MARYLAND
DEPARTMENT OF
BUDGET & MANAGEMENT

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QUESTIONS AND RESPONSES # 3
PROJECT NO. Q001002014
Department of Public Safety and Correctional Services
Inmate Mental Health Care Services
January 27, 2012

Ladies/Gentlemen**:**

This List of Questions and Responses #3, questions #138 through #157, is being issued to clarify certain information contained in the above named RFP. The statements and interpretations of contract requirements which are stated in the following questions of potential Offerors are not binding on the State, unless the State expressly amends the RFP. Nothing in the State's responses to these questions is to be construed as agreement to or acceptance by the State of any statement or interpretation on the part of the vendor asking the question as to what the contract does or does not require.

138. Please provide a list of mental health care statistics by site for each of the past three years that includes the number of:

- *a.* *Routine sick call encounters* – 5265 (6 months data*)
- *b.* *Urgent sick call encounters* – 594 (6 months data*)
- *c.* *Chronic care clinic encounters*
- *d.* *Crisis interventions*
- *e.* *Special confinement rounds* - 121,135 rounds in a 6 month period*
- *f.* *Emergent IMMS referrals*
- *g.* *Urgent IMMS referrals*
- *h.* *Routine IMMS referrals*
- *i.* *Suicide/homicide risk assessment screenings* - 28786 for calendar year 2011
- *j.* *Mental health 7 day intake exams* – 12818 for calendar year 2011.
- *k.* *Referrals to the Patuxent Assessment Unit*
- *l.* *IMHTU Referrals*
- *m.* *IMHTU patient days*
- *n.* *Medication orders* – (psychiatric medication fills): FY 2009; 129,949, FY2010; 171,450, FY2011; 206,736
- *o.* *Average number of daily medications administered by mental health staff* – the administration of medications has not previously been the responsibility of the Mental Health Contractor and therefore no statistics are available
- *p.* *Lab orders* – see response to Questions and Response#1, Question #4
- *q.* *Inmate grievances* – typically 5-10 per month related to mental health services.

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r. *Completed suicides* FY09 – 9, FY10 – 7, FY11 – 4.
s. *Suicide attempts*
t. *State mental health facility/hospital referrals*
u. *Off-site specialty or hospital care referrals* - none

* DPSCS has revamped its data gathering procedures and is providing the most recent 6 months of data for extrapolation as to the number of occurrences of these activities for several years into the past and future. The historical reference provided is not to be construed as a guarantee or an indication of what may occur under the duration of the Contract.

RESPONSE: See above. The remainder of these statistics is not available thus far. The Department is still gathering statistical information. Should more information become available, it will be issued in Questions and Responses #4. Unless otherwise stated, three years of statistics is not available.

139. Section 3.11 of the RFP indicates the mental health contractor will be required to utilize the biometric timekeeping system established by the medical contractor. Since the medical services contract is currently under the procurement process, there is no way for companies responding to the mental health RFP to know the type of, or costs associated with, the biomedical timekeeping system to be ultimately implemented by the medical contractor. Additionally, the mental health contractor will need to establish an electronic interface with the biomedical timekeeping system in order to track its employees and generate reports.

Placing the mental health contractor at risk for the costs of this interface creates an unfair advantage for any medical vendor who may also be bidding on the mental health contract. How will the potential costs for each bidder be equalized?

RESPONSE: First, the Department reiterates that it requires biometric time recording to be used under future Inmate health related contracts. Second, it is impractical for two or more Inmate health related contractors to have their own biometric time recording systems, with multiple pieces of biometric equipment being located adjacent to each other in Department facilities. Third, even if the impracticality of multiple pieces of biometric equipment being located adjacent to each other in Department facilities was not an issue, because of the absolute requirement for the use of biometric time recoding for future Inmate health related contracts it is likely that at least some offerors that plan to respond to this Mental Health RFP would have to obtain an entirely new time recording system to meet the requirements of this RFP.

