



- 1. If Collaborators aren't MTEC members, can they wait to join when the awards are announced?**  
*Yes, MTEC membership is not required for submission of an enhanced white paper. If your project is recommended for award, only the prime organization will be required to become an MTEC member at that time. Subcontractors do not need to be members if recommended for award, but are welcome to become members to take advantage of the membership benefits.*
- 2. If an offerer intends to submit an enhanced white paper that doesn't include a proposal to act as a primary contractor, but rather to function only in a subcontractor role, how should this affect the enhanced white paper?**  
*Yes, you may submit an enhanced white paper. The last bullet in Section 1 of the Enhanced White Paper template requires you to specify if you are in need of partners. It would be expected that you describe your intentions/desire to become a subcontractor to another organization in your Enhanced White Paper.*
- 3. RPP, Page 5: How do Phases I-IV in the diagram correlate to Tasks I-5? For instance, will successful completion of Task 3 be a proof of concept for Phase II or Phase III? Please clarify.**  
*Phase 1 in the NETCCN diagram loosely correlates to Task 1 in the RPP. Phase 2 in the NETCCN diagram loosely correlates to Task 2 in the RPP. Phase 2 in the NETCCN diagram loosely correlates to Task 3 in the RPP. Phase IV and the Enabling Technologies boxes reflect future phases of NETCCN that are not yet funded.*
- 4. RPP, Page 9: How heavily does having a cost-sharing component weigh in the Best Value evaluation? As discussed in section 5.2 of the RPP and during the proposer's conference, the optimal submissions will involve teams, but if a submission does not define teaming, they may be considered for their own unique contributions that could add value to another team. Evaluations will be focused on the capabilities of the team, but not specifically on best value. Best value is related to the entire review process as outlined in section 6 of the RPP.**
- 5. RPP, Page 13, 5.1: The last sentence of the first paragraph states: "The vision for this effort is to extend local tele-critical care capability sets to a broader, flexible network – first locally, then step-wise regionally and nationally – that can be leveraged wherever there is need." Do you mean that the desired system will integrate with existing tele-critical infrastructure and processes at the local level (wherever they exist) versus providing a total integrated solution that replaces them during the emergency? As discussed in the proposer's conference, then NETCCN system must operate under disaster conditions and should not be tied to a specific, EMR existing implementation. It is about leveraging a minimal footprint solution set that can be used nationwide.**
- 6. In support of COVID-19 response, the goal of this RPP is to support the rapid development, deployment and testing of NETCCN - a cloud-based, low-resource, stand-alone health information management system for the creation and coordination of flexible and extendable "virtual critical care wards". What does "low resource" mean in this scenario? As discussed in**



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*the proposers conference, low resource means minimal equipment (e.g. cell phone) and minimal communications as you might experience in a disaster situation.*

- 7. RPP, Page 14, ff: Do you intend that any individual virtual hospital ward/ICU will be populated by patients who are collocated within a single facility/site (be it a local hospital, gymnasium, etc.) and who are attended by the same onsite staff, or is there the possibility that a single ward might be composed of patients who are geographically distributed, with heterogeneous infrastructure and different onsite staff?**

*The Government wants Offerors to prescribe the solution. The Government does not want to prescribe the solution.*

- 8. Per the example of the elderly man receiving palliative care at home, could a single virtual ward potentially be composed of a cluster of patients receiving care in their respective homes?**

*Many teams out there already are already thinking through this problem. Offerors are required to describe how they will cohort or cluster the patients and describe how they will manage patients remotely. Offerors are required to describe how care teams will be organized to manage the patients. The Government will not be prescriptive on how this should be done. The Government does not want to trifle innovation.*

- 9. The U.S. Government DoD currently has up to \$7M FY20 funds for Tasks 1, 2, and 3 of this program. Total value for Tasks 1 through 5 was estimated at \$37M. \$7M is for Tasks 1,2,3. Is the remaining \$30M for Tasks 4 and 5?**

*We published the pre-announcement based on a holistic budget. The RPP includes known funding for Tasks 1-3. We expect additional funds but we are not currently in a position to promise additional funding for Tasks 4 and 5.*

- 10. RPP, Pages 18-20, Medical Experts: What is the expected role for the contractor's medical experts beyond development of the software and staffing model? For instance, is it expected that the offeror will participate in the selection and/or staffing of telecare medical experts for implementation of Tasks 1-5? How about during an actual response? Or are the contractor medical experts only for advising the development team?**

*The Government has critical care (CC) teams that can provide telecritical support. For Offerors that are unable to bring CC teams as part of their proposals, the Government may be able to connect/partner you. However, TATRC cannot guarantee that they can partner you with a robust telecritical care team. TATRC's telecritical care team will not be enough. For Task 1, you don't need a lot of CC providers to complete this task. If possible, Offerors should include clinical staff as part of their complete team to support the execution of the scope of work.*

- 11. RPP, page 18, Task 1: How is success defined in Task 1? Will the Govt provide use/test cases that we measure the system against, or is it up to the Offeror to put forward performance criteria?**



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*Combination of both. For each stage, TATRC will have a kickoff meeting with Awardees and review down select criteria and expectations.*

**12. RPP, Page 18, Task 1: What are the roles/functions of the Govt medical SMEs vs. the Offeror's medical SMEs?**

*Govt SMEs will participate in the management of the project. The Offeror's medical SMEs should be preferably critical care subject matter experts [SMEs], who will assist in the production of a solution composed of software, hardware, and workflow (+/- data analytics). Note: Upon award, the Awardee will be connected to government clinical SMEs.*

**13. Will these slides be available for download from Beta Sam or from MTEC?**

*No, they will not be posted to Beta Sam. They will be posted to the MTEC website contingent on approval from Army contracting and potentially the Army public affairs office.*

*[https://www.mtec-sc.org/wp-content/uploads/2020/04/MTEC-20-10-COVID-19\\_NETCCN-Proposers-Conference-SlidesFINAL.pdf](https://www.mtec-sc.org/wp-content/uploads/2020/04/MTEC-20-10-COVID-19_NETCCN-Proposers-Conference-SlidesFINAL.pdf)*

**14. Physicians are licensed to practice medicine by each individual state. There have been some temporary exceptions given related to this during the COVID-19 crisis but those are set to expire at a later date. How will this project handle the issues with delivering care across state lines and will the Offeror's physicians be required to be licensed in multiple states in order to participate?**

*This project is to produce a deliverable for use during a national emergency. How it is used outside of a national emergency or disaster is a future exercise to be sorted out by the Offeror.*

**15. Is HITRUST, FEDRAMP Cloud Security Platform required during Tasks 1, 2 or 3 or can the process to obtain FEDRAMP be in progress?**

*It is not mentioned in Task 1, but cited in Task 2 so that you know where the systems needs to go in the future.*

**16. Who will be responsible for malpractice coverage for the offeror's physicians? Malpractice coverage will have the same issues as licensure regarding state requirements.**

