# MDH EHR - RFP Questions and Answers May 11, 2020

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| *1* | What data needs to be included in facilities reporting to the State Opioid Treatment Authority? | N/A |
| 2 | General Tab<br>• 4.4 What specific areas of productivity reports for staff is desired?<br>• 4.7 What are the measurement parameters?<br>• 4.9 Is there specific behavior trends that are desired to track?<br>• 4.12 By what standards are you defining a well written Treatment Plan? Do you have a desired format with all the wanted information? | Specific answers to these questions are dependent on numerous factors that are not determined at this point. For your RFP response, you only need to indicate if you have the requisite capabilities. These specifics may be addressed during the vendor demonstration phase of the evaluation process, for which MDH will provide specific scenarios for vendor to demonstrate (such as a specific report or business process). |
| 3 | Revenue Cycle - Requirements<br>• 2.9 What are you specifically looking to track?<br>• Medical Records – 3.9 Can you provide specific of desired report data? | See number 3 above |
| *4* | EHR Requirements<br>• 1.8 Is this refer to all Lab Panels<br>• Provider section – 7.13 Can you expound on what is desired in the way of Order Tracking? Which Orders? | Yes. Not all may be appropriate.<br><br>Orders that need Provider oversight such as signature or review. |
| 5 | Section 2.1.2 indicates that MDH is seeking an EHR that is cloud hosted and running in its own instance in a single data base. Are there any issues or limits with data availability/data sharing within MDH facilities (such as records for RICA youth patients in the same system as Perkins Center psychiatric patients)? | No |
| 6 | Section 2.2.1 indicates that MDH has 20 boards that license and regulate healthcare professionals; is a staff credentialing solution part of what MDH is seeking in from the new EHR? | No |
| 7 | Section 2.2.1 indicates that Public Health Services Administration (PHS) is part of the scope of work for the two PHS Chronic Care Facilities (Deer's Head Center and Western Maryland Center); are any of the PHS outpatient clinics across the 9 major units/24 local health departments also included in the scope of this proposal? | No, only the 12 facilities listed in the RFP are in scope. |
| 8 | Section 2.2.1 indicates that services are provided to criminal justice/forensic clients—is this only within the inpatient facilities or also within throughout the jail system as outpatient services in the community as part of the Office of Judicial Services (OJS) Community Forensic Aftercare Program (CFAP)? | Inpatient facilities |
| 9 | Section 2.2.6 indicates that MDH seeks to increase the scope and quality of reports and analytics that are generated without expanding beyond the areas of key functionality outlined in 2.2.5; can MDH provide a list of or de-identified versions of sample reports and analytics in use today as a benchmark to define acceptance against in terms of new reports/analytics? | See number 3 above |

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| 10 | Section 2.2.8 indicates that six of the facilities purchase/receive medications dispensed by external pharmacies; can MDH elaborate on the process they expect to use for medication administration records for drugs dispensed by external pharmacy systems versus closed loop medication administration for orders dispensed by in-house pharmacies using the new EHR pharmacy solution? | Would be mapped during implementation |
| 11 | Per section 2.2.11, is an interface required for data that was extracted from HMIS but will now come from the new EHR to the Maryland State Police for gun purchases by psychiatric patients? If yes, can MDH provide specifications for what data must be interfaced/extracted? | Data Required: Full Name, Date of Birth, Sex, Social Security Number<br>With the exception of some legal classes, all patients over 16 years of age with a continuous 30-day length of stay.<br>All patients in HMIS records, about 1988 to current<br>Patients reported to HMIS from the MDH Office of Administrative Hearings *(OAH)* via SFTP<br>Patients reported to HMIS from in-state private mental health facilities via SFTP or a secure browser interface.<br>Data specifications are the same for all reporting facilities.<br>All data is transmitted to the MSP daily via a secure FTP connection to replace the prior day's data.<br>The MSP will not require a connection to the new EHR. |
| 12 | Section 2.3 indicates that data cleaning and conversion must be completed and a process will need to be created for identifying and merging duplicate patient records; customarily, that work is performed by State resources who manage the systems in use today and are most familiar with patients regarding duplicates/merges. Does MDH expect this work to be completed by the contractor since it is listed under "contractor responsibilities and tasks"? Will a contractor be granted data access and decision making ability for identification and merging/cleaning the data? | It will be a critical part of the implementation project and the vendor will have responsibility for ensuring its completion from a project management standpoint. Because MDH resources know the legacy data best, they will have a major role in the process and provide significant resource effort to the migration. Vendor will be provided with whatever access is necessary to complete this phase of the project successfully. |
| 13 | Section 2.3 lists digitizing images of non-structured data from previous records and indexing them to the electronic chart; generally speaking, this work falls on the client side rather than the vendor in order to keep costs down for travel to where the hardcopy records are. Can you please provide clarification on this requirement, whether it should be vendor or client responsibility and the volume/size, duration back in time, and quantity of records to be scanned? | This will be completed by MDH and is outside of this scope of work. |
| 14 | Section 2.3 indicates that contractors must identify interfaces needs for each facility for lab, pharmacy, and Gaia DIAPro dialysis; can MDH provide a complete list of external interfaces required and specifications or will those interfaces become work/change orders on top of the base contract? | FBI's National Instant Criminal Background Check System (*NICS*)<br>Data for patients prohibited from a firearm purchase are transmitted by SFTP to the Department of Public Safety and Correctional Services. Data fields required are full name, Date of Birth, Sex, Social Security Number. With the exception of some legal classes, all patients over 16 years of age, with a continuous 30-day length of stay ending after October 1, 2013 are included. Data is formatted to specifications provided by NICS and is limited<br>Maryland State Police *(MSP)*<br>See #13<br>Billing |

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| | | Patient billing documents are sent to external payors using HIPAA EDI records, type 837. Payment notifications are received in EDI records type 835.<br>**Automated Drug Fill**<br>Springfield State Hospital is using a Taylst automated drug filling system. Pharmacy patient drug selections are formatted to a .txt file as defined by the system manufacturer.<br>**CRISP**<br>MDH 90 day census facility patient data is sent weekly to an SFTP server for retrieval by crisphealth.org in a CSV format agreed upon by CRISP.<br>**NEWMAC**<br>Current daily census facility patient data is sent with GNUPG encryption to mdh.ediops for patient insurance payment crosschecking.<br>**National Association of State Mental Health Program Directors Research Institute (NRI)**<br>The data is extracted and massaged into 6 NRI defined .txt files and transmitted to NRI using an NRI provided process.<br>1. Unit .(defined annually by facility personnel)<br>2. Episode (HMIS ADT data)<br>3. Event (HMIS ADTdata)<br>4. Diagnostic (HMIS ADT data)<br>5. HBIPS Core Measures (HMIS ADT data)<br>6. Global Population (Facility defined and keyed at the facility) |
| *15* | Section 2.9 requires an SLA from the contractor for system performance; does MDH already have expected benchmarks that must be attained or is this up to the contractor to self-specify? | It will the vendor's responsibility to self-specify |
| 16 | Section 2.2.4 and Section 3.10.1 indicates a limitation with the current systems in use that do not meet Meaningful Use (MU) standards; we understand MDH is seeking an MU certified EHR system. Is the intent to implement and deploy full MU functionality at all sites including Behavioral Health given the data collection, reporting, health information exchange, patient portal, and workflows that doing so entails since that functionality exceeds the scope of 2.2.5 and 2.2.6 Key Functionality? | yes |
| 17 | Section 5.3 part G in the Technical Proposal seeks an approach for legacy data; can the State share how it plans to handle historical data—will everything be migrated to the new EHR or can queries/views be created for the data bases or to an existing data warehouse? | Most likely the latter approach, but we will look to selected vendor to help design an appropriate plan during the planning phase. |
| *18* | For the Product Requirements in section 5.3.2 Letter H item 13, is this only for third party components or for each module of the comprehensive EHR? | For the EHR solution |
| *19* | Section 5.3.2 Letter H item 13 part xiii indicates the State is using SecureAuth for SSO; is this a desired integration or is the state seeking a replacement SSO solution? | Looking for vendor recommendation based on their solution requirements |
| *20* | Does MDH have an existing MPI Master Patient Index that will require integration? | Yes, MDH does have a Master Patient Index; at each institution for their patients, and a combined view at the central office, also available for use from each facility. This functionality will be required in the new EHR.<br>See the following for an explanation of our current file structure. |