Given the above considerations the Department reasoned that requiring the Inmate medical services contractor, the contractor with by far the highest number of employees located on Department premises, to provide a single biometric time recording system that was fully usable by Other Healthcare Contractors was the most reasonable and cost efficient solution.

Any requirement in a specification may afford one or some offerors an advantage over other offerors in that it/they may have already satisfied that requirement while other offerors have to build the future cost of satisfying the requirement into their contract price. This is an inescapable fact. This inescapable fact evidences itself for almost any contract when non-incumbent firms are seeking to displace an incumbent firm for a given contract award.

Getting back to the requirements of this RFP, even if there was a standalone requirement for the mental health contractor to have a biometric time recording system, this requirement could result in a lower cost for an offeror that already has a biometric time recording system versus one that does not.

The bottom line is the Department cannot fail to require something it needs simply because some offerors may have to build-in the cost to satisfy that requirement while others don't.

But the Department is also not insensitive to this issue. We look to see if there are ways to avoid possibly affording an inherent cost advantage to one offeror over another without compromising Department requirements. But we also look at the magnitude of the issue in deciding whether any attempt to neutralize a possible cost advantage among offerors is warranted.

In response to this question we both do not see a reasonable alternative to the requirement, and also do not consider the possible cost to establish an interface with the biometric time recording system of the medical contractor as likely in and of itself to be the deciding factor in the selection of an offeror for the awarding of the DPSCS mental health contract. Accordingly, we will not revise the requirements of the RFP in this regard.

However, given that the medical services RFP requires the medical services contractor to provide a "data feed", which would include an interface, via this answer we are revising the answer previously provided under Question and Responses #1, item #22 to remove the words, "if the medical contract will agree to an interface". The Department will require the medical services contractor to accommodate such an interface if one is requested by the mental health contractor. But we reiterate the part of the answer to question 22 that states the cost of such an interface will be borne by the mental health contractor.

140. Section 3.6.3.1 and TAB K reference Regional DON's; however, Attachment O does not reference Regional DON's but does reference Charge Nurses for the Baltimore and Jessup SDA.

Is the responder to consider the title of Regional DON to be synonymous with the title Charge Nurse listed on Attachment O?

RESPONSE: Yes, as per the version of Attachment O issued with Amendment #1 and the Revised (updated version issued with Amendment #3), the Charge Nurse and Regional DON Positions can be considered synonymous. In Offerors' technical proposals either title may be used.

141. RFP section 2.1, 3rd bullet: Please confirm that managing at least 10,000 inmates across all company locations meets this requirement.

RESPONSE: Yes, managing the full array of mental health services for a cumulative total of at least 10,000 inmates will satisfy this individual qualification, as long as the 3 other bulleted qualifications in this RFP Section 2.1 are simultaneously satisfied. (i.e., if the Offeror, to include a parent firm if that parent firm provides a written guarantee of the performance of its subsidiary Offeror, has provided a full array of mental health services for at least 10,000 inmates continuously for the last 3 years, spread out over a minimum of 6 different

institutions, with at least one institution having at least 1,500 inmates, the minimum qualifications of this RFP Section 2.1 would be determined to have been met).

142. *RFP section 3.38.3.2: Please define "electronic database." Does an Excel spreadsheet qualify?*

RESPONSE: An electronic database is a database that can be created and maintained electronically; therefore, an Excel spreadsheet qualifies as an electronic database

143. *RFP section 3.38.3.2: Can the database information requested be extracted from the medical provider's electronic medical record (NextGen)?*

RESPONSE: Yes.

144. *RFP section 3.38.3.2: Is this database information expected to be maintained separate from the medical provider's electronic medical record (NextGen)?*

RESPONSE: No, the database information can be extracted from NextGen and therefore is not expected to be maintained separately from the Medical Contractor's electronic medical record.