*Offerors will be responsible. Offerors could bring solutions to this question into their submission. Offerors could potentially take advantage of Good Samaritan laws, but this is not all thought through at this point. This RPP is not intended to fund and support malpractice insurance, reimbursement, etc. The sustainment and scaling evaluation factor will take into account challenges like this.*

**17. RPP, page 17, Item 4: The offeror is responsible for developing a staffing model that incorporates and calibrates for onsite proceduralists of varying levels of expertise/experience with critical care. What is the responsibility of the offeror with respect to the selection of specific onsite proceduralists? Do we simply provide the staffing model, or would we have a role/responsibility in recruiting and assessing them? The proposal is asking for the staffing**



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*model. The actual providers and patients would be determined by the locations of need and available of specialty care at the time of the disaster incident.*

- 18. Virtual plus local staffing model for at least 100 to 150 patients should be developed and well described by Offerors as a deliverable What does "deliverable" mean? Is this described as part of the RPP response (white paper) or a deliverable of Tasks 1, 2, and 3? A deliverable is a work product from the contract award. Staffing models are a specific deliverable to be provided within Tasks 1, 2 and 3 – e.g. a basic staffing model, and then how it can be scaled over time in a widespread disaster environment.**
- 19. RPP, Page 17, Item 5: This item states that the virtual plus local staffing model for at least 100-150 patients should be developed and described as a deliverable. Does this number represent the largest patient population that we would be dealing with to successfully complete Task 3? No, it is describing scaling of telecritical care. The number of patients will depend on the number of telecritical care experts. Ratios described in the presentation slides are notional. Offerors should describe what they think will work.**
- 20. This should be cloud based, ideally hosted on a HITRUST, FEDRAMP complaint server Is it the cloud security platform or the server HITRUST, FEDRAMP? The expectation is that the end products will be successfully hosted in a cloud based environment that is compliant with both HITRUST and FEDRAMP requirements**
- 21. RPP, page 18, Task 1: For early user testing, who will determine and supply the early user population? The offeror or the Govt? The offeror should include this as part of their proposal. The government (COR) will work with the awardees to approve or refine their plans.**
- 22. RPP, page 18, sec 5.2: We assume the contractor would be responsible for performing the alpha testing which would then be reviewed by Govt SMEs for pass/fail. Is this understanding correct? Yes, however the government may also conduct their own user assessments in addition to the offeror's testing for evaluation purposes**
- 23. Will reference tables be included in page count (Table of Contents, List of Exhibits, List of Acronyms, etc.) These are included in the page count. Please refer to the RPP for the contents required for the Enhanced White Paper.**
- 24. RPP, page 18, Task 2: For the beta testing, who will determine and supply the selected national TCC partners--the offeror or the Govt? Will the Govt supply the facilities? The offeror will propose clinical partners. Awardees will work with the government to facilitate collaboration across NETCCN awardees and clinical partners.**



**25. Is the "Prototype Project" the 45-day deliverable or the 15-day deliverable?**

*The prototype is the 15 day deliverable, scaling is the 45 day deliverable.*

**26. The Offeror must provide an estimate based on the technical approach proposed in the Enhanced White Paper. The following chart (tailored as appropriate shall be included in the Enhanced White Paper. If selected for award, a full cost proposal will be requested. Can MTEC clarify what should be included in the cost proposal for Section 3.1? Is it just a summary of estimated costs for Tasks 1 through 5? If team is later recommended for funding and invited to submit full cost proposal, does that cost proposal need to match the summary cost proposal submitted with the white paper? How are the 2 different?**

*The cost estimate included in the Enhanced White Paper is a very high level overview of the cost. Step 2 Cost Proposal is a very detailed cost proposal.*

**27. The Offeror must provide an estimate based on the technical approach proposed in the Enhanced White Paper. The following chart (tailored as appropriate shall be included in the Enhanced White Paper. If selected for award, a full cost proposal will be requested. What types of costs are included in the summary cost proposal with the white paper? Labor costs, product costs? Do we have to factor in any hardware purchase costs such as laptops, mobile devices, medical equipment, etc.? What about travel costs?**

*We don't imagine that you will be providing hardware as part of the solution. If you need to purchase hardware, then you need to include it in the proposal. We are wanting Offerors to use mobile devices as the hardware. The focus of the RPP is not the hardware.*

**28. Because members are encouraged to team - and the teaming org may not be a MTEC member - can these slides be available on the MTEC general site (ie not restricted to MTEC members)? Maybe another question is - do all team members need to be MTEC members?**

*The slides will be posted to the MTEC public website contingent on approval from Army contracting and potentially the Army public affairs office. MTEC membership is not required for submission of an enhanced white paper. If your project is recommended for award, only the prime organization will be required to become an MTEC member at that time. Subcontractors do not need to be members if recommended for award, but are welcome to become members to take advantage of the membership benefits.*

**29. RPP, page 19, Task 2: The first bullet at the top of the page requires scalability testing for multiple state coverage. It seems like this kind of coverage would apply more to later stages of development (for instance, Phase IV and Tasks 4-5). Please clarify.**

*If your task 1 delivers a prototype, then you need to think how it will work for more than 1 site. In these terms, you are scaling your network and you are expected to evaluate that.*

**30. Page 16, 2e - Integrated information sharing should include the ability to push training and educational materials to frontline clinicians, especially those who will be asked to provide care outside of their pre-emergency scope of practice. Question: Is this training for providers on**



**how to use the system or how to perform the role they are being asked to perform?**

*Training for users to use the app or web portal.*

**31. RPP, page 19, Tasks 2 and 3: Is the training component in the application intended strictly to train users how to navigate and maintain the application, or will it also encompass medical components of tele-critical care?**

*One of the challenges of providing care across the network. Different standards of care across regions of US. Need to communicate to different providers. Offerors could think about pushing a webinar. This effort may result in a governance structure for guidance on how to deal with a national emergency or disaster. This RPP focuses on models of care.*

**32. RPP, page 19, Task 3: The first bullet requires deployment to “multiple sites (dozens of sites are anticipated).” The implied scale of this requirement would seem to be tied to later Phases/Tasks. Please clarify. Multiple sites is the correct description for task 3. The expectation is that the early prototype in Task 1 should scale to multiple sites by task 3.**

**33. Can we get Lauren's contact info?**

*[Lauren.Palestrini@officer.mtec-sc.org](mailto:Lauren.Palestrini@officer.mtec-sc.org)*

**34. RPP, page 19, Task 3: How and when will deployment sites be selected, and by whom?**

*The offeror will propose clinical partners. Awardees will work with the government to facilitate collaboration across NETCCN awardees and clinical partners.*

**35. Is the \$7 million per team or a total to be divided between up to 6 teams?**

*To be divided to award up to 6 teams.*

**36. Are the 45 days calendar days or business days?**

*Calendar days.*

**37. RPP, page 19: This section states that the system will “ideally” be hosted on a HITRUST, FEDRAMP compliant server. Would it be acceptable for the application to be securely hosted on Azure Government Cloud by a certified Microsoft Government Cloud Solutions Provider?**