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| | | Two file structures contain patient demographics, the Client Master File (CLMST) and the Patient Discharge File (PATDS). CLMST contains a single record for each episode of a patient and is created at admission and identified with an "A" patient id if a first admission episode or an "R" patient id if the patient is returning from a prior episode. . A patient can have multiple "R" records, only 1 "A" record in the CLMST file. The "PATDS" file is created at patient discharge, and with the addition of some specific discharge data, is a copy of the CLMST record of the discharge episode which contains the latest demographics. There is 1 PATDS record regardless the number of episodes. The PATDs record is identified by a unique number assigned to patients at their first admission. That unique PATDS number is recorded in each CLMST episode record.<br>The CLMST id is a 10 position field, starting with an "A", followed with a 9 digit number, incremented automatically at each institution within a range of numbers unique to that institution. The PATDS is a 10 digit number, also incremented automatically within a facility unique range. Indexed files and logical views exist over both CLMST and PATDS.<br>The CLMST and PATDS are maintained at each facility. The central office system maintains the CLMST and the PATDS files by combining those files from each institution, updated once daily. |
| *21* | Does the MDH desire to replace Optimus system for LTC and MDS functionality referenced in Section 2.2.2 letters G & H, or interface the new EHR to it? Are all functional requirements covered in Appendix 4 for LTC? | Replace |
| *22* | Does the MDH desire to continue to use the e-Chart system referenced in section 2.2.3 for infection control with an interface to the new EHR, or replace the current infection control system functionality? If replace, are all Infection Control system requirements specified in Appendix 4 since Infection Control is listed in Section 2.2.5 as Key Functionality? | Replace |
| *23* | Does the MDH desire an employee health module since one is referenced in section 2.2.3 today or an interface to the existing e-Staff system? If seeking a replacement, are the requirements covered in Appendix 4? | No |
| *24* | Section 2.2.11 references utilization review user groups; is MDH seeking a UR package solution? If yes, are all utilization review requirements detailed in Appendix 4? | No |
| *25* | Section 2.2.6 references that the scope of work is limited to the current key functionality detailed in 2.2.5 as "Phase 1"; is there another anticipated phase of the project with additional desired functionality? | Not at this point. |
| *26* | What is the number of Lab locations that have/will have instruments?<br>• i.e. One main lab with 7 remote locations, only five have instruments to be interfaced (In this use case, A Multi-Site installation with each remote lab using a unique location identifier in a single database and a single billing entity)<br>Will the main lab run a single operational SAAS system or will there be multiple servers with separate databases (In this use | No main lab. Only Deer's Head has high complex CLIA cert - all others waived testing |

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| | case, 31 multiple stand-alone lab sites with separate databases and billing requirements). | |
| *27* | Provide a list of labs (locations) that will require a reference lab "send-out" interface<br>• Include the name of the reference lab to be interfaced by location. | All facilities have waived testing lab on site. |
| *28* | Please provide a detailed list of lab instruments to be interfaced to the LIS component<br>a. This should be by location<br>b. Should include Make & Model of the instrument and interface type (if known)<br>i. i.e. interface Type = Host Query, Direct Connect, Uni-directional, Dynamic Download or connection via Data Manager<br>ii. Above list is an example and not all-inclusive | Not necessary for response |
| *29* | Will the system require emailing of results directly from the LIS or will all results go to the HIS for distribution? | Duplicate above |
| *30* | Is the desire of the state to have the system generate one single charge per day that represents the per diem charge for both room & board and ancillaries for Medicaid chronic and mental health insurance claims? Or would all charges be posted to the patient account and billed accordingly, but the system address the contractual adjustment based on the per diem rate for that payer and service? | Yes, as it applies to Medicaid chronic and mental health insurance claims, the system should generate a "single charge per day." Patients at our facilities are billed per diem at a set, unique rate for each facility. However, Medicare Part B and Medicare Part A (Ancillary) billing is done per CPT code rate.<br>The system should also be able to bill Private Pay/Sponsor at an established per diem rate. |
| *31* | Where do we need to respond to the narrative questions that are in Appendix 4? For example, in the same box right below the response key, NA=Not Available? We are placing the A, CP, P, NA right under the line # (the blank line since there is not a response column). Is this acceptable? | Your approach is fine as long as it is easily understood. You can also transfer to an editable format and create an additional column to the right and add answers there. |
| *32* | Can MDH provide the number of FTEs per the 12 facilities? And the number of providers who are able to prescribe at each facility? | Provided in other responses |
| *33* | How many non-clinical personnel will need access to the EHR system at each facility – e.g. administration, medical records, etc? | See lists of employee classifications in other answers |
| *34* | How many individuals have script writing capabilities – or would have a license to prescribe medication at each facility? | See lists of employee classifications in other answers |
| *35* | Can MDH explain what is meant by "Public Jurisdiction user accounts?" | N/A |
| *36* | How many total employees will MDH have active in the software solution? The RPF provided Clinical User counts but may not have accounted for all staff including billing, admin, security, clergy, state police, and/or other user types or roles. | See numbers and lists of employees in other answers |
| *37* | Learning Management System. Does MDH have a Learning Management System with the capability to execute course registration, attendance tracking, virtual instructor-led courses, eLearning content (e.g., web-based trainings, videos, course materials), and/or course evaluations/store evaluation results? | No |

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| *38* | eLearning Content Development. Does MDH have a preferred eLearning content development software package (e.g., Adobe Captivate)? | No |
| *39* | Training. From which organization will MDH End Users (individuals who will be trainers) come from? Will they be full-time trainers or will this be a part-time duty in addition to other job duties (e.g., nurse, clinician, billing)? | Could be either or both, whatever approach works best. Will be determined during implementation. |
| *40* | How many MDH Pharmacists and pharmacy staff will need access to the pharmacy solution and how many MDH Pharmacists and pharmacy staff will be access the pharmacy solution simultaneously or concurrently? | For the MDH adult facilities there are 25 pharmacists and 13 pharmacy technicians that could be signed on simultaneously. . |
| *41* | How many MDH staff will require rights to electronically order labs? | All docs, see #40 |
| *42* | Does MDH currently use a third-party billing company to submit claims, if so, what is the name of the clearing house? | We do not use a third-party biller. However, we use MyAbility as our intermediary for Medicare Part A, Part B and Commercial Insurance Billing. https://www.myabilitynetwork.com/Auth/?redirect=%2fClaims |
| *43* | Can MDH please confirm the expectation around the use of HIPAA transaction code sets. Will MDH require the following in addition to the 837/835 Health Care Claims and Health Care Claim Payment/Remit Advice:<br><br>270/271 Inquiry/Response for Eligibility<br>276/277 Inquiry/Response for Claim Status<br>278 Referral Certification, Authorization, Extensions and Appeals<br>999 Acknowledgement | We will require the receipt of 837/835, 271, 277CA and a 999 Acknowledgement reports. |
| *44* | Does each MDH facility maintain different rates with the same third-party commercial insurance payors? | Our Billing rates are set by our Cost Accounting unit each year. Each MDH facility will have their own per diem rate that is used to bill for patient services. However, in some instances, the facility may negotiate a different rate with a commercial payor for a particular patient |
| *45* | Can MDH provide an estimate of the number of Real-Time Eligibility transaction requests sent each month? | We average about 20 Medicare Eligibility requests per month via MyAbility. However, we run a TPQY query via CARES/MMIS for every patient admitted to any of our facilities to determine various eligibilities. For FY 20 to date, we've run roughly 1000 TPQY queries via MMIS/CARES. So about 111 per month including patient Transfers from one facility to another. |
| *46* | How may prescribers will prescribe medications that need to be sent to an outside pharmacy using e-prescribing functionality? Will MDH require the use of institutional DEA numbers in addition to individual prescriber DEA numbers? | None |
| *47* | Does MDH have any standard required reports that must be submitted to other State Agencies, if so, would MDH be willing to provide samples along with the frequency and format of required data submissions? | Chesapeake Regional Informational System for our Patients (CRISP): A 90 day patient census containing limited patient demographics is sent weekly to an SFTP server for retrieval by crisphealth.org in a CSV format agreed upon by CRISP. (Exhibit 1 for data structure)<br>Maryland Medicaid: A daily census of all facilities is sent with GNUPG encryption to mdh.ediops for patient insurance payment crosschecking. (Exhibitc 3 & 4 for data structure) |

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| | | Maryland State Police (MSP): A daily transmission of limited patient data as defined within Maryland Senate Bill 2013-281 for patients meeting the requirements contained in the Senate Bill.<br>Data Required: Full Name, Date of Birth, Sex, Social Security Number<br>With the exception of some legal classes, all patients over 16 years of age with a continuous 30-day length of stay are reported<br>Patients include:<br>1. All patients in HMIS records, about 1988 to current<br>2. Patients reported to HMIS from the MDH Office of Administrative Hearings (OAH) via SFTP<br>3. Patients reported to HMIS from in-state private mental health facilities via SFTP or a secure browser interface.<br>Data is transmitted as a .txt to the MSP daily via a secure FTP connection replacing the prior day's data.<br>The MSP will not require a connection to the new EHR.<br><br>Here are some additional reports:<br>February-2020-DOR Monthly Fiscal Year Payer and Charges Report<br>February-2020-DOR Monthly Payer Population and Charges Report<br>Long Term Care Survey (On Demand report for various facilities)<br>Nursing Home Quarterly Assessment Report (sent to external Medicaid auditor)<br>Revenue Recovery Report<br>Medicare Bad Debt Report<br>Medicare / Medicaid Billed Days Report<br>Nursing Home Billed Days Report<br>Medicare Credit Report<br>State Loan Repayment Program Report (some facilities require this report)<br>Average Daily Population Report<br>Census Report |
| *48* | Given the unique circumstances we respectfully request MDH extend the Proposal Due (Closing) Date and Time to 30 days post MDH releasing the responses to the vendor questions. This will ensure vendors have enough time to comprehensively address the RFP requirements inclusive of clarifications provided in the response to vendor questions. | Not at this time, but we may reconsider later in May if necessary. |
| *49* | *Appendix 4 - Functional and Business Requirements – Pharmacy*. 5.10 User shall have the ability to define and maintain user-defined patient data. Can MDH provide a specific use case? Is this specific to the pharmacy solution or a general requirement throughout the EHR? | For the pharmacy solution it is to allow the user/administrator to define the fields that are needed, not just default to what was originally programmed in the system. Are there any blank fields in the database that can be customized is one way to look at it. |
| *50* | *Appendix 4 - Functional and Business Requirements – Pharmacy*. 6.53 User shall have the ability to dispense drugs based on NDC or GSN. Will the state accept the ability to dispense drugs based on GSI and NDC if the utilized drug compendia publisher is Medi-Span? | Yes |
| *51* | *Appendix 4 - Functional and Business Requirements – Pharmacy*. 10.10 Please describe the capabilities of the Offeror's software to process floor stock orders. Please share examples of medications maintained as floor stock and any protocols/standing order examples that initiate the use of the floor stock. | Floor stock is items that are not dispensed to a particular patient but available on a particular nursing unit. Examples would be acetaminophen (Tylenol) and select controlled medications like lorazepam(Ativan). |