145. *Per RFP 3.8.2, the contractor must maintain credentialing information for all professionals listed in 1.2.56. Our company only credentials physicians, physician assistants, nurse practitioners, and mental health professionals at the master or doctoral level. For non-providers (RNs, LPNs, etc.) and bachelor-level mental health professionals, we only verify and maintain a copy of their license. Is this sufficient for the purposes of this contract?*

RESPONSE: The basic rule to follow is any professional treatment staff that is required to hold a professional license in the State of Maryland to practice in their field, must have approved credentials. The Department does not have credentialing requirements in excess of the requirements of the licensing entity for the profession.

However, Per Section 3.8.2, the Contractor must maintain credentialing documentation as outlined in Section 3.8.2 to include searchable, secure (password protected) read-only access by internet or LAN connection by ACOMS and other appropriate Department personnel. Accordingly, whereas verifying, for instance, that a RN has a license may be sufficient to meet the requirements of the licensing entity, maintaining a copy of that license on file will only satisfy Section 3.8.2 if that license copy is scanned and inputted into a Department accessible credentialing database.

Administrative personnel not practicing under a license should have a resume on file which demonstrates experience in their field relevant to the position held.

146. *RFP 3.8.2(2) requires the contractor to maintain all credential related documents. Can you provide a complete list of all required documents?*

RESPONSE: This would include, but not be limited to any information from their licensing boards such a complaints, reprimands, or limits to their license.

147. RFP section 3.8.2(3)&(4) state the contract must provide all required licenses, certificates, etc. prior to the performance of any services. Our company conducts a "fast track" for credential applications which includes completion of the application, submission of all required documents, and verification of license. However, it can take a Credential Verification Organization (CVO) weeks to complete a file. Will the DPSCS allow staff to begin work with a fast track pending a complete file from the CVO?

RESPONSE: There is no RFP Section 3.8.2(4). Staff will not be allowed to perform any services under the contract until all required credentialing is in the credentialing database required under 3.8.2. (Also see the answers to questions 146 and 147 above). If what the questioner identifies as a "fast track" satisfies the requirements of the licensing entity and RFP section 3.8.2, then the Staff may provide services under the contract

148. RFP Section 3.8.3(4) states the contractor is required to have accessible on site malpractice claims history. Does the Department require loss runs or just a narrative of malpractice claims?

RESPONSE: A narrative of malpractice claims is sufficient.

149. RFP Section 3.8.3(9) states the contractor is required to have accessible on site evidence of review of health and present illicit drug non-use. For the purposes of this contract, what specifically does the Department deem as acceptable evidence?

RESPONSE: An initial drug screen is acceptable evidence.

150. RFP Section 3.8.3(11) states the contractor shall have accessible on site State of Maryland evidence of Declaration Statements. What constitute evidence of Declaration Statements?

RESPONSE: This requirement has been removed per Amendment #3, Item #4

151. RFP pg. 77, 3.38.3.2 Mental Health Chronic Care electronic database: Will DPSCS consider developing new templates in the EPHR to accommodate this requirement.

RESPONSE: As of the Contract Go-live Date, the Contractor is expected to maintain a mental health chronic care electronic database as required by the RFP. The EHR which is currently provided by NextGen has not been customized yet to include a template for mental health chronic care. The State will consider replacing the mental health chronic care electronic database with a report directly derived from NextGen if and when these customizations are completed.

152. Attachment F, Price Proposal Form: Please clarify if the quoted 4,000 MH population figure includes or excludes the BCBIC population that has not been committed (as defined

in section 3.3.2.3 on page 30). If the BCBIC non-committed population is included, please advise as to the inmate count for the BCBIC non-committed MH population.

RESPONSE: A decision as to whether an Arrestee is committed is made within 24 hours of the Arrestee's arrival at BCBIC. All committed Arrestees are included in the total population for which full mental health services may be needed. Unless and until an actual commitment occurs, Arrestees are only subject to the initial suicide screening which takes place within 2 hours of arrival, and any need for an emergency response.