*Yes, that would be a prudent first step.*

**38. Per the statement on page 34 stating, "If no SOW is submitted with the proposal, there may be no award." Can the SOW be submitted with the full cost proposal after down select?**

*As per Section 10 of the RPP, SOW (4.1) is required as part of your Enhanced White Paper submission.*

**39. Is it guaranteed that the initial 7m will be awarded? Or is that still subject to change?**

*Yes, \$7M is currently available. It will be awarded contingent on the quality of the submissions received.*





**40. Considering the Section 1 response on timeliness, are details on tasks 4 & 5 required? Or, is this only for the first 45 days?**

*As stated on Page 18 of the RPP, "The intent of this RPP 20-10-COVID-19\_NETCCN\_TATRC is to initially award Tasks 1, 2, and 3. Information regarding Tasks 4 and 5 is intended to provide context so the Offeror is aware of potential work that could follow-on after the completion of Tasks 1, 2, and 3. The Offeror does need to price and provide details on how they would complete this follow-on work in Tasks 4 and 5." The level of detail for Tasks 4 and 5 should be to the best of the Offeror's ability at the time of submission.*

**41. Tasks 4 and 5 are very amorphous, and the scope and pricing will be subject to extensive reevaluation and revision depending on the results of Tasks 1-3 and the data that is uncovered regarding local abilities and the desired peripherals to be linked to the system. We assume that we can revisit the pricing for these tasks later (in the event that a follow-on award is made), and will not be strictly held to the ballpark estimates we will make for this white paper. Is that correct?**

*Yes, that is correct.*

**42. Task 3 talks about using real world data. Question: Will the Government provide assistance obtaining an interim Authority to Operate (iATO) prior to the start of Task 3 (which is 30 days after award)?** *The government will assist when appropriate, however as discussed in the proposers conference, there is no expectation of achieving a full ATO by phase 3, but the offeror must have a clear path to accomplish this as a follow-on activity, should funding be available.*

**43. Will a 3rd party security organization be conducting a security authorization for the system prior to go-live?**

*Not to our knowledge. There is no expectation that this would be needed within the first 45 days (Tasks 1-3). We want you to be prepared to achieve security requirements in time, but would only be a component for a Tasks 4 and 5. Security authorization will be a topic that is addressed during the kick off meeting between Awardees and Government. NOTE: Information must also be HIPPA compliant.*

**44. The White Paper cover page requires that we assert the validity of our offer for 3 years after close of the RPP. That would be an extensive period to certify the proposed cost. What is the minimum acceptable period of proposal validity for the cost?**

*If your company is unable to assert a 3-year validity period, please assert what your organization is able to with a recommended minimum of 180 days.*

**45. The available funding of up to \$7M is to be allocated to up to 6 potential awardees for the demonstration project. This means approximately \$1.16 M for each of the initial awards. Please validate this understanding.**

*It is not necessary that the \$7M be divided up evenly. In addition, please take into account that we intend to downselect after each task, so the number of Awardees may be reduced from task to task.*



- 46. Appendix 4.1: Statement of Work: Should the proposed SOW identify the offeror and teammates by name in delineating the tasks, or should it be written in an offeror-agnostic style, i.e., "the contractor team"?**

*It is helpful to identify teammates' tasks in the SOW.*

- 47. Would it be permitted to be a part of 2 different proposals for this award, esp if I am not the PI for either?**

*Yes.*

- 48. What kind of contract funding vehicle is anticipated for this task--e.g., firm fixed price, cost reimbursable, etc.?**

*This is up to the Offeror to choose between firm fixed price or cost reimbursable.*

- 49. If an authorization is required to go-live, what framework, revision, and level is the 3rd party security organization following to provide authorization (NIST 800-53, HIPAA, etc.)? As discussed in the proposer's conference, there is no expectation of 3<sup>rd</sup> party approvals by the end of phase 3, but the proposers should keep these important factors in mind for follow on work that will require this.**

- 50. If we are a WOSB non-traditional defense contractor (with a FedRAMP Ready) cloud application (Impact Moderate / Public Cloud) is it correct that we do not have to contribute 1/3 of the budget?**

*That is correct.*

- 51. Does a non traditional provider need a cost share component to their proposal?**

*No, it is not required to meet the Other Transaction Agreement compliance requirement.*

- 52. Will integration with an existing IT Service Management system be required, or may the offeror leverage their own? The offeror can propose their own IT system, if applicable.**

- 53. Our understanding is that if the prime has never held a DoD contract and is performing a significant amount of the work on the team, then it qualifies as a nontraditional defense contractor. Is this correct? Yes**

- 54. What liability (if any) does the contractor team assume for any potential claims associated with performance of the deployed system and patient outcomes during an actual emergency?**

*The offeror assumes liability for care delivered as part of this project.*

- 55. In 5.2.4 it says the NETCCN traffic might be prioritized over less crucial communications. Question: Should offerors include tasks in the PWS to configure local networks to prioritize NETCCN traffic, or can we assume the local system administrators will configure their**





**networks to prioritize NETCCN traffic?** *The proposer should describe approaches as to how this data could be prioritized as the local sites will vary in each disaster and will not be known ahead of time.*

**56. Is there a minimum set of onsite hardware/bandwidth standards/capabilities/ infrastructure that will apply to the care sites that we can assume in structuring our solution?**

*A mobile phone.*

**57. What is the difference between data rights and ownership of technical IP?**

*Use the data rights table to assert all of the IP that you own. The Government will review this and negotiate with you.*

**58. Can I assume that in 95% of cases, the local site will use an EMR of the local health system as is the case in NY and Chicago? In other words, the sites will use existing EMRs and the solution should be able to integrate with those EMRs in days?**

*Assume no EMR because you may not have connectivity in an emergency setting. The proposed solution should be standalone.*

**59. Outside of HIPPA and HITRUST, are there any other government standards that the system needs to meet?** *FEDRAMP cloud computing environment, as stated in the RPP.*

**60. Seems like a US public university qualifies as NRI, and therefore is not required to provide any cost sharing? Is the cost sharing still recommended also in these cases, and would this be taken into consideration in the reviews of the proposal? Although not required the government does look favorably on any cost share proposed.**

**61. In respect to being at the prime level, how do DFARS flow-downs apply?**

*Any flowdowns from the MTEC OTA are found in the Base Agreement located on the MTEC website.*

**62. Will insurance verification need to be part of the physician/patient encounter workflow?**

*The Government does not want to prescribe this. Offeror must propose what they think is best.*

**63. Is functionality that allows physicians to submit orders for on-site care and collect feedback on the results required (i.e., to instruct on-site staff on services and tasks to be performed)?**

*The offerors are asked to propose solutions for a disaster scenarios where specialty consultative care can be effectively communicated to the remote site, and monitoring remotely but we are not specifying the mechanism in which that occurs.*