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| *52* | *Appendix 4 - Functional and Business Requirements - General Functions* 4.17 The system shall provide a native mechanism for exporting data to NRI / ORYX. Can the State please provide further technical specifications for the NRI/ORX data submission? Does this also include all five HBIPS measures? Can MDH also elaborate on any other reporting requirements apart from the NRI related reporting requirements laid out in section 2.2.10. | National Association of State Mental Health Program Directors Research Institute (NRI) - Reporting to be forwarded CMS and The Joint Commission<br><br>Data is extracted and massaged from each facility into 6 NRI defined .txt files and transmitted to NRI using an NRI provided process.<br><br>1. Unit .(defined annually by facility personnel)<br>2. Episode (HMIS ADT data)<br>3. Event (HMIS ADTdata)<br>4. Diagnostic (HMIS ADT data)<br>5. HBIPS Core Measures (HMIS ADT data)<br>6. Global Population (Facility defined and keyed at the facility) |
| *53* | *Appendix 4 - Functional and Business Requirements - General Functions* 5.11 The system interface with medical devices (e.g., glucometers) to obtain and record clinical information. Can MDH provide a listing of the devices along with manufacturer? | Not needed for response; vendor can provide list of devices that it either can or cannot interface |
| *54* | *Appendix 4 - Functional and Business Requirements - General Functions* 5.5 The system shall exchange patient information with the Maryland county health departments. Can MDH provide additional details on the exchange of information? Specifically, the data that is required and the frequency of the exchange? A comprehensive listing of such systems will help vendors evaluate the integration needs of the state for the EHR implementation. | Reason for communication with the health department are health care providers are required to report communicable disease outbreaks as well as some other conditions- the frequency would really depend on the facility and what is happening locally.<br><br>Currently all reporting to local health departments is done on paper and faxed, or filling in the form electronically and attaching the PDF to an email. |
| *55* | *Appendix 4 - Functional and Business Requirements - General Functions* 5.6 The system shall exchange patient information with the Maryland Office of Forensic Services. Can MDH please specify the data that is required to be exchanged? Specifically, the data that is required and the frequency of the exchange? | N/A |
| *56* | *Appendix 4 - Functional and Business Requirements - General Functions* 5.7 The system shall exchange patient clinical information with the Department of Corrections and Public Safety. Can MDH specify the data that is required to be exchanged? Specifically, the data that is required and the frequency of the exchange? | none |
| *57* | *Appendix 4 - Functional and Business Requirements - General Functions* 1.10 User shall have the ability to apply updates to subscription based services (such as reference databases) without contractor's assistance. Generally, a SaaS model includes these updates as part of the overall offering. Can MDH provide examples of subscription based services that require updates to be managed by MDH? If these examples are included in the vendors SaaS model is this still a requirement? | If updates are already included, then requirement should be met. |
| *58* | *Appendix 4 - Functional and Business Requirements - General Functions* 1.14 System shall provide a mechanism for expunging records according to State Law. These records must be deleted but retained in a manner that is sealed but still accessible. Can MDH please clarify between medical | We follow the legal requirements. |

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| | necessity and legal requirements and how do you differentiate between the two.? | |
| *59* | *Appendix 4 - Functional and Business Requirements - EHR* 1.6 The system shall assist in consolidating blood draws on lab orders to reduce needle sticks. Is this requirement applicable to the EHR or lab system? | Could be either or both (lab techs don't always do the draws) |
| *60* | *Appendix 4 - Functional and Business Requirements - EHR* 1.8 The system shall suggest lower cost panels when appropriate. Is this requirement applicable to the EHR or lab system? | EHR |
| *61* | *Appendix 4 - Functional and Business Requirements - Revenue Cycle* 1.13 The system shall have the ability to attach scanned historical documents to patient record and tagging images with meta data. Can MDH provide specific use case for the use of meta data and an estimate of the anticipated storage required to manage historical documents? | N/A |
| *62* | *Appendix 4 - Functional and Business Requirements EHR 4.3-* Treatment plans shall drive the capture of required documents throughout the course of treatment. What specific documents does MDH require, it would be helpful to understand scope of the request to ensure the response key aligns with the work effort (A = out of the box, CP = custom programming) Does MDH envision the content to be publicly available or require programming to meet this requirement? | The expectation is the SaaS solution will provide all requirements through configuration without any custom programming. |
| *63* | *Appendix 4 - Functional and Business Requirements EHR 7.1 -* Providers shall be able to view lab, x-ray results, nursing notes. Does MDH utilize a centralized PACS solution? | No |
| *64* | *Contractor Requirements: Scope of* Work - *Section 2.3 Contractor Responsibilities and Tasks:* Please describe the expectation for "existing patient data will need to be cleaned and converted." Does MDH assume the vendor will assist in the export and cleansing of data out of the existing systems or will this be completed by MDH staff? With reference to creation of digital images of records, it is our understanding that the physical paper records will be scanned and then attached to the patient's profile in the EHR. Can MDH clarify if the expectation is correct and if the vendor is responsible for scanning and attaching the paper records to the EHR or if this is the responsibility of MDH? | Vendor will be expected to manage the process within overall project plan. MDH team will have primarily responsibility for data conversion, with vendor's help and guidance as needed. Change orders will be used if vendor resources are needed.<br><br>Digitization of archive files will be a separate project. |
| *65* | *Contractor Requirements: Scope of* Work - *Section 2.3 Contractor Responsibilities and Tasks:* Can MDH elaborate on the need for cleansing data prior to conversion. Can MDH highlight the current level of data quality, data integrity, and data completeness with the data stored in existing systems? | Will be completed during implementation. |
| *66* | *Contractor Requirements: Scope of* Work - *Section 2.3 Existing patient data will need to be cleaned and converted. This process will need to identify and combine duplicate patient records across multiple facilities. The process will include creating digital images of records that are not in a structured digital format (e.g., paper records) and attaching* | Assuming the conversion of approximately 1350 existing patients with an estimate of 200 documents each, a total of 270,000 documents will need data conversion and cleaning. Note some existing patients have been patients for 5, 10, 20 years with a corresponding number of paper records. |

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| | *them to the patient's record.* Can MDH elaborate on the total count of records considered in-scope for data cleansing and conversion across all the systems? | |
| *67* | *Contractor Requirements: Scope of* Work - *Section 2.3*. We understand that HMIS is the key system from which data needs to be cleansed, converted and migrated into the EHR. Can MDH provide a list of other systems from which the data is expected to be converted? | Other systems, i.e. patient records, will include those in the medical records department of each facility. HMIS was created to capture and maintain patient movement, i.e. Admission, Transfers, Discharges, all for the purpose of billing, and with the exception of patient diagnostic findings, no medical data is recorded within the HMIS. |
| *68* | *2.3 Contractor Responsibilities and Tasks* – Data Conversion. Can MDH provide additional information on the current export capability for paper based? Is MDH able to estimate the storage size of digitized files? | Not at this time. |
| *69* | *2.3 Contractor Responsibilities and Tasks* - Data Conversion: Can MDH please provide technical specifications for each system migrating data into the new EHR? | Not at this time. |
| *70* | *Contractor Requirements: Scope of* Work - *Section 2.3. The Contractor shall also address the interface needs of each facility to internal and external laboratory systems, external pharmacy contractors, and the Gaia DIAPro dialysis system.* Does MDH have any interfacing needs apart from catering to needs of each facility to interface with internal and external laboratory systems, external pharmacy contractors, and DIAPro dialysis system? If yes, can MDH provide a list of all such systems the EHR is expected to interface with? | See #16 |
| *71* | *Contractor Requirements: General – Section 3.2.4 Return and Maintenance of State Data*. Upon termination or the expiration of the Contract Term, the Contractor shall: (a) return to the State all State data in either the form it was provided to the Contractor or in a mutually agreed format along with the schema necessary to read such data. Is the state willing to define a mutually agreed format during the contracting phase of the procurement? | Yes |
| *72* | *5.3 Volume I - Technical Proposal, F. Offeror Technical Response to RFP Requirements and Proposed Work Plan (Submit under TAB E)* the sentence is incomplete *"Identify and describe the various non-production environments the Offeror is proposing to support project development activities from initiation through the entire contract duration. Provide a diagram depicting these non-production environments and the"* Can DMH include the additional detail? | Answered previously |
| *73* | *2.2.11 Current Systems: User Groups* - The Maryland State Police (MSP) also queries a database extracted from HMIS (and augmented with data from all other State hospitals) to determine if a gun purchaser has been a psychiatric patient. Can DMH please provide additional detail on the requirement and desired workflow? Is the expectation that MSP is assigned a role within the system which provides them limited access to Patient Data or does MSP require a separate database? | MSP will not be accessing their data as it resides within the EHR. They use their own query system. Question #13 contains the requirements for the MSP. Data is received daily from the OAH and private mental health facilities in Maryland. This data qualifies as a denial for a firearm purchase. HMIS determines within its patient records for any new qualified patient (30-day) and combines those records with those received from OAH and private facilities. The combined file is prepared daily for a SFTP pickup by the MSP. |

