, floor mats for ROM gait training, rails. Remote physical therapy is Off-site physical therapy provided through community providers. See Amendment 1 to the RFP.*

166. With regard to RFP § 3.19.4: Equipment and Supplies, we understand that the contract requires the Medical Contractor to “provide for use by the Mental Health Contractor the following telemedicine equipment.” With regard to that statement, please clarify the following.
a. Does “provide for use” indicate that the Medical Contractor will allow the Mental Health Contractor to access the existing equipment or is it the State’s intention for the Medical Contractor to purchase additional units at all sites?

_The Medical Contractor is to assure that the specified equipment is available at WCI and is to acquire additional equipment for the sites specified. This equipment will be dedicated to the use of the Mental Health Contractor._

b. Does the statement, “The Department also wishes to establish units at ECI, JCI, NBCI, Patuxent with an additional unit on hand” indicate that the Medical Contractor is to purchase only these five new units, or is it the State’s intention for the Medical Contractor to purchase additional units at all sites?

_The Medical Contractor is to purchase equipment for the sites specified plus an additional unit to be available for placement as directed by the Department’s Chief Medical Officer. This equipment is for the exclusive use of the Mental Health Contractor._

167. Equipment and Supplies, Section 3.19.4 – page 58- The RFP states, “The Contractor shall provide for use by the Mental Health Contractor the following telemedicine equipment: a Polycom Real Presence Practitioner Cart 8000 (or equivalent), stethoscopes, blood pressure reading equipment, electrocardiogram equipment and enhanced imaging cameras. There is currently a telepsychiatry unit at WCI that is equipped. The Department also wishes to establish units at ECI, JCI, NBCI, Patuxent with an additional unit on hand for deployment at the discretion of the Department. The cost of acquiring and maintaining existing and new equipment shall be included in the Contractor’s Financial Proposal Form.”

a. The mental health contractor is currently using the medical vendor’s In Touch telehealth system for providing offsite telemedicine services. The RFP requires pricing for a Polycom system, which is separate from and incompatible with In Touch. Does the Department intend for the medical vendor to support two different types of equipment and/or change current practices?

_All equipment used by all Healthcare Contractors is the property of the Department. Offerors are free to propose equipment that is equivalent to the Polycom Real Presence Practitioner Cart 8000. See Amendment 3._

b. Further, the equipment listed (stethoscopes, blood pressure reading equipment, electrocardiogram equipment and enhanced imaging cameras) is not currently used for telepsychiatry (and is incompatible with the current In Touch system when paired with a Polycom system). Was this an oversight or are vendors responsible for pricing this equipment?

_See Amendment 3._
168. Section 3.12 – page 43 – Will the currently installed Kronos timekeeping system, including equipment (clocks) at each site, be retained by the Department and available for use by the new contractor?

_The Kronos timekeeping system, including clocks, is the property of the State and will be available for use by the new Contractor. Offerors may propose new timekeeping systems in their Technical Proposals._

169. The RFP requires the contractor to be responsible for all oral surgeries and inpatient, ER, and off-site ambulatory dental procedures, with the exception of dental prosthetics, dentures, and on-site operative procedures performed by the Dental Contractor. The Contractor will also be responsible for the cost of hospital-based emergency dental care. Please confirm that RFP Attachments T-1 and T-2 incorporate the costs of such dental services.

_Attachments T-1 and T-2 incorporate the costs of dental services._

170. With the extension to March 30, 2017, may vendors still submit questions up to five (5) days prior to the Proposal due date?

_Vendors are encouraged to submit all questions as early as possible. Questions submitted five days prior to the proposal due date may not receive an answer based on the availability of time to research and communicate an answer._

171. Please confirm the data in Attachment T-1. For example, the totals on the graphs don't always tie to the totals on the detail pages. Ex: Pg 2, Inpatient Admits for July 2015 = 95. The same information on Page 4 detail indicates 65. Occurs in several categories. Please provide the accurate data by category in this Attachment.