**64. Will there be a need for live, multi-party video encounters?**

*The Government does not want to prescribe this. Offeror must propose what they think is best.*

**65. Will remote staff need to have oversight features or the ability to patch into an existing**



**session?**

*Offeror should propose his/her best staffing model. If the question is referring to customer/technical support, then the Offeror must build this in.*

- 66. When a patient is added to the system, is it expected that the system will automatically pull information from various sources so that the physician will see the medical history for the patient (i.e., past history, meds, investigations, encounters, and vitals)? Do not assume any available connection to a EMR, PHR for the initial tasks.**
- 67. Is it required for every sub-contractor to become a member of MTEC upon selection in addition to the prime? No just the prime.**
- 68. How should offerors provide costs that are unknown? For example, the cost of hosting in AWS GovCloud will vary based on the volume of traffic, number of CPUs required to process that traffic, and volume of data stored. Should Offerors provide variable costs as a cost per patient, or per provider? The offerors should propose costs based on their unique concept of the solution set, this will not be prescribed by the government.**
- 69. What roles and pricing model would be used for vendor support post-Task 5? Would it be for support/maintenance/help desk/hosting/enhancement? How would the vendor be compensated for any technology use that is provided with restricted rights? The proposers should explain their cost models for sustainment for consideration, this will not be prescribed by the government in advance.**
- 70. If we are proposing commercially available off the shelf solutions in developing this proposal, what is the treatment for IP right?**  
*Please complete the IP/Data Rights table to include your assertions and these will be reviewed and negotiated by the Government if selected for award.*
- 71. Does the Govt anticipate requiring 24/7 contractor support during Tasks 4-5 and beyond?**  
*During disaster situations, this may be a requirement*
- 72. What is the definition (size standard) for a Small Business for this procurement?**  
*The U.S. Small Business Administration (SBA) size standards will be used to determine business size. Small business size standards define the largest that a business concern, including all of its affiliates, may be and yet qualify as a small business concern for SBA and most other federal programs. The SBA has established two widely used size standards – 500 employees for most manufacturing and \$7.5 million in average annual receipts for many non-manufacturing industries.*



**73. Should the Appendices be submitted as a separate file or just included at the end of the White Paper?**

*Yes, they are uploaded into BIDS as separate files.*

**74. What is the desired roll-out scale for each Task? Please refer to the NETCCN diagram for patient to provider ratios for Phases 1-3 as they align to tasks 1-3 in this RPP.**

**75. Is it expected that there will be multiple awardees for the same function and type of service that will be competing against each other for a down-select to the next task?**

*Yes.*

**76. Is a library of video tutorials related to system use and solutions to potential issues a desired feature? Training aids are desired, the government will not be prescriptive of the nature of those training aids, but keep in mind that communications may be limited or disrupted in disaster scenarios.**

**77. For the funding of Task 1/2/3 and the statement that multiple awards (up to 6) may be issued. Are the awards designed to address specific aspects of Task 1/2/3 or could the awards be duplicative? i.e. you have 2 contracts providing their respective solution for all of Task. Each proposer should submit a proposed that is comprehensive for Task 1-3 whenever possible. There is no intent to award multiple awards to the same proposers.**

**78. If a program is led by a public university, is cost sharing required? Not if the University is considered a Non Profit Research Institution. A Nonprofit Research Institution means an entity whose primary purpose is conducting research and that is (1) described in section 501(c) of the IRS code of 1986, AND (2) exempt from tax under section 501(a) of that code.**

**79. What level is considered "significant participation" of non traditional defense contractor? Level of significance can vary depending upon the value the significant parties bring to the effort. Section 2.8 outlines the rationale to justify significance. Please be sure to complete the Warranties and Representations to explain the significance and role for each NDC or NRI.**

**80. For Section 2.1: Programmatic Relevance, Subparagraph "Timeliness: Describe how you will deploy your technology for field use." What format would you like this information in (e.g. Gantt Chart, bulleted list, etc)?**

*There is no required format. You should use the format that best conveys your information.*

**81. Can the funding be used to pay for subcontracts for specific parts of the work? Is there any limitations in how and when subcontractors are identified? Should these be identified in advance of submission, or can these be managed by the grantee after the award?**

*Subcontractor support is allowed. At the time of EWP submission, please provide as much*



*information as you can regarding the proposed Subcontractors. However, if requested to provide a full cost proposal, Subcontractor costs should be provided with the same level of detail requested for the Prime. The Proposal Preparation Guide, which you will have access to, if selected, provides further information.*

**82. Must we use the exact same headings in the template in our response?**

*I would encourage you to do so.*

**83. Who do we contact again to see if our company is a nontraditional/traditional contractor? You**

**can check with your accounting department.** *Usually if you are a small business and you don't do a lot of business with the DOD you would be considered non-traditional. Here is the definition. The term Nontraditional Defense Contractor is a business unit that has not, for a period of at least one-year prior to the issue date of the MTEC Request for Project Proposals, entered into or performed on any contract or subcontract that is subject to full coverage under the cost accounting standards (CAS) prescribed pursuant to section 26 of the Office of Federal Procurement Policy Act (41 U.S.C. 422) and the regulations implementing such action.*

**84. Approximately when will MTEC notify offerors after the Stage 1 evaluation? As soon as**

*possible.*

**85. Who can we contact for assistance on teaming?**

*Already answered above.*

**86. Will these slides be made available for sharing after the presentation? All very helpful. Thank you.**

*Already answered above.*

**87. Does the definition of Nontraditional Defense Contractor that references work on contracts or subcontracts refer to defense contracts or any federal contract?**

The term Nontraditional Defense Contractor is a business unit that has not, for a period of at least one-year prior to the issue date of the MTEC Request for Project Proposals, entered into or performed on **any contract or subcontract** that is subject to full coverage under the cost accounting standards (CAS) prescribed pursuant to section 26 of the Office of Federal Procurement Policy Act (41 U.S.C. 422) and the regulations implementing such action.