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| *74* | *2.4 Responsibilities and Tasks 2.4.1 Contractor-Supplied Hardware, Software, and Materials* A. SaaS applications shall be accessible from various client devices through a thin client interface such as a Web browser (e.g., Web-based email) or a program interface. Will end users be accessing the application from a web browser that is opened within a thin client user session, or will end users be accessing the application from outside of session initiated via a thin client? | Both |
| *75* | *2.4 Responsibilities and Tasks 2.4.1 Contractor-Supplied Hardware, Software, and Materials* C. The Contractor is responsible for the acquisition and operation of all hardware, software and network support related to the services being provided, and shall keep all software current. Can MDH please specify if this is limited to the hardware necessary to provide the SaaS solution to the state or if this includes end user hardware and devices including:<br><br>. Laptops<br>b. PC's<br>c. PC mobile stations<br>d. Scanners (barcode, document)<br>e. Printers (paper, label}<br>f. Networking connectivity<br>g. Unit dosage packaging for pharmacy<br>h. Pharmacy dispensing equipment in floors (dispensing cabinets, controlled substance dispensing)<br>i. If yes, do you have needs defined by facility? If not in scope, is MDH going to provide equipment to the facilities as the system is rolled out? | Limited to the hardware necessary to provide SaaS to the state. |
| *76* | The RFP requires a subscription-based SaaS solution however, many of the requirements throughout section 5.3 related to Hosting and Support read as a requirement and or process related to an on-premise solution. Will MDH allow vendors to propose a solution that we feel is most advantageous to the state in performance and price and identify any exceptions to the requirements based on SaaS delivery model? In addition, can MDH clarify how the following requirements are applicable to a Saas solution?<br><br>5.3.F.2.A – Production Landscape<br>F.2.B - Non-Production Landscape<br>F.2.C – Data Management<br>F.2.D – Configuration Management<br>F.2.E – Integration and Interfaces<br>F.2.F – Development of Custom Objects<br>F.2.G – Legacy Reporting<br>F.2.H – Testing Tools | Vendor should disregard if the requirement does not apply to a SaaS solution model. |
| *77* | *2.7.3 Backup* – If a vendors SaaS solution provides for an alternative to the backup requirements described in this section is MDH open to considering an approach more aligned with a SaaS delivery model? | Yes |
| *78* | *3.8 Problem Escalation Procedure* - What ticketing system does the State currently use? | MDH does not use a single ticketing system. OET (IT and Shared Services) use Solarwinds |

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| *79* | *3.10.3 Personnel Roles* -There are no defined requirements or scope for Organizational Change Management, communications, or post-go live field support within the RFP, but there is a key position listed. Please describe the required duties and deliverables associated with the Lead for Organization Change Management key position. | MDH will have an internal OCM team to support the PMO. Vendor may still want to provide OCM support depending on their project methodology. |
| *80* | *2.1.2 The new EHR system will replace the legacy healthcare management information system (HMIS) used for census and billing, as well as a legacy pharmacy system and other clinical systems.* We understand that the new EHR will replace the legacy healthcare management information system (HMIS) AND the legacy pharmacy system. Can you please elaborate on the "other clinical systems" which MDH envisions to replace via the new EHR? | MDH expects to run one system across all facilities and central office for the core functions stated within the RFP. All current systems are listed in the RFP. For facilities that are currently running a health records system, they will be replaced. |
| *81* | 2.2.2.B - Does Springfield hospital use any internal/external laboratory? Will it require any Orders/Results interface?<br>2.2.4.C.4 - We understand that HMIS is partitioned per facility. Is HMIS is the "system of record" for patient demographics? Also, can the state confirm if there are no duplicate records within HMIS partitioned for each facility? | Waived testing on site, external send to LabCorp<br><br>HMIS is the system of record for patient demographics.<br><br>Patients are identified with a unique “internal” number for each episode within a particular facility. There are no duplicate records in the data set for that “internal” number. However, if an incoming patient is not identified correctly, and it is not recognized the patient has prior episodes at the facility, that a new “internal” number is assigned. This is an unusual occurrence and corrected if discovered, but can not confirm it does not still exist. |
| *82* | *2.2.8 - MDH also operates six other inpatient facilities that use the HMIS ADT module for patient census information but purchase their medications from outside pharmacies. They are not using the existing pharmacy management system and will not receive medications dispensed by the new EHR solution. Are the "6 other inpatient" facilities referred herein other than the 12 facilities identified in section 2.2?* | No |
| *83* | 2.2.1 The Department and Health Care Facilities - 1) Can you provide a table of the following statistics by facility on a monthly basis for 2019, 2018 and 2017<br>a. Patient visits (inpatient vs outpatient)<br>b. Facility census statistics<br>c. Medical claims by provider and payer (Medicaid, commercial)<br>d. Total billed<br>e. Total collected<br>f. Scripts written<br>g. Scripts fulfilled | Not at this time |
| *84* | Would you be able to provide a Total or a Per Facility Net Patient Revenue (NPR) figure or what is sometimes referred to as a Net Client Revenue figure for the 12 MDH facilities listed in the RFP? This is for budgetary pricing purposes. | Yes, via our Monthly and YTD Revenue Recovery Reports we can provide Facility Revenue reports. |
| *85* | It seems that the hospitals and facilities run by MDH are more of in-patient facilities where patients are admitted for the long-term much like long-term-care facilities like SNFs or Group Homes. Is this a correct? If not then, would these | Yes, inpatient, but licensed as hospitals and NSFs and RTC |

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| | facilities be characterized as typical out-patient clinics? (Rev-Cycle #1.8) | |
| *86* | we cater mostly to long-term-care facilities where almost similar data is captured and charted but with a slightly different perspective. Would State consider customizations in the software so it can be repurposed for MDH's use? | No |
| *87* | Would State consider a solution where multiple vendors are involved such as EHR from one company and the Billing or Pharmacy system from another company? | No |
| *88* | Is it acceptable to MDH that some of the roles defined will be modified as appropriate for a SaaS model provided service in which vendor will be responsible all system/hosting requirements for the EMR system? | Yes |
| *89* | Can MDH provide the number of FTEs per the 12 facilities? And the number of providers who are able to prescribe at each facility? | Yes, see #40-45 |
| *90* | How many non-clinical personnel will need access to the EHR system at each facility – e.g. administration, medical records, etc? | Answered previously |
| *91* | How many individuals have script writing capabilities – or would have a license to prescribe medication at each facility? | Answered previously |
| *92* | Can MDH provide more clarity around the Living Wage reporting? Does this requirement apply to this EHR procurement? | duplicate |
| *93* | Can MDH explain what is meant by "Public Jurisdiction user accounts?" | duplicate |
| *94* | 2.2.2.E Thomas B. Finan Center - Cumberland "The AIMS pharmacy module is used for dispensing medications." When was this system implemented and what is the latest software version? Is this system currently connected to an EHR platform? | Not needed for response |
| *95* | 2.2.2 MCH Facilities- Are services provided by staff in non-clinical settings, i.e., patients home? If so, what services are provided? | No |
| *96* | 2.2.3 Current Systems: Overview- "SchuyLab is a laboratory system used at Deer's Head for accessioning and processing specimens and reporting results via instrument interfaces." Will SchuyLab be used in the future or replaced? | Yes will be used |
| *97* | 2.2.4 Current Systems: Challenges- "Heavy reliance on paper and manual processes in workflows create an environment with many opportunities for delay and error." Why do some locations have EHR's and others not? Has there been a problem with adoption in locations where an EHR is not present? | To date, most facilities have run their clinical systems independently. No major adoption issues. |
| *98* | 2.2.4.B Access to Information "D. There are a limited number of workstations available to physicians, nurses and other clinicians, and MDH will need to assess the expansion of the local network to accommodate additional workstations, as well as the type of workstation (desktop, laptop, tablet)." What are the state's plans to equip the physicians, nurses and other clinicials with the appropriate hardware and network connectivity to support the "SaaS" EHR? Will the assessment be conducted by the state or is it expected to be performed by the EHR provider? Who will be responsible for equipment and network acquisition? | MDH will equip physicians, etc. as needed, and will procure necessary infrastructure. Major enhancements are already being made to infrastructure. |