_See corrected Attachment T-1 issued as part of Amendment 3._

172. Please confirm the cost data on Page 11 of Attachment T-1 for inpatient admissions cost is per inpatient admit.

_The cost data is total cost per inpatient admit._


a. Are these amounts inclusive or exclusive of Medicaid and other third party reimbursement costs?

_The amounts are inclusive of all reimbursements from Medicaid and other third parties._

b. Do these amounts include the cost of ER services if the ER visit directly resulted in an inpatient admission?
Yes.

174. Inpatient Services July 2015 – June 2016 Annual UM Report – Page 19 – On the schedule ER Cost Per Visit – per 1,000 Inmates, do these costs represent total ER costs or ER costs excluding ER visits that resulted in inpatient admissions?

_The amounts reflect ER costs excluding those resulting in inpatient admissions._

175. Please confirm the cost data on page 34 of Attachment T-1 for outpatient surgery costs is average cost per surgery or cost in total.

_The data reflects average cost per surgery._

176. Please provide details of onsite lab, radiology, dialysis and other services by month by facility for the last 2 years.

_Attachment QA – 8 reflects radiology data for FY 15 and 16. Attachment QA – 9 reflects dialysis data for FY 14, 15 and 16. Following is the list of the top 10 lab tests performed in FY 16:_

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>TEST DESCRIPTION</th>
<th>No. of tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>85025</td>
<td>CBC/DIFF/PLT</td>
<td>18091</td>
</tr>
<tr>
<td>80053</td>
<td>COMP MET PANEL</td>
<td>17797</td>
</tr>
<tr>
<td>80061</td>
<td>WEXFORD LIPID PANEL</td>
<td>8804</td>
</tr>
<tr>
<td>83036</td>
<td>HBA1C</td>
<td>6066</td>
</tr>
<tr>
<td>84443</td>
<td>TSH</td>
<td>4696</td>
</tr>
<tr>
<td>81001</td>
<td>URINE WITH MICRO</td>
<td>3990</td>
</tr>
<tr>
<td>89999</td>
<td>WEXFORD THYROID PANEL WITH TSH</td>
<td>2771</td>
</tr>
<tr>
<td>80048</td>
<td>BASIC MET PANEL</td>
<td>2585</td>
</tr>
<tr>
<td>86592</td>
<td>RPR</td>
<td>2323</td>
</tr>
<tr>
<td>86803</td>
<td>HEPATITIS C AB</td>
<td>2053</td>
</tr>
</tbody>
</table>

177. It is understood that there is a requirement to maintain a population of at least five patients daily at Bon Secours Hospital. Are there always inmates available who qualify for admission to the Bon Secours Hospital? Has there been any recent history where maintaining the five patient minimum has been a challenge? Please provide historical data showing the average daily population for DPSCS patients at Bon Secours.
Generally, there is no difficulty in satisfying the requirement to maintain at least five patients. Approximate average daily population (not including weekends and holidays) was 6.2 for calendar 2015 and 5.38 in 2016.

178. Bon Secours has the only secure IP unit and is to be given priority when inpatient services are required. Of the total IP hospital days reported for FY 15 and FY 16 in Attachment T, how many were at Bon Secours?

The total number of hospital days at Bon Secours was 1944 in calendar 2015 and 1602 in calendar 2016.

179. With regard to Dialysis costs – does the $2.3M include the dialysis drugs? Please provide the breakout of the $2.3M by type of service (i.e. Infusion vs. drugs).

Dialysis drugs are provided by the Pharmacy Contractor.

180. Dialysis patients have reduced significantly over the last few fiscal years – has the Department implemented a new program that supports this reduction? Can the Department estimate what the Dialysis patient population will be in FY 2018?

The Department has not implemented a new program. The Inmate population has declined, HIV therapy has improved and diabetic complications have been reduced. The Department cannot provide an estimate of future population.