**88. Funding:**

**-How much additional funding do you believe will be available for phases 4 and 5?** *Phase 4 and 5 will only be offered if funding is available, the amount of funding is unknown at this time.*

**-How much funding do you believe will be available to manage maintenance of the solution on a go-forward basis? Do you anticipate it would be fee for service? An Annual fee? That**



*information is unknown at this time.*

- 89. Where in the application is a bibliography desired/allowed? I suspect that a strong application might have an extensive bibliography, particularly to demonstrate prior work done in this area, which speaks to feasibility.**

*It must be included within the specified page limits of the enhanced white paper.*

- 90. Will the \$7M be split among the up to 6 awardees for this phase?**

*Already answered above.*

- 91. Awards:**

**-Is it preferred that clinical staffing of virtual intensivists, CCRNs, RTs, and other specialists be included in responses to this RPP?**

**-How will this be staffed clinically? By DoD/National Guard personnel or would the government plan to issue solicitations for staffing or award non-compete awards for staffing?**

**-What would be the structure of the award? Fee for service?**

*The offerors should propose clinical partners as part of their proposal and not rely on the government for clinical staffing. This project will not support reimbursement for clinical service delivery.*

- 92. Assessment Fee:**

**-Could you please expand on section 2.11 in regards to licensing/commercialization? What would be an example of how a proposed project would be licensed/commercialized?**

**-What amount does the "200% of the government funding provided" refer to? Would it be the amount that the entire teamed group receives from the government (for example, \$1 million of the total \$7 million, therefore the amount is capped at \$2 million?)**

*By definition "Commercialization is the process of introducing new products or services to the market" It involves production, distribution, sales, and other key functions related to bringing technology to the market. The 200% cap applies to the total Government Funding provided for the entire project. For example, if the total project value includes cost share, cost share would not be included in calculating the 200% cap.*

- 93. Can offerors modify their cover page as long as it contains the required information and certifications as defined in the RPP?**

*We prefer that you use the format described within the RPP.*

- 94. Will contract terms include DFARS 252.204.7012 Safeguarding Covered Defense Information and Cyber Incident Reporting?**

*No*



**95. How important are radiology images availability in the neccn context?** *No requirement at this time.*

**96. Is there an identified “alpha” test site and “beta” test site? Is it permissible to perform the alpha demonstration from a site that is already operational for civilian hospitals?**  
*No, Offerors will suggest these.*

**97. For the central hub site, will the DoD, DHA, or Army staff that hub for alpha and beta tests, or will staffing be with our project team? Our intent for the Alpha test is to show the staffing by current intensivists, critical care nurses, respiratory therapists, etc., but we would like clarification for staffing for the beta test.** *The offeror will propose clinical staffing for the project.*

**98. Is there a target EMR/HMR that is of particular interest to DoD for the demonstration phases?**  
*There is no requirement for an EMR/HMR integration for Tasks 1-3*

**99. Is there a target FEDRAMP provider or can we negotiate for any HITRUST FEDRAMP provider?**  
*No.*

**100. Can offerors modify the appendix templates long as it contains all the information verbatim as defined in each on in the RPP? Can we include a cover page for each of the separate appendices?**  
*We recommend that you use the templates provided.*

**101. Is the intent to host the NETCCN from a physical hub location and allow users to remotely access central hub control center displays?**  
-If answer is both, will our proposal need to include the PCs, laptops, monitors, networking devices for the central hub?  
-Must the central hub be in a DoD area; or could we co-locate with a civilian telemedicine group?  
*The project seeks to support “anywhere to anywhere” connectivity and not necessarily hub and spoke. The offerors should propose hardware as appropriate to support their models of care and technology solution(s).*

**102. What personnel IT/network resources are anticipated to be available during rollout of the solution? Experience with routers, firewalls, wireless access points, switches, etc.** The offerors should not assume that the government will supply staff to support IT and/or network for this project.

**103. Is a “principle investigator” required for this effort?**





*The PI should be the person in charge of the effort, in other words, the PI may be the project lead Point of Contact.*

- 104. Can you please give other examples of known barriers which need to be addressed? (per the statement from Col Pamplin) *Compressed timeline, device interoperability, network access/reliability, provider licensing and credentialing, billing and reimbursement for services***
- 105. Liability coverage is an important barrier for scaling telemedicine systems. Are offerors expected to provide the liability coverage for field implementation, especially for task 3 (regional implementation)? *No this will be after task 3***
- 106. Dr Pamplin, do you expect another wave of infections in the fall after temperatures come down from the peak during summer? *We are following guidance from the CDC on this – which does raise the concern of a COVID-19 resurgence.***
- 107. When you say that "Section 1" is the first decision gate for submitters - are you referring to the TWO PAGE Section 1 in the Proposal Guideline? *yes***
- 108. The use case is different than that for the warfighter in that the COVID can invade your home and disrupt your family. It is more complicated in that respect. Triage has a multiplier factor. *All should be considered in your proposed solution set.***
- 109. How will other DoD healthcare and communication programs (like Genesis, JEDI) impact the proposed NETCCN solution? *If we move into a future phase, yes it will impact it a lot, but we are not there yet.***
- 110. What requirement is there for data in motion security? *No, not in Tasks 1-3***
- 111. The RPP mentions "Beta testing by selected tele-critical care partners using real patients and experience providers." Have the Tele-critical care partners been identified already? What types of organizations does MTEC envision staffing the central hub? Is that a part of this RPP? *Offerors should propose clinical partners for their team proposals.***
- 112. Is the NETCCN solution insulated from current commercial tele-ICU in some fashion to current installations continue to rely on existing solutions? *NETCCN is intended for use when either the Tele-ICU tools do not exist or are disabled due to the nature of the disaster.***



- 113.** In the Small, Rural Hospital example, is MTEC expecting that these hospitals would staff up to handle the 100-150 patients, or is that number exclusive to the field hospital example? *Both should be considered.*
- 114.** Cellular assets (smarthones, tablets) endpoints are critical for telecritical care - for both the providers, responders and patients. This applies to both field or portable healthcare, virtual healthcare formal hospital settings. Today, mobile endpoints can totally replace other IT computing assets as well as be hand carried and docked at work stations by staff. Does the NETCCN requirement include offerors providing these mobile endpoints as part of their solution? *As discussed in the proposers conference, the hardware should be readily on hand, such as a mobile phone.*
- 115.** Is the NETCCN solution insulated from current commercial tele-ICU in some fashion so current installations continue to rely on existing solutions rather than overwhelm the new NETCCN solution? *They are separate entities.*
- 116.** How much can we utilize existing technology and patient care models which are not currently critical care scenarios? Can they be integrated into the NETCCN? Many primary care physicians already have tele health or tele medicine tools and procedures which enable patients (sheltered at home) to interact with healthcare professionals remotely (from home). My son recently was diagnosed and give a prescription by allowing the doctor to see his rash via a smart phone. This is not a critical care scenario, but it demonstrates how the tele medicine tools are already available and being utilized today. *The intent is to propose existing technology solution sets, as there is not time to develop new ones and meet the timetables.*
- 117.** The RPP mentions, "It is recommended that high fidelity simulation and/ or real-world use guides agile development in this phase." Is there a want for a demonstration using simulation to prove that the suggested solution is actually functional? What does this exactly mean? *High fidelity simulation helps randomize care situations w and without tools and allows for a rapid iterative process. In the RPP, high fidelity simulation should be used to guide the development.*
- 118.** Is there a situational awareness requirement to support patient transfer from a lower level of care to a higher level of care if resources are available and patient clinical status permits? This is another use case for the system to monitor patients during transfer. It seems *plausible to include this as part of the proposed system.*
- 119.** We understand that the EHR info integration may not initially be required in a tele critical care model, but what about patients who have existing lung diseases which can increase their