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| *99* | 2.2.4.C Integration "6. There is no integration with the Maryland health information exchange, CRISP, so patient history, medication, allergies, problems cannot be obtained electronically." Has a minimum level of information been established for integration with CRISP? | yes |
| *100* | 2.2.4.C Integration "7. There is no integration with county health department systems." Do all of counties in Maryland have health information systems? Have they been independently constructed or is there commonality to systems? Are they currently connected to, or is there a plan to connect them to CRISP? What integration in required or anticipated? | To be determined during implementation |
| *101* | 2.2.4.C Integration "8. There is no integration with the Department of Public Safety and Correctional Services (DPSCD) nor with other county jail systems." Do the correctional facilities participate in a common system or have a "CRISP-like"system for interconnectivity? What EHR system(s) are in place at the correctional facilities? What integration is required? | Do not know at this point. Will be part of implementation if necessary. |
| *102* | 2.2.5. C Pharmacy Is the system expected to provide pharmacy management? If so, how many facilities will required this capability? | No |
| *103* | 2.2.6 Current Systems: Census / Billing / Revenue Cycle "MDH seeks to increase the scope and quality of the reports and analytics that it generates from the new EHR system."" Has there been any determination on the scope, quantity and anayltics required? Has there been a process to determine this or is this analysis and expectation of the project?" | Not at this point. Will be part of implementation. |
| *104* | 2.2.11 Current Systems: User Groups "The Maryland State Police (MSP) also queries a database extracted from HMIS (and augmented with data from all other State hospitals) to determine if a gun purchaser has been a psychiatric patient." Who will be responsible for building the new query to support this legacy data base? | The Maryland State Police is using their own query and will not need a connection to the new EHR |
| *105* | 2.3 Contractor Responsibilities and Tasks "Existing patient data will need to be cleaned and converted. This process will need to identify and combine duplicate patient records across multiple facilities." How many "electronic" health records does the State expect to be converted from the legacy EHR systems? | Assuming the conversion of approximately 1350 existing patients with an estimate of 200 documents each, a total of 270,000 documents will need data conversion and cleaning. Note some existing patients have been patients for 5, 10, 20 years with a corresponding number of paper records. |
| *106* | 2.3 Contractor Responsibilities and Tasks "Existing patient data will need to be cleaned and converted. This process will need to identify and combine duplicate patient records across multiple facilities. The process will include creating digital images of records that are not in a structured digital format (e.g., paper records) and attaching them to the patient's record." Converting patient paper records as described above is extremely labor intensive and costly. It will also require the involvement of State resources to analyze the records to verify that they should be combined. Does the State really want to convert these paper records? If yes, how many paper patient records need to be converted? Also, if yes, will the State dedicate the required number of State resources to this process? | MDH has not decided yet as to how many years of records will be digitized, but this will be done separately from EHR. Many facilities are already in process of digitizing paper files. |
| *107* | 2.3 Contractor Responsibilities and Tasks - The Contractor shall also address the interface needs of each facility to internal and external laboratory systems, external pharmacy | Answered previously |

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| | contractors, and the Gaia DIAPro dialysis system. These interfaces will need to be in place when the new system is implemented at each facility. Please provide a list and description of all interfaces that need to be developed. | |
| *108* | 2.4.1 Contractor-Supplied Hardware, Software, and Materials - "The Contractor is responsible for the acquisition and operation of all hardware, software and network support related to the services being provided, and shall keep all software current." Our SaaS EHR solution is a web-browser based solution that will access the Internet via the the State's network. Is this statement limited to the hardware, software and network of the SaaS vendor's infrastructure to support the Saas EHR solution or are you referencing the State's hardware, software and network support to provide a web browser for the SaaS EHR solution? If the State's hardware, software and network is included, please provide detailed information regarding what needs to be supported. | This only refers to vendor's infrastructure and hardware. MDH will provide same to enable its ability to access SaaS system via web browser. |
| *109* | 2.4.1 Contractor-Supplied Hardware, Software, and Materials - The Contractor shall prepare software releases and stage at the Department for validation in the system test environment. The Department will provide authorization to proceed. The Department will have the ability to manage the distribution of these releases to the appropriate sites. To support this requirement, the Contractor shall propose, provide and fully describe their solution for updating all sites with any new software releases. A test system can be provided. However, all sites will receive the update once approved since there is only one instance of the SaaS EHR for the MD Dept of Health. Adding individual instances will significantly increase the cost. Is one instance that is updated for all sites at the same time acceptable? | yes |
| *110* | 2.6 Training - How many trainers will need to be trained using a train-the-trainer approach? | Will be determined during the implementation phase. You can estimate if needed based on existing number of employees and users. |
| *111* | 2.6 Training, 2.6.1 and 2.6.3 2.6.1 speaks to vendor provided training and 2.6.3 speaks to a train the trainer approach? These sections appear to contradict each other. Please delineate the training approach MDH would like to employ. | Will likely require both approaches. The approach used will be dependent on needs and best practice for each situation. |
| *112* | 2.6.4.A Technical and Operations Training - "A. Provide a combination of hands-on and classroom training for technical and system operations staff. The Contractor shall ensure that sufficient training sessions are scheduled to train all staff identified in the use of the system in hosted environment." To what extent will technical and systems operations staff be associated with the project throughout the systems development lifecycle? | They will be engaged to whatever extent is needed. We expect many MDH resources to be assigned full time to the project. |
| *113* | 2.6.4.A Technical and Operations Training - The technical and operations training described by the State goes well beyond what is typically provided in a SaaS environment since the SaaS environment is operated by the SaaS vendor. Please confirm that the technical and operations training only includes the tasks that will be performed by the State (e.g., user administration) and not tasks that will be performed by the SaaS vendor (e.g., system table maintenance) | Correct. |
| *114* | 2.7 Required Project Policies, Guidelines and Methodologies / and 4.3.3 Nonvisual Access - "C. The State of Maryland Information Technology Non-Visual Standards at: | Yes |

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| | http://doit.maryland.gov/policies/Pages/ContractPolicies.aspx" EHR systems are not typically designed or developed to support non-visual use and it is unlikely that any vendor would "warrant" their technology to that effect under this contract. Are third party tools and their limitations acceptable "equivalent access" for the effective use by non-visual means? What third-party tools is the state using for this purpose? | |
| *115* | 2.8.4 Deliverable Descriptions / Acceptance Criteria - Some of the deliverables described in this section do not apply to a typical Software as a Service (SaaS) implementation. For example, a system design document that describes the entire system is not applicable since a SaaS solution is not a custom solution. Likewise, a complete system administration manual is not need because the SaaS vendor manages the system. Can vendors substitute their standard SaaS deliverable set? If no, can vendors limit the scope of deliverables to applicable SaaS items and mark non-applicable deliverables as non-applicable? | Yes and yes |
| *116* | 2.8.4.7 Data Migration Plan - Who will be responsible for the cleansing and conversion of data from existing electronic systems? What forms of conversion are acceptable for manual records and who will be responsible for loading them into the system? | MDH will conduct these tasks. |
| *117* | 2.8.4 Deliverable Descriptions / Acceptance Criteria - Being an ecologically friendly company, and given the fact that our software is so easy to use and includes online help, we do not provide technical and user manuals. Is our eco friendly approach acceptable to the State? | Yes |
| *118* | 2.9 Service Level Agreement (SLA) - SaaS based software solutions are web-based thin client architectures. Given this, we do not anticipate network related performance issues. However, please confirm that the technical environment and any network performance issues will be addressed by MDH. | Yes, anything that pertains to our infrastructure will be addressed by MDH. |
| *119* | 2.9 Service Level Agreement (SLA) - SaaS based software products, not administered in a private cloud, are usually monitored for performance against mutually agreed upon performance metrics and not stress tested like traditional software. Resources in a cloud-based platform are dynamically allocated to meet defined and agreed upon performance standards. We expect to monitor the performance of the system against these metrics. Is this approach acceptable to MDH? | Please indicate as such in your proposal. |
| *120* | 3 Contractor Requirements: General - Is MDH expecting the team to be on-site for the duration of the project? If so, will appropriate space be allocated for the project team? Is it acceptable to have team members work remotely? What provisions have been or will be made for the site implementation teams? | The project work should be done remotely whenever possible. But when on site, appropriate space will be provided. |
| *121* | 3.3.6 Travel Reimbursement It states that "Travel will not be reimbursed under this RFP." Many of the team members do not reside in the the Baltimore area and the 12 implementation sites are scattered across the state. Is MDH expecting the travel cost to be part of the hourly rate? | Yes |
| *122* | 3.10.3 Personnel Roles - A Lead for Organizational Change Management (OCM) is listed. However, there doesn't appear to be any scope for OCM in the RFP, which leads to the assumption that OCM is the responsibility of the State. | OCM will be conducted by MDH. Vendor can still propose if it's part of their methodology. |

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| | Please explain the need for this role including the OCM responsibilities of the vendor. | |
| *123* | 3.10.3 Personnel Roles - A Lead Technical Configurator by module is listed. Our SaaS solution does not have modules like some legacy monolithic EHR's. Can we delete this role if we don't need it? | Vendors may propose however they deem appropriate. |
| *124* | 3.10.3 and Appendix 5 - A Labor Category Match for the minimum qualifications could not be found in the RFP Appendix 5 for the following roles: Lead Technical Configurator by Mode, Lead for System Integrations & Interfaces; Lead for Organization Change Management; Lead for Data Conversions; Lead for Infrastructure and Security, are there minimum qualifications for these roles? | Qualifications for these roles would be equal or greater to industry standards for such roles, but there is no specific criteria. |
| *125* | 3.10.3 and Appendix 5 - The LCAT descriptions do not directly match the Appendix 5 listed LCATS. Are these Personnel Requirements applicable for the required sample resumes? | Provide for the list of positions in 3.10.3; use Appendix 5 as a guide. |
| *126* | 3.11 Substitution of Personnel - If this is a fixed fee project does this clause still apply? Isn't it the vendors responsibility to manage the resources to a successful deliverable outcome? | MDH must approve all resources assigned to the project, so if a change is needed, MDH will need to vet the candidate via resume review and a possible interview. Changes will need to occur for various reasons over course of the project. MDH wants to ensure that all resources assigned are qualified and appropriate for the role. |
| *127* | 4.8 Public Information Act Notice -Our proposals are considered "Confidential and Proprietary" in their entirety and contain non-disclosure provisions. Please provide guidance. | Requirements of the Law are clearly described. |
| *128* | 5.3.2 (Page 56 of 117) - The language for the requirement a) is cut-toff/incomplete. Would the Government please state the full requirement so that we may ensure that we are providing a complete answer in response to the requirement. | Sentence should end after environments (disregard 'and the'). |
| *129* | General - How many forms, both electronic and paper, does the State expect to be converted to the new SaaS EHR? | Do not know at this point. Will be part of implementation. If needed for response, please just provide assumptions that you use to arrive at your outcome. |
| *130* | General-How many reports, both electronic and paper, does the State expect to be converted to the new SaaS EHR? | Do not know at this point. Will be part of implementation. If needed for response, please just provide assumptions that you use to arrive at your outcome. |
| *131* | General - Has the organization developed a health outcomes orientation and what is it based on - patient, cost, recurrence, compliance, etc.? | No |
| *132* | General How does the organization collaborate and communicate around patient care given the current environment? | Not needed for response |
| *133* | General - Aside from the systems identified, what is the existing technical environment of MDH? Can documentation on the existing infrastructure, networks, data centers and environment be made available? | This is provided adequately in the RFP |
| *134* | General-Approximately how many patient records are stored in the existing EHR systems? Conversely, how many are manual? | There are 110,000 patient records and approximately 1,000,000 supporting movement records stored in the HMIS system. An estimate of 200 patient paper records exist for each patient. |
| *135* | General - What is the organization's experience with enterprise-wide initiatives? | Limited |
| *136* | Appendix 4 - General - 1.10 Please provide some examples of the subscription based services. | Example is provided, seems straightforward |
| *137* | Appendix 4 - General - 3.4 Please define 'multiple units'. Does it mean departments, wards or some other concept? | Patient/Resident units (i.e. West 1, South 2, Cottage 3) |