153. *Attachment O, MH Staffing Pattern: Based upon the revised attachment O, the total FTEs and the itemized schedule are not consistently applied throughout the document. This could lead to significantly different interpretation by bidders as to the RFP staffing plan. Should bidders rely solely on the total FTE column and assume those hours are spread over the schedule? Or, should bidders assume D = 8 hours, E = 8 hours, N=8 hours and the FTEs are not necessarily appropriate?*

If the schedule shows D/E, does this represent 8 hours split across 2 shifts, or 16 hours, with 8 hours on day and 8 hours on evening? Some examples include (but are not limited to) the following:

- *BSDA Sentenced Psych schedule shows 1.4 FTE, total shows 1.5 FTE*
- *BSDA Sentenced NP Psych schedule shows 1.0 FTE, total shows .2 FTE*
- *IMHU/MDC NP Psych schedule shows 1.4 FTE, total shows 1.0 FTE*
- *IMHU/MDC NP Psych schedule shows 1.4 FTE, total shows 1.5 FTE*
- *IMHU RN schedule shows 1.4 FTE, total shows 2.8 FTE*
- *MH Sallyport CBIF NP Psych schedule shows 1.4 FTE, total shows .8 FTE*

RESPONSE: Revised Attachment O is being updated and is included with Amendment #3, Item #5.

154. *RFP pg. 28, 3.6.14; Questions & Responses #1, pg.9 item 33: The Contractor will be required to pay all costs associated with obtaining accreditation including the initial audit and any subsequent re-audits due to failure to pass an initial audit. Questions and Responses #1 item 33 states that portion of costs for NCCHC & ACA related to mental health will be the contractor's responsibility. NCCHC and ACA Accreditation fees are not segregated by medical and mental health services. Could the State elaborate on how they determine the portion that applies to MH services?*

RESPONSE: This question pertains to RFP section 3.2.14, not 3.6.14. The States rescinds its answer to Questions & Responses #1, Item #33, in that any costs directly billed by an accreditation entity associated with obtaining accreditation will be paid by the Department. However, all costs incurred by the Contractor to assist the Department to obtain accreditation, such as personnel costs, running reports, taking remedial actions, etc. will still be born by the Contractor. See Amendment #3, item #6, which revises Section 3.2.14, not 3.6.14

155. *RFP pg. 29, 3.3.2 Billing Adjustments for Inmate Census Changes: The RFP requires a contract revenue mechanism where the fully loaded per inmate per month cost is utilized for changes in mental health ADP outside a population window. Because of the nature of the mental health contract, more than 90% of the cost of services is fixed in nature (i.e.*

staffing costs). Incurred costs will not decrease with reductions in population, given the requirement that the contractor provides hours in accordance with the staffing plan, ensuring that 96% of the hours identified in the plan are worked every month. Given this possible revenue reduction with no offset in cost, vendors assume a substantial risk of losses with the contract. Would the State consider using a variable per inmate monthly fee for population adjustments that reflects the true reduction in cost with population changes? If the State desires a full per inmate fee reduction, will the State provide for a staffing modification within the initial contract to reduce staff when the mental health ADP falls below the population window?

RESPONSE: The Department has analyzed historical population fluctuations and came to the conclusion that the chance of the ADP going higher or lower than the 400 Inmate (an approximately 10% change from the 4,000, 4,100, 4,200 estimate of Inmates with mental illness) annual threshold outlined was minimal, thus the impact on contractor finances also would be minimal. In addition, if there was a change in excess of the 400 (10%) variation threshold, the revenue change for each additional/fewer Inmate is only $1/4000^{th}$ of the annual contract price. It is extremely unlikely that any plausible scenario would occur given the 4% staffing shortfall permitted for clinical positions (96% vs. 100%) and using the questioners own statement that 10% of costs are variable that would not permit the Contractor to fully cover its costs under the current requirements of the RFP. Accordingly, the Department declines to make any changes in Section 3.3.2.