**risk of death?**

*One of the challenges is that many of these questions coming in from those listening in are focused on the health care system we have in front of us. NETCCN is designed to be mobile, adaptable, flexible, and able to collect information in the event that there is no health care system available. Consider the analogy to contact tracing. Consider Hurricane Maria or Katrina as use cases.*

**120. Most rural hospitals have a EMR. In those cases would NETCCN documentation still be required?** *Yes, in emergency situations NETCCN would could be used outside of formal hospitals, which do not have an EMR.*

**121. How do you plan to address the current issues of inaccurate, unreliable testing tools? Many of the deaths today are because there are false negative results due to problems with the testing tools being given for the few citizens who can find a source for testing the virus.** *Specific virus testing is not part of this RPP*

**122. Will we have access to provisioning data of physical devices, in cases you need to "drop in" ventilators and other equipment, to help with connectivity?** *Awardees will work within their teams to ensure device connectivity.*

**123. Do we need to have training/guidance for clinical/non-clinical/civilian personnel fully thought through, or can this be developed past task 3?** *Some end user training is expected to be provided in Task 1 so the government can use the prototype, but it can be expanded over the phases.*

**124. Will the proposed solution be envisioned to serve more than the patient populations with COVID-19 related illnesses? For example, hospitals will require staffing and expertise to continue to provide usual care to their patients presenting with stroke, MI, trauma needs that require critical care support on top of the COVID-19 surge. Would the proposed solution need to support patients with primary needs in OB, NICU, Peds, and Behavioral health?** *NETCCN is intended to provide support in disasters, the current disaster is COVID-19 centric, but provided remote consultative support for all disasters is the intent of the project.*

**125. Is there a lifting of HIPAA requirements for this purpose?** *No*

**126. Is the 15 day window calendar days or workdays?** *calendar*

**127. We have seen problems with the role out of other important DoD healthcare platforms in**



the field. For example, there were integration and performance issues in the Northwest when the Genesis program infrastructure were initially rolled out? Will there be over-sight on the NETCCN program to ensure there are not delays or design issues? What are the plans for corrective actions? Will there be change control option to fix or replace failing technology and/or incompetent vendors? *The government will implement the down-select process described in the RPP to ensure awardees meet project requirements.*

- 128.** For the cloud-based HITRUST, FedRamp compliant server as a part of Task 2, will an ATO/IATO need to be obtained, or is the expectation that an ATO/IATO will already be in place? *As discussed in the proposers conference the ATO/IATO will apply to task 4, which is currently unfunded.*
- 129.** Should we anticipate the solution also meet FEMA and HHS requirements? Or will those possibly be separate efforts? *The intent is for NETCCN to be used by the DoD and FEMA/HHS in the future.*
- 130.** Are the offers concerned that the pandemic could prevent assembly of groups for large scale testing at single sites or across a region? *No*
- 131.** What if the submitter has 3-4 systems that need to be combined to facilitate Task 3, but cannot be integrated in Task 1 (15 days) - but the 3-4 systems demonstrate comprehensive capabilities that are being and will be integrated by Task 3 (45 days) *Please outline your details approach in your submission.*
- 132.** Is the government primarily looking for a software solution? *Software is only one aspect to be addressed in this RPP.*
- 133.** During beta testing, will the gov't provide the "national tele-critical care partners using real patients and experienced providers"? *Offers and their clinical partners should incorporate this in their proposals.*
- 134.** Is real-time physiologic data is included in the software requirements? *Please review Section 5 of the RPP.*
- 135.** For tasks 2 and 3, does the offeror have to actually supply the providers OR describe the staffing model that could be implemented with the government as a partner? *The offerors and their clinical teams should supply providers.*
- 136.** Is there a role for a telementoring application that helps guide the performance of critical care tasks? *Possibly*
- 137.** Do you anticipate the need for interaction between non .mil and .mil environments? Especially as you deal with local providers in rural areas.



*It is likely that there will be military and non-military awardees in the NETCCN project.*

**138. It is difficult to have a clinical partner to field this solution within the timeframe.** *Yes, this timeframe is extremely compressed.*

**139. What is the period of review to assess deliverables between tasks? The RPP suggests each task begins immediately after the prior is completed, but the presentation suggests there is a 1-2 week period of review between tasks.** *Awardees will work with the project COR to schedule reviews.*

**140. The RPP says that you would consider conceptual solutions?** *Offerors should propose actual – not conceptual - solutions that meet the staged requirements.*

**141. How does the content of the SOW differ from that in the white paper itself? There seems to be some overlap in content.** *There can be overlap. We ask for the SOW separately so we can easily negotiate the SOW and make adjustments. The SOW is what goes on contract.*

**142. We are confident that cloud services will be an important tool for data management of the NETCCN program. Will there be a separate bid for the cloud providers? Or, do we need to have our partnership with cloud providers defined for the RPP before the award?** *This needs to be part of your proposal*

**143. Will a solution that assumes that patient registration and cohorting will be done in the EMR of a local health system pass the minimum required capabilities screening?** *There is no EMR requirement in this RPP.*

**144. Will the different 6-7 awardees need to collaborate on a system that eventually converges? Or will they be individual, disconnected systems?** *Not all of the Task 1 awardees will advance to task 2. Those that do advance should expect some collaboration and or lessons learned by task 3*

**145. Is a small business able to serve as a Prime with additional small business and nonprofit research partners or would you prefer to see a team of small businesses reach out to MTEC staff for teaming with MTEC members?**

*You should propose the best team to accomplish the required scope of work. There is no preference to reach out to MTEC staff for teaming with MTEC members.*

**146. Is there any requirement to manage and secure mobile devices given the security concerns about patient data on mobile devices?** *Yes, your proposal should address how you intend to protect patient data.*

**147. If we are a technology vendor with primary capabilities in sections 4-5 should we still try and team to include capabilities or will this not be evaluated?** *As stated in the RPP- team are*



*preferred, but those could be internal teams or external partnerships – that is at the proposer’s discretion.*

**148. Col. Pamplin mentioned getting going "within two weeks" (arguably, 5/11 based on 4/27 submission). Earlier slide suggested 5/27 award. Can you clarify?**

*Yes, if we can move faster to award, then we would love to do so.*

**149. Are Proposers to include the Clinical Staff as part of the Proposal? Meaning are the Clinical Staff to be employees or partners of the Proposer? Offerors should include clinical partners and expertise as part of their proposals.**

**150. Documentation outside the standard electronic medical record sounds like a bad idea. Can you describe this point a bit more? As stated in the proposers conference, in a disaster scenario the EMR may not be available. The intent is that a mature NETCCN solution could export data to EMRs in the future, but that is not a requirement of tasks 1-3**

**151. Regarding scale/capacities, how many clinicians/patients should the solution accommodate? Offerors should propose how many clinicians / patients and other aspects of scalability their solutions can support.**

**152. What level of granularity on staff and telecritical care personnel is expected via the request for "a well described clinical and staffing model that incorporates the technology in a simple reliable manner for scaling during a disaster". Is it truly a model, or is there an expectation of the offeror to provide full staff / telecritical care augmentation as well? Offerors should describe their clinical models as part of their proposals.**