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| *138* | Appendix 4 - General - 4.6 What tools will be used to measure level of depression and what would be the criteria for score comparison? | For Chronics -PHQ-9/PHQ-9 (OV |
| *139* | Appendix 4 - General - 4.13 Please define how projection calculations are generated today. Are there established algorithms or they based on physician determined timeframes? | Varies, just looking for capabilities for discharge projections |
| *140* | Appendix 4 - General - 5.1 Is the current LIS system compatible with APIs (Application Programing Interface) or do they currently use APIs? | https://labspec.com/schuyler-house-schuylab/ https://www.orchardsoft.com/ |
| *141* | Appendix 4 - General - 5.2 Please provide a list of external labs required to be interfaced. | Duplicate from original set of questions |
| *142* | Appendix 4 - RevCycle - 2.2 Is this feature required to just capture these appointments or is it envisioned that external service providers having access to these appointments? | Both |
| *143* | Appendix 4 - RevCycle - 2.9 Please elaborate on "track off-grounds hospitalization and outpatient care" - does this mean electronically through exchange of records from HIE or other EMRs or ability to track within the application through manual entry? | Both |
| *144* | Appendix 4 - RevCycle - 3.7 Does the term 'encoder' refer to a coding software like encoderpro? | This refers to a software application that would complete encoding, but not any particular encoder |
| *145* | Appendix 4 - EHR - 1.5 - Does this refer to Internal or External imaging centers or both? | Both |
| *146* | Appendix 4 - EHR - 3.1s - Please provide examples of how these documents need to be linked within the application. | This should explain how other custom electronic documents (examples provided) would be integrated, if necessary |
| *147* | Appendix 4 - EHR - 3.1v Please define 'agency level'. | MDH |
| *148* | Appendix 4 - EHR - 3.6 Please define "online crisis plan". Does this mean the patient has to be able to view it online through a portal or some other mechanism? | Yes, it must be “online” for any appropriate people to review |
| *149* | Appendix 4 - EHR - 5.9 Would the communication be with Internal or External pharmacy or both? | Both |
| *150* | Appendix 4 - Lab - 1.9 Please list commonly used databases? | Not needed for response |
| *151* | Appendix 4 - Pharmacy - 1.2 Is this requirement only referring to integrated external labs? | External and internal |
| *152* | Would you be able to provide a Total or a Per Facility Net Patient Revenue (NPR) figure or what is sometimes referred to as a Net Client Revenue figure for the 12 MDH facilities listed in the RFP? This is for budgetary pricing purposes. | duplicate |
| *153* | Does the MDH have an existing encoder/coding product that requires an interface to the proposed billing/revenue cycle management functionality per Appendix 4 Rev Cycle section 3 item 3.7/line 93 or is MDH seeking an encoder as part of the revenue cycle solution? | No and would consider |
| *154* | Can the MDH provide the number of anticipated users by facility for revenue cycle (coding, billing, accounts receivable) activities? Those specific types of anticipated users are not defined in section 2.2.2 MDH Facilities. | Keep in mind, staffing is fluid. Currently, all billing and receivables are performed at a central location with roughly 7 Fiscal Accounts Technicians. We currently have 11 Financial Agents and support staff throughout our facilities that support the billing and accounts receivable process. We do not use an encoder product. We have a fully integrated ICD-10 lookup Inquiry program on all facility partitions on the |

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| | | IBM iSeries which is tied to our inhouse billing program. Additionally, we have 2 Information Services staff that support all IT and billing functions ie processing, editing, validating, and submitting 837 files and generating various on demand reports. |
| *155* | Does the MDH have a Central or Enterprise Billing/Revenue office or does each facility manage revenue cycle independently? | Centralized |
| *156* | Per Appendix 4 in pharmacy section 5.1: User shall have the ability to maintain patient profiles. Patient data requirements are listed in Appendix 3, however Appendix 3 of the bid is a non-disclosure agreement and does not list the patient data requirements being referenced. Can MDH provide the correct reference link and/or the patient data requirements? | Disregard second sentence in the Requirement. First part applies to generally accepted patient data requirements. |
| *157* | Per Appendix 4 pharmacy section 5.4 and 5.5, are pharmacists entering the diagnosis written on paper medication orders currently into the HMIS and/or pharmacy systems? In the EHR, typically providers enter the diagnosis data to maintain a current problem list rather than pharmacy staff entering the data. Is such an alternative workflow acceptable and can a comment be added to these items and others in Appendix 4 when the system meets the requirement out-of-box but there may be a work-flow change? | Yes |
| *158* | Appendix 4 Pharmacy tab item 5.10 asks: "User shall have the ability to define and maintain user-defined patient data". What data is MDH asking for that would be "user defined" versus part of standard patient record capture? | Ad hoc reports such as those required by regulatory surveys or best practice research |
| *159* | Are vendors permitted to add comments to Appendix 4 column E to explain how the proposed system either meets a requirement or makes a requirement unnecessary due to work flow changes for more efficient staff processes? | Yes |
| *160* | Do the MDH pharmacies have a policy for dispensing generic forms of medications unless otherwise specified by the ordering provider? (Appendix 4 Section 6.0) | yes |
| *161* | Do the MDH facilities have a policy for therapeutic drug substitution for a defined list of medications? If yes, is the list the same at each facility? (Appendix 4 Section 6.0) | Yes |
| *162* | Per section 2.2.2, several facilities use Allied and Pharma Care external pharmacies. Does Allied and Pharma Care have the capability to interface to the new EHR using HL7 or NCPDP to allow orders to flow from the EHR to the external pharmacy, and back to the EHR for a nurse administration (bar code medication admin) process? | Allied-Yes, SCRIPT-software, currently in use |
| *163* | Is the Allied and Pharma Care external pharmacy considered a retail pharmacy or a contracted services pharmacy? | Contracted |
| *164* | Under Appendix 4 Pharmacy Tab items 5.1 and 5.3, is MDH seeking NCPDP and Medicare D billing for retail pharmacy only or also inpatient behavioral health medications? | Could be both |

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| *165* | For Appendix 4 pharmacy item 6.54, does each MHD facility have its own defined ISMP list of medications for Tall Man lettering, or is a single shared list used for all 12 facilities? | This is referring to the ISMP list that is available on their website. In addition, a facility may find it necessary to define their own tall man lettering for medications not in the ISMP list. |
| *166* | In Appendix 4 pharmacy is item 6.61 in reference to patient self meds needing full directions versus nurse administered inpatient medications? If not, what is the requirement in reference to? | Printing of a label for a refill from the pharmacy not on site. The reprinted label without instructions generally comes with a prescription number associated with residents/patients and instructions. The facility would not need the directions when requesting a refill. An example would be if the resident/patient was on a social leave of absence overnight and on medications, the individual or family member would need more information on the label for proper administration |
| *167* | The RFP pricing format is seeking a price per facility over each of the seven years. Not all sites will go live at the same time—should the work be evenly spread over the seven years even if a site is not live until the end of year 2? | Subscription pricing for each facility should start when that facility is live on the SaaS. Pricing for each facility should also include appropriate implementation costs. Any project overhead (such as project management) should be allocated across all facilities for the implementation period. Please provide any assumptions that you make to arrive at your pricing. |
| *168* | Has MDH determined which sites or type of facility should be prioritized to "go live" first(mental health, forensics, complex medical, developmentally disabled)? | We have not made those decisions. We anticipate making those decisions during the preliminary planning period with the vendor and will be looking to the vendor for guidance as to the best route to take with respect to bringing up the facilities. |
| *169* | Per section 2.2.2, Clifton, Springfield, Sykesville SETT, Spring Grove, Finan, and Eastern Shore all have on-site pharmacies. Spring Grove has a notation that in addition to inpatient unit dose medications, they also dispense 30 day supply of medications. Is this a version of retail outpatient pharmacy for discharge meds, leave of absence, and trial placements? Do all of the sites with on-site pharmacies require 30 day supply functionality or only Spring Grove? What about the Allied sites—how does the process work to remotely order meds labeled for ambulatory use if the patient hasn't been discharged in the system before the contract pharmacy order is placed? | Yes, function of d/c plan |
| *170* | Per section 2.2.2, do either the RICA or the GLGRICA facilities offer forensics as part of adolescent treatment or would those individuals be receiving care at adult facilities? | Yes, forensic services offered….but this is not relevant to response |
| *171* | Per section 2.2.2, does the Sykesville SETT offer forensic services as part of their court involvement active treatment programs? | Yes |
| *172* | Per section 2.2.2, can you provide laboratory specifications for Springfield, Sykesville SETT, and Eastern Shore facilities—do they have an in-house laboratory or do that require interfaces to external laboratory systems? If external interfaces are required, can you provide details on how many interfaces are required? | duplicate |
| *173* | Under Appendix 4 General Requirements item 5.10, what pharmacy automation integration is required in addition to Omnicell across the 12 facilities? | Currently we have one Talyst machine in one facility. We are looking for compatibility with the industry standard in automation. |