181. We note that RFP §1.12 clearly states “alternate Proposals will not be accepted.” Given this statement, please confirm that the DPSCS will accept supplemental innovative programs and resources (in addition to the base RFP requirements) that will increase operational and clinical efficiency and add value to the DPSCS inmate health care program. Otherwise, the DPSCS will not receive the potential benefit of new and/or original programs that bidders have developed.

Proposals must respond to all of the requirements of the RFP and may not suggest another pricing model. Offerors are encouraged to submit as part of the Proposal enhanced or supplemental innovative programs that meet the requirements of the RFP but could increase efficiency and add value to the health care program.

182. Once Offerors price the base staffing plan provided in RFP Attachment R, are they permitted to submit additional staffing plans that offer alternatives to that base plan?

Section 4.4.2.7.1 provides, in part, as follows: The Department has identified the recommended clinical and non-clinical staffing plan for the Contract in Attachment R. While it is the opinion of the Department that the suggested staffing plan contained in Attachment R is appropriate to perform the scope of work outlined in this RFP, the Offeror may propose a different clinical and/or non-clinical staffing plan. If the staffing plan proposed by the Offeror varies from the Department recommendation in Attachment R, the Offeror must submit its proposed plan using the same titles, location, and format as
Attachment R detailing its proposed clinical and non-clinical staffing plan, identifying each change from Attachment R, explaining the rationale for each change, and describing how the change will affect the delivery of services.

183. With regard to RFP §3.27.1.3 of RFP Amendment #1, please clarify the following.

a. Is it the DPSCS’s intent to expand annual TB testing to (a) all 23,000+ inmates; or (b) only those inmates who are symptomatic?

*Neither Amendment 1 nor Amendment 2 contained any revision to Section 3.27. Section 3.27.1.3 of the RFP requires annual TB testing of all Inmates. This reflects current practice.*

b. Is it the DPSCS’s intent to expand annual chest x-rays for (a) all inmates who previously tested positive for TB; or (b) only those inmates who previously tested positive for TB and who are symptomatic?

*Section 3.27.1.3 of the RFP requires annual chest x-rays for all Inmates who previously tested positive for TB. This reflects current practice.*

184. §3.29.2.3 of RFP Amendment #1, Attachment V states that the Awarded Vendor will incur Liquidated Damages for “Failure to maintain an electronic Medication Administration Record (e-MAR).” However, no eMAR exists currently in the DPSCS system for the Vendor to maintain.

a. Is the DPSCS requiring the medical Vendor to implement an eMAR?

*No. The Department anticipates that an EMAR will be implemented during the contract term. Contractor staff will be required to use the EMAR when it is implemented.*

b. If yes, what is the required timeframe for the eMAR in order for the medical Vendor to avoid liquidated damages?

*See revised Attachment V issued with Amendment 3.*

c. If yes, please discuss why this is the responsibility of the medical Vendor and not the pharmacy Vendor, as any eMAR will need to fully integrate with the Pharmacy Vendor’s prescription fulfillment and management software.

*See the answer to 204 (a).*

185. We have made numerous attempts to meet / discuss the RFP requirements with Bon Secours with no success. Is there a particular person we should be talking to or have they been told not to discuss with any potential vendor?

*Offerors should not contact Bon Secours for information related to the RFP. Offerors are reminded that Section 1.5 of the RFP provides that the Procurement Officer is the*
sole point of contact in the State for purposes of this solicitation prior to the award of any Contract.

186. Under the current contract, Chronic Care patient charts are reviewed every 90 days. However §3.30.6 of RFP Amendment #1 requires such chart review on a monthly basis, which will significantly increase labor costs. Furthermore, since many stable Chronic Care patients are only seen every 90 days, a monthly chart review would be wasteful and inefficient. Therefore:

a. Will the DPSCS allow the Awarded Vendor to continue the current practice of conducting chart reviews on a 90-day basis (without incurring Liquidated Damages)?

*See Amendment 3.*

b. Alternatively, will the DPSCS amend the monthly chart review language in §3.30.6 of RFP Amendment #1 to apply to only those Chronic Care patients who have actually seen a clinician within the past month?

*See Amendment 3.*