**153. In the response to RPP, are you looking to understand how each component of the solution fits within the FDA framework? Offerors should propose technical solutions that meet appropriate FDA clearance.**

**154. How important is the ability to visualize data across the system? and allow data visualizations to help assist the teams in their job? It is important.**

**155. Even though this is called a tele-critical care network, for a patient who is stuck at home, it is unlikely to have critical care level monitoring. Is that the expectation? The NETCCN solution set could be expanded outside of the ICU setting in the future, so that use case should be considered.**

**156. Where can we find the database of the MTEC network of other “talents? On the MTEC members only website.**

**157. FedRAMP and HITEC were mentioned as required standards. Is compliance with DoD**





**network standards such as the Approved Products List and Encryption FIPS 140-2 in motion and at rest required as well?** *Consider those factors with respect to scaling to Task 4, which at this time is unfunded.*

**158. What is the relative importance of capability to scale versus demonstrated scale/adoption?**

*The screening requirement for "Feasibility/Timeliness" in Section 6 of the RPP describes this criteria: "Does the proposed project support rapid development of all the capabilities described in the RPP, and does it seem reasonable and realistic to accomplish the project tasks on time as outlined in Section 5 of the RPP and with high quality?"*

**159. The announcement email includes requirements not included in the actual RPP file (20-10-COVID-19\_NETCCN.PDF). For example, in task 1 the email requires "The Offeror must also be able to describe information assurance and cyber security features of their product"**

**Is the additional guidance provided in the email announcement strictly for potential discussions after submission of RPP responses? Please clarify if bidders are required to respond to the scope elements in the email announcement that do not show up in the RPP file.** Offerors should address cyber security features as part of the feasibility of their proposals.

**160. Why the short timeline? doesn't this essentially preclude innovation?** *We are in a disaster environment at this time and need to move out to support our nation.*

**161. Should we assume there is portable x-ray capability in the gymnasium example (for Tasks 1-3)?**

*Make no assumptions about hospital capabilities for Tasks 1-3.*

**162. To what extent will the solution need to support documentation by staff at the patient's bedside?** *Offerors should propose these functions per Section 5 of the RPP.*

**163. Task 4 calls for integration of medical devices beyond wearables. How many devices does the government want to see demonstrated? And are any of them to be government furnished equipment? Or does the awardee need to cost and provide those?** *The offeror should describe the medical devices, wearables and other technologies in their solutions.*

**164. Besides from SMEs on the team to guide configuration/development/deployment, is it the expectation to have a network / source of intensivists or other critical care specialists to staff the virtual ICU / command center?** *Offerors should describe the clinical components of their teams.*

**165. How many users are expected for Task 3 - deployment at regional- or state-level?** *This is not defined at this time.*

**166. Do all of the devices that will be used for remote monitoring and evaluation require FDA**

**approval?**

*The Government has not described any specific devices for this effort. It depends on what you propose. The timelines for this project will not support de novo review by FDA.*

**167. The proposal will include hardware, software, services and staffing model. Does it have to include staff that will go with these units or will military assign 2 nurses per portable unit for say a ward of 10 ICU beds deployed in a tele-critical care setting with an intensivist at a central location?** *Staffing should not include assignment of nurses by the military*

**168. Can additional staff be allocated on site at peak surges for the gymnasium scenario?** *This is up to the offerors, as appropriate*

**169. Is there an option to send a “palliative care kit” [monitoring/sensor device(s), basic pharmaceuticals, other palliative treatments, etc.] to the patient (which might arrive on Day 2 or 3) in the at home scenario example?**

*Device component of this effort is not really until Tasks 4 and 5.*

**170. It is stated that patient flow including to lower acuity care areas, and one of the examples involves patient / family at home. Is it expected that the solution does not just connect across multiple virtual ICU, but also to virtual ward/clinic and home spanning the continuum of care?** *This is up to offerors as appropriate. The goal of the project is anywhere to anywhere connectivity.*

**171. Is it required or encouraged for the solution to demonstrate extensibility to additional / new devices/data streams/non-covdi19 therapeutic areas?** *This is up to offerors, as appropriate*

**172. What are the range of palliative care treatments available to a patient at home?** *This is up to the offerors, as appropriate*

**173. While intended as a national emergency response, should solution address privacy protection of patient data and enforcement of state medical board / federal licensing requirements?** *Yes, as appropriate.*

**174. In the field, who will provide the Tier 0 and Tier 1 operations support?** *It is up to offerors to describe their approach to operations support.*

**175. Remote documentation will be largely manual as opposed to automated entry at hospitals..e.g. labs, vitals, vent settings...is that the intent?** *Correct – do not assume connectivity or use of an EHR.*

**176. Should the solution address assets requirement in terms of equipment (e.g. monitors/beds),**



**supply (e.g. PPE) to standup and operationalize a virtual ward?** *Offerors should NOT plan to propose the purchase of beds, PPE and labor to stand up and maintain field hospitals and other virtual wards as part of this project.*

**177. If a prime contractor is a large company and the small business is providing the technology, will this model be acceptable?** *If it adheres to the requirements outlined in the RPP*

**178. Are beta sites selected by MTEC or identified by each offeror as part of their proposal?** *By offerors*

**179. Will the government provide the field hardware and devices?** *Offerors will propose approaches appropriate their platforms and models of care*

**180. Regarding SMEs, how many SMEs is the offeror expected to provide, and how many of them need to be actively participating in e-ICU or remote treatment platforms?** *It is up to the offeror to provide clinical expertise on their team to demonstrate appropriate capability and capacity to meet the project requirements.*

**181. Have the sites been determined? Where? How many? Do they know the local environment requirements? What is the minimum / least common denominator infrastructure considerations? Have the sites been determined? Where? How many? Do they know the local environment requirements? What is the minimum / least common denominator infrastructure considerations?** *Offerors should assume mobile connectivity. The offeror will propose sites.*

**182. How many sites will the offeror need to implement? How will the sites be chosen (by the offeror or MTEC)?** *The offeror will propose this.*

**183. Is this solution seen as a SaaS solution that is totally turnkey?** *It is up to the offerors to propose this.*

**184. What is the availability and access requirements for the data sources? How many data sources are anticipated to be integrated? ? What is the format of the data to be ingested?** *It is up to the offeror to propose this.*

**185. Do the physicians, nurses, and other medical personal already have the hardware with video and other telecommunication capabilities to be able to participate in the ecosystem or would the hardware need to be supplied as well?** *It is up to the offeror to propose a model for this*

**186. (a) Does the offeror's cloud system require both HITRUST and FedRAMP certification? (b) FedRAMP grants authorizations to Cloud providers at three impact levels: low, medium, high based on the nature of data being handled by the cloud platform. Based on your analysis what risk level would you assign to NETCCN 's cloud platform (c) Will the ATO**