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| *174* | Under Appendix 4 General Requirements item 5.3, what pharmacies require integration for orders and MARs? Section 2.2.2 only details a single external pharmacy system called Allied—are there more? | Currently Potomac Center and SETT have a contract with Pharma Care; Allied is the contract vendor for the Chronics and Holly Center. |
| *175* | Under Appendix 4 Pharmacy item 12.1, do all the facilities use the same drug wholesale/purchasing organization (i.e. Cardinal/McKesson)? What company or companies is/are used? | The current Prime Vendor for Maryland is Cardinal Health. There was a 5 year contract signed in January 2020. |
| *176* | Under Appendix 4 Pharmacy 16.2, can you provide a sample of the "My Medication Card" in use for a patient on leave of absence or being discharged? | something similar to this: https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/facility_licensing_and_investigations/pdf/Medicationcardpdf.pdf?la=en |
| *177* | Per Appendix 4 General Requirements item 1.14, can you please provide the Maryland medical records law for retention, expunging records, and sealing records/sealed record availability? | This is public information and should be readily accessible. |
| *178* | Section 2.2.2 defines what types of care are provided by each of the 12 facilities; do any of the facilities provide chemotherapy? | No chemo |
| *179* | Section 2.2.2 explains the types of care provided by each of the 11 facilities; for those treating medically complex patients are the Total Parenteral Nutrition (TPN) formulas mixed on-site or purchased pre-mixed? | TPN requires pharmacist oversite for mixing. Depends on the pharmacy arrangements of the facility |
| *180* | Per Section 2.2.2, the Deer's Head and Spring Grove facilities use existing imaging systems. Are those systems meant to be replaced or interfaced to the new EHR? If replaced, does the MDH require a PACS imaging solution or only order entry/results and report functionality? | Interfaced |
| *181* | Per Appendix 4 Pharmacy tab item 17.3 can you provide a list of the different models and total number of automated packaging devices that require an integration? | There is one packaging machine as listed in the RFP - OS-PAC (Autopac) JV 500SL by Talyst |
| *182* | Per Appendix 4 Pharmacy tab item 17.4 can you provide a list of the different models and total number of automated dispensing devices that require an integration? | No current dispensing devices in place, need to be compatible with the industry standard. |
| *183* | Section 2.2.2 describes the Finan facility as using a home-grown medical records application called DPOE—is the intent to decommission this system or interface to it? | decommission |
| *184* | Should the costs for interfaces specific to a facility, such as the DiaPro system interface needed by Deer's Head, be accounted for in the facility-specific costs line or under the "General" category that is part of Appendix 4? | By facility if it is limited to that facility |
| *185* | Section 2.2.2 provides user information for each sites, but not all are broken down by type of user. Can you please provide how many pharmacist users by facility, how many prescribers by facility with break-outs for mid-level providers such as PAs and NPs, how many non-clinical administrative staff by facility, how many RNs, LPNs, and Aides by facility? | Provided in number 234 below |

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| *186* | It is customary to see more users with an enterprise EHR solution than when a hospital uses specific siloed applications—does the MDH have an estimated concurrent user count for the new EHR? | Previously answered |
| *187* | Per Attachment B pricing, facilities should be broken down under the SaaS years. Should this be at the facility level or are you seeking a per user cost? | Facility level, but it would be helpful to provide details as to how you arrive at that number (so also provide per user costs). |
| *188* | Per section 2.2.2, Perkins is a forensic maximum security site—does this facility require revenue cycle/billing functionality for data reporting and budget only or also Medicare/Medicaid billing? | yes |
| *189* | Per Appendix 4 EHR Requirements item 10.6 Telepsychiatry, can MHD provide the number of psychiatrists per facility who would use the system? | None |
| *190* | Per Appendix 4 EHR Requirements item 10.6 Telepsychiatry, can MHD provide the number of hours yearly that the system would be used? | None |
| *191* | Throughout Appendix 4, if an item is met with a third-party partner, should pricing be included in Attachment B? | Pricing should be included but does not need to be separated out. We are looking for turn-key pricing by facility. |
| *192* | Per Attachment B, is the MDH seeking a pricing model that is heavier "up front" for implementation, heavier in the SaaS years, or balanced across the duration of the contract? | Pricing should be as accrued. Implementation costs up front, and subscription on an annual basis as outlined in the document. |
| *193* | Are the expectations that the Contractor will clean the data from their legacy application(s), e.g. to merge duplicate records from the multiple facilities? Or is MDH going to do that, and the Contractor just needs to include this activity in the Plan? | MDH will conduct those tasks and vendor will include/monitor in the overall project plan. |
| *194* | Are the expectations that the Contractor will create the digital images of their paper records? Or do they just need the ability to upload these digital images into EHR? | MDH will address digitization separately. Yes images must be able to upload to EHR. |
| *195* | The State of Maryland Information Technology Project Oversight at: https://doit.maryland.gov/policies/Pages/default.aspx.aspx; -- The link appears to be broken. Can you provide a link to the State of Maryland Information Technology Project Oversight information? | https://doit.maryland.gov/policies/Pages/default.aspx |
| *196* | Section 2.2.2. - Can MDH complete the grid below with the additional user count information needed that was not included in the section for all users needing access to the system? Additionally please confirm or update the information that we populated in the grid based on what was provided | Answered |
| *197* | Will the 75 Academic staff at RICA Rockville be accessing the system in addition to the other staff members at that facility? | Yes |
| *198* | Who is the consultant that assisted with the requirements gathering and validation? | A&T Systems, Inc. and Angarai |

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| *199* | Section 2.2.6 - Are you billing Medicare Part D in any facility and if so, which ones? | We do not bill Medicare Part D through our DOR monthly billing processes |
| *200* | Section 2.2.6 - Does MDH have the 837 companion guides for all of the different payors that use the "837 Translator" program? | No |
| *201* | Section 2.2.8 Please confirm that only Finan, Spring Grove, Springfield, Perkins, Eastern Shore and Sykesville SETT (thru Springfield) will use the pharmacy management system. | No longer SETT |
| *202* | Section 2.3 - Are the expectations that the Contractor will be responsible to clean the data from MDH's legacy application(s), e.g. to merge duplicate records from the multiple facilities? Or is MDH responsible for the task of data cleansing and can then provide to Contractor in standard format that can then be uploaded to the new system and the Contractor just needs to include this activity in the Plan? | MDH will primarily contact data cleansing under guidance from vendor and provide to vendor for upload as needed. |
| *203* | Are the expectations that the Contractor will create the digital images of MDH's paper records or does MDH just need the ability to upload these digital images into the new system? | No and yes |
| *204* | Section 2.4.1.C - Please clarify that the Contractor is responsible for all hardware, software and network support as only related to the SaaS environment. MDH is responsible for all State hardware such as end-user devices (workstations, tablets, printers, etc.), State-side network and services to manage State Network. | That is correct. |
| *205* | Section 2.6 Training- Does MDH expect that the Contractor will supply all end user training materials and provide hard copies of any handouts or manuals? | Yes, although they can/should be electronic copies, not hard (printed) copies. |
| *206* | Deliverables Summary Table ID #2.8.4.12 requests "In MS Word format with system screenshots the detailed Training Plan shall…". This sentence appears to be missing some context. Screen shots are not generally in a "Training Plan". They are often part of training materials. Can the State clarify what type of "system screenshots" would be required in a "Training Plan"? | Vendor can determine the type of documentation used for training plan and materials. |
| *207* | The question is around the proposal submission format for RFP Sections 2 and 3. Is it MDH"s expectation that the vendor simply acknowledge these statements as they are informational OR is there an expectation of a narrative response? Two examples would be:<br>a. 2.2.2 MDH Facilities. Vendor can simply acknowledge the information as there doesn't seem to be an expectation of a narrative.<br>b.2.2.4 Current Systems Challenges: Vendor could acknowledge the information but also provide a narrative as to how they would overcome these challenges. | Narratives as to how challenges would be addressed are welcome but not required. These sections are primarily informational only; no additional acknowledgement is necessary. |
| *208* | Section 3.10.4 Labor Categories. To be responsive to this RFP, Offerors must explain in Staffing Plan how they are capable of providing the labor categories listed below. There does not appear to be a separate area to submit a Staffing Plan, should the vendor include the staffing plan in this section? | Yes that will be fine. |
| *209* | Contractor Roles listed in section 3.10.3 are different than Labor Categories in 3.10.4 and in Attachment B. Can MDH clarify the difference between the Contractor Roles and Labor Categories? | Answered previously |