156. *RFP pg. 34, 3.6.1.1: The language as proposed by the RFP notes that any additional staff (absent a material change) will be added at contractor's expense. These changes could be required without any change in the MH population of the system. The section also clarifies that the additional staff will be added to the staffing plan, which is subject to liquidated damages. Therefore, if the vendor does not staff to the required higher levels, they will pay back to the state for services for which they never received any compensation. Would the DPSCS consider revising this language to exclude positions added at no cost to the State from the staffing payback computations?*

RESPONSE: The Department has suggested what it believes to be an adequate staffing plan, as per Attachment O. However, Offerors are free to propose either higher or lower staffing numbers with the requirement that they explain why they believe their proposed staffing is appropriate. During the proposals evaluation process Offerors proposing different staffing than in Attachment O will be apprised if, notwithstanding the explanation in its proposal for the variance, it is believed that the proposed staffing is inappropriate, including if the proposed staffing plan is totally unacceptable. If such an Offeror still believes its proposed staffing is appropriate, except for staffing plans deemed totally unacceptable the Offeror may be given the benefit of doubt and permitted to continue with its proposed staffing plan. In this situation the benefit of doubt would largely be based upon the very provision that the questioner now wants to be removed (i.e., that its proposed staffing plan has to be augmented if it proves inadequate without additional cost to the Department). If the Department were to provide the relief requested the Contractor would be insulated from any adverse effect from the alternate staffing plan it proposed. The Department is unwilling to do this. Accordingly, the Department declines to make the requested change.

157. The Liquidated Damages provisions described in the RFP and in Attachment Q differ from the Liquidated Damages provisions of the current contract and will result in increased costs due to the 100% minimum thresholds established in Attachment Q. There is also an apparent incongruence between the description of the Liquidated Damages Amount and the Performance Standard in some of the items in Attachment Q.

For example, in items 3.24 and 3.24.3 in Attachment Q, the liquidated damages amount is listed as "$50, each missed element on audited patient charts." However, the Performance Standard describes a requirement to perform a screening/assessment within a certain timeframe, not a requirement to complete elements of patient charts, thus making it difficult to determine whether the damages will be assessed based on completeness of individual patient records or on whether or not a required patient screening/assessment was conducted. It seems the appropriate penalty for these two examples should be tied to whether or not the required screening/assessment occurred and that penalties for chart completeness should be listed under performance standards related to charting.

Please clarify whether liquidated damages will be based upon whether the performance standard for completing a screening/assessment within the required timeframe was met, or upon the completeness of elements within patient charts related to these screenings/assessments.

RESPONSE: The questioner is drawing an improper distinction between assessments being fully completed versus entered into the EHR within the stated timeframe. There are specific aspects of the assessment instrument which must be answered. Until all assessment elements are completed there should be no entry in the EHR. An incomplete entry in the EHR will not satisfy the requirements of the RFP, regardless of whether the entry is made within the required timeframe.

Accordingly, it is reiterated that Liquidated Damages will be imposed under either or both of the following circumstances: all elements of the assessment are not properly completed as of the time the entry is made in the EHR and any incomplete segment of the EHR entry is not competed within the timeframe required for entry; or, no EHR entry is made within the required timeframe. If there is an entry within the required timeframe but there are elements of the assessment that are not entered, $50 will be invoked as liquidated damages for each element not entered. If an EHR entry is not made within the required timeframe the liquidated damages invoked will be the sum of $50 times the total number of elements in the assessment (e.g., if there are 10 elements in the assessment and the EHR entry is not made within the required timeframe, the total of the liquidated damages for this occasion will be $500).

Remember proposals are due on February 13, 2012 no later than 2:00 p.m. If there are questions concerning this solicitation, please contact me via e-mail at ptracey@dbm.state.md.us or call me at (410) 260-7918 as soon as possible.

Date Issued: 01/27/2012 By:

Patti Tracey
Procurement Officer