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| *210* | Section 5.3.2.F Is MDH expecting the offeror to cross reference a specific requirement from Appendix A for every section of the RFP requirements in Sections 2 and Section 3? | That would be helpful but not required. It would certainly improve the readability of the proposal. |
| *211* | Requirement 1.2 Financial and clinical information for a patient shall be transferred to the new facility when a patient is transferred. Is DOH referring to a transfer internally from one facility to another or to an external facility or both? | Internally |
| *212* | Requirement 1.17 The system shall be able to track patient movement between facilities. Similar to Requirement 1.2, but this is transferring of clinical and financial information between facilities and that the history of a client's movement between facilities is documented and displayed. | Not a question |
| *213* | Section 3.2.C. In regard to handling the state's legacy data,<br>a. If the state were to want us to host a copy of a database, or a solution for them, then the state would need to provide all required solution requirements for us to price (DB size, Solution CPU/RAM/Storage requirements, Operating system, Database Vendor and Version, and any other third party applications | Not part of this response, would be addressed at contract termination. |
| *214* | RFP Section 2.3 States the following "Existing patient data will need to be cleaned and converted. This process will need to identify and combine duplicate patient records across multiple facilities. The process will include creating digital images of records that are not in a structured digital format (e.g., paper records) and attaching them to the patient's record."<br><br>a. What is the State's expectation related to "patient data will need to be cleaned and converted". Is the State expecting non-electronic data (paper data) to be cleaned or will all converted data structured digital data?<br>b. If the State is requesting that paper data be manually cleaned and entered, what is the patient population that this will be required? Is it only active patients?<br>c. Does the State expect only active patient charts to be digitized and attached to the patient's record? If yes, is it the entire chart or only a limited history? If no, how many patient charts must be digitized and how much of each chart? | Answered in previous questions |
| *215* | Requirement 5.5 - 5.7 – What patient information is MDH looking to exchange with Maryland county health departments and Maryland Office of Forensic Services and Maryland DCPS? Information needed include data elements, systems that these entities own to which we would exchange data | Answered previously |
| *216* | Requirement 5.9 – Does MDH need to upload a PDF of the treatment plan to the Medicaid database and is this just for the DD facilities? | No |
| *217* | EHR Requirement 5.2 Did MDH inadvertently miss this requirement? | Yes |
| *218* | EHR Requirement 5.10 What type of communication is MDH seeking that would be supported by the EHR? | data |
| *219* | Rev Cycle Requirements Requirement 1.10 What does MDH mean by registration error? | An error in registration information |

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| *220* | Can MDH provide more details as to the types of beds/levels of care being provided at each facility and Please also confirm the ALU's are considered residential beds or inpatient beds, which is how we interpreted them. | Perkins: Inpatient- 289, Total number of licensed beds- 298, Total number of beds- 289*<br>Springfield: inpatient 220, licensed beds -220, # of beds - 220<br>SETT (now in Hagerstown): Residential- 45, Total number of beds-59, Total number of licensed beds-62, budgeted beds-58<br>Deers Head: Inpatient-66, Skilled Nursing-80, Total number of Licensed beds- 146, Total number of beds- 146<br>Eastern Shore: Total number of Licensed beds- 84, Total number of beds- 84*<br>Western MD Hospital Center: Inpatient- 19, Skilled Nurse-36, total number of licensed beds: 123<br>Holly Center: Residential- 51, Total number of Licensed beds- 150, Total number of beds- 51<br>Potomac Center: Residential- 27,Total number of beds- 28, Total number of licensed beds- 32, budgeted beds- 28.<br>RICA Baltimore: Residential-45, Total numbers of beds-45*<br>RICA Gildner: Residential- currently 48, going to 53, total number of beds-53, total number of licensed beds- 80<br>Finan Center: Total number of licensed beds-88 |
| *221* | The RFP document states the response can be emailed, in the eMD website, it looks like the documents can be uploaded to the site, what is the proper procedure for submitting a response? The website states the solicitation type is RFP; Double Envelope Proposal, what does this mean? | The Department is aware the eMMA allows for uploading responses to the website, however, the RFP has requested all responses to be sent to Queen Davis's email.<br>With specific instructions for submission format. Please follow those guidelines. |
| *222* | Section 6.2 indicates that scores will be lower for responses that note "concur" or "will comply", however many of the section 2 and section 3 portions of the technical response are terms and conditions that must be met. Does this refer only to section 5.3.2 letter F item 2 Technical architecture or also to 5.3.2 Letter F item 1 that addresses RFP sections 2 and 3? | The Department will consider all responses on the merit for which they're given. As with any response to a question, if it is detailed with greater understanding, that could possibly allow for better critique or it could prove there is no understanding. However, the Department will not decide how a vendor should respond to this RFP. The Department expect all requirements to be addressed. The amount of detail is left to the responding vendor.<br>223 |
| *223* | Is the intent that the detailed technical response be contained primarily within 5.3.2 Letter F item 2 beginning at "Technical Architecture" or spread equally between 5.3.2 Letter F item 1 and item 2? | The section referenced (5.3.2) gives specific guidelines on how to present your response. The detail in section F of 5.3.2 details the order in which the technical response is to be formatted. Please follow the specific instructions in this section for ease of review from the evaluating team members. |
| *224* | Is there supposed to be a TAB N? Instructions (Page 61 of 117) seem to go from N. Legal Action Summary (Submit under TAB M) to O. Technical Proposal – Required Forms and Certifications (Submit under TAB O). | The Department deleted Tab N from the requirement as there is no MBE requirement. |
| *225* | Can MDH provide more clarity around the Living Wage reporting? Does this requirement apply to this EHR procurement? | There are instructions referenced for the living wage requirement. The responding vendor should check off that which applies to their company. This is a requirement of the RFP |
| *226* | 4.8 Public Information Act Notice -Our proposals are considered "Confidential and Proprietary" in their entirety and contain non-disclosure provisions. Please provide guidance. | As requested in the RFP, the responding vendor is to inform the Department that which is considered proprietary and or confidential information in their proposal. The RFP also requests a PIA copy be submitted with the proposal with all information considered proprietary/confidential redacted. See sections 4.8 and 5.3 (B) |
| *227* | 29.1.c. Limitations of Liability For all other claims, damages, loss, costs, expenses, suits or actions in any way related to this Contract and regardless of the basis on which the claim is made, Contractor's liability shall not exceed <<two (2) >>times the total value of the Contract or $1,000,000, whichever is greater. Section 6 ("Indemnification") of this {MISSING WORDS} The above limitation of liability is per | Third-party claims arising under Section 6 ("Indemnification") of this Contract are included in this limitation of liability only if the State is immune from liability. Contractor's liability for third-party claims arising under Section 6 of this Contract shall be unlimited if the State is not immune from liability for claims arising under Section 6. |

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| | incident. It appears that words are missing. Please supply the missing words. In addition, this paragraph raises concerns about unlimited liability. Please confirm that the maximum liability "shall not exceed <<two (2) >>times the total value of the Contract or $1,000,000, whichever is greater" in aggregate since per incident creates the potential for unlimited liability which will not be acceptable to most contractors | The Department can confirm that the phrase "<<two (2) >> times the total value of the contract or $1,000,000, whichever is greater," etc. is correct. |
| *228* | The State of Maryland Information Technology Project Oversight at: https://doit.maryland.gov/policies/Pages/default.aspx.aspx; --The link appears to be broken. Can you provide a link to the State of Maryland Information Technology Project Oversight information? | That Department is working to fix the sight. **Hopefully at the time of publishing these the Q&As the issue will be corrected.** |
| *229* | Contractor Roles listed in section 3.10.3 are different than Labor Categories in 3.10.4 and in Attachment B. Can MDH clarify the difference between the Contractor Roles and Labor Categories? | 3.10.3 describes the type of resources the Department requires for Contractor's fulfillment of the services. Section 3.10.4 provides the named Labor Categories the Contractor shall use to match as the labor category hat best suits the role of each position when submitting the resumes leave up to the vendor to match for |

# MDH EHR - RFP Questions and Answers May 11, 2020

#221: Section 2.2.2. - Can MDH complete the grid below with the additional user count information needed that was not included in the section for all users needing access to the system?

We've completed most of the grid per the information we could gather accurately. Also, we'd estimate approximately 36 pharmacists across the entire system. Currently, we outsource this function to the University of MD.

| Facility | # of Medical Doctors | # of Prescribers that are NOT Medical Doctors, i.e. Psychiatrists, NP's | # of non-Prescribers that may enter orders on behalf of another clinician, i.e. meds, labs, radiology, etc. | # of ALL other Staff not included in the previous 5 columns that would access the system, incl medical records, other clinical staff, administrative staff | Total # of Staff |
|---|---|---|---|---|---|
| CT Perkins | 23 | 58 | 294 | 84 | 352 |
| Springfield Sykesville | 11 | 33 | 251 | 94 | 378 |
| Potomac Center/SETT | 1 | 5 | 144 | 14 | 95+75=170 |
| Spring Grove | 13 | 44 | 450 | 92 | 600 |
| Finan Center | 4 | 9 | 105 | 21 | 130 |
| Eastern Shore | 9 | 9 | 84 | 33 | 126 |
| Deer's Head | 4 | 7 | 152 | 35 | 188 |
| Western Maryland | 5 | 6 | 122 | 24 | 151 |
| Holly Center | 1 | 5 | 120 | 23 | 148 |
| Potomac Center | | | | | 95 |
| RICA Baltimore | 1 | 6 | 67 | 25 | 98 |
| JLG RICA Rockville | 3 | 9 | 59 | 21 | 93 |