**approval process be expedited to meet the security review and approval requirements for the application to meet the desired timelines?** *Proposers should plan to have a PATH to FedRAMP conformance by the end of Phase 3*

**187. How should we include special qualifications of team SME's in the proposal?** *The offeror should include information on team members' qualifications as appropriate to demonstrate experience and skills*

**188. a) Is the offeror expected to develop use cases to demonstrate the capture, exchange and archive of medical information (as part of the Alpha testing in Task 1)?**

**b) Does the offeror need to demonstrate mobile technology and IoT integration as part of Alpha testing in task 1?**

*The offeror should plan to demonstrate the functions of their platform per the requirements*

**189. For illustrative example #3 you mention mobile devices and wearables, are those provided by NTCCN or will those need to be provided by those selected for the Tasks 1-3?** *The offeror should propose the approach best aligned with their model*

**190. For Task 1 (15 days) and Task 2 (30 days), are these in calendar days of business days?** *Calendar days*

**191. RPP indicates that during Task-3 a movement from generic data transmission to more specific COVID-19 format would occur. Is it safe to assume that during alpha and beta testing generic clinical data from patients and non COVID-19 specific protocols and guidelines can be used to test the validity of systems?** *Yes*

**192. Is deployment and transportation of wearables to patients at home anticipated as part of the First System deployment ? if so, how is the transportation time factored into the 45 day rapid evaluation window?** *It is up to the offeror to incorporate transportation and other activities into their delivery plans*

**193. Is it mandatory for the offeror to present evidence of demonstrated capability of handling large magnitude of patients/workflow in the context of ICU nationally with previously established systems?** *Not necessarily*

**194. Do the data rights assertions address data used during alpha and beta testing or patient data collected in the offeror's system in steady state usage?**

*Please insert all proposed data assertions into the provided data rights table for review and negotiation by the Government, if selected for award. Please see Appendix 4.2. Data Rights are also discussed in Article 9 of the Base Agreement which is found on the MTEC website.*



- 195. Are you expecting Staff e.g. do we need to provides physicians and nurses are those assumed to be your network of providers? *Offerors need to provide***
- 196. RPP clearly describes the expected timeframe for each of the 5 tasks; however in section 1: Initial screening summary - is the request to "indicate the estimated time of completion for each task referring to timeframes less than those proposed in the RPP? *Correct.***
- 197. Our clinical partner is overwhelmed now and cannot do a proposal. We would use them but we don't expect they can make it in time. Would you help us find a replacement partner and add them at a later time under these terrible circumstances. *Potentially, but it would be preferable for offerors to form their own teams***
- 198. With Tasks 1-3, with those deliverables, is there an expectation of installing beyond the tasks? *Perhaps, it would be dependent upon the offeror's solution set performance and availability of funding.***
- 199. For each awardee, will there be a customer team working with the awardee to provide timely feedback to meet the aggressive timeline? *There will be a government COR***
- 200. One of the deliverables is a virtual + local staffing model for at least 100-150 patients. Are you looking for a staffing model for each alternate site? E.g., CAH, rural hospitals, field hospitals, gymnasium, gymnasium, etc. *Not necessarily***
- 201. Do the non traditional contractors, have to be FEDRAMP certified? *As part of a team that offerors' solutions must have a clear path to FEDRAMP certification***
- 202. Is the expectation that the application would capture medical device data in near-real time? *Not necessarily***
- 203. Is the \$7M in available funding to cover all Task 1-3 awardees? *Yes.***
- 204. While both have been mentioned, is the emphasis primarily on a patient-specific self care in a home setting or enabling tele-intensivist treatment of critically ill in a temporary setup (e.g., Javits center in NYC)? *The scope of this RPP is Tele-critical care (not self-care)***
- 205. How many awards will be made (what size, ie \$)? *Up to 6 awards. There is no prescribed amount per award.***
- 206. Can you elaborate on expectations related to data rights for proposed technology platforms? *Please see Appendix 4.2 of the Enhanced White Paper template and Article 9 of the MTEC Base Agreement.***



- 207. What assumptions can we make about types of monitoring and device connectivity? Is it fair to assume that a critical care patient at baseline will require SpO2, HR, and BP, while the system should support a patient with invasive monitoring on ventilation. Is it fair to assume that these devices already have some type of connectivity, e.g. monitoring gateways. Assume baseline mobile connectivity**
- 208. Is it important for deployable equipment to be built in hard cases. As an example air dropped, stored in warehouses. Not necessarily.**
- 209. What is expectation for deployment at the end of Task3? How many hospitals? Is there an expectation support is after 45 days? For how long? This will be determined by future funding and project plans.**
- 210. Does the care staffing model include both tele-ICU (virtual) staff and local staff on the ground. The RPP reads like the requirement is only to describe staffing models for virtual staff only. It is for both (distance and originating sites)**
- 211. Due to contractor travel restrictions during the COVID-19 emergency, can Tasks 1 through 3 be executed completely remotely? Yes**
- 212. In the white paper, should we describe our way or views on the project? You describe your approach to the problem.**
- 213. If you are an AI/data management company, how essential is a current HITRUST/FEDRAMP to the proposal? Offeror team proposals should demonstrate a path to this capability.**
- 214. There are far better solutions than cellular for remote areas including the US. We have deployed them with Microsoft in Africa and the US. Please be open to non-cellular AND cellular possibilities. Also not every person's tablet eg iPad, Samsung do not have cellular capability - but are better devices for a simple easy-to-use care system. Acknowledged.**
- 215. Please explain whether clinical resources (doctors, nurses, etc) are in the scope of the RPP - can we propose "virtual bunkers" - a distributed clinical team rendering telemedicine services - as part of the submission? Yes – offerors should propose models as appropriate.**
- 216. Are you envisioning Continuous Monitoring / vs Round & Report - or both? Offerors should propose what they view as appropriate**
- 217. Is it assumed that the non critical care provider who is providing care at the bedside also needs to be able to document care in the platform or just the critical care physician? Both**
- 218. Use of a HITRUST, FEDRAMP Cloud Security Platform: Is HITRUST, FEDRAMP Cloud Security**





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**Platform required during Tasks 1, 2 or 3 or can the process to obtain FEDRAMP be in progress?**  
*In progress.*

- 219. Should we assume pandemic situations for the use cases, or be more general with severe chronic and respiratory conditions? Assume some patients will be COVID positive.**  
*Assume some patients will be COVID positive.*
- 220. What type of medical liability immunity will be provided for Health care staff "walking" family members/friends through patient care? This project does not offer additional or special medical liability immunity.**  
*This project does not offer additional or special medical liability immunity.*
- 221. Is the government aware of FirstNet - a nationwide high-speed broadband communications network, dedicated to the first responder community and operational today - supporting COVID by the DoD and FEMA? FirstNet was established by Congress and competitively awarded by the Federal Government. Yes. This is different than FirstNet.**  
*Yes. This is different than FirstNet.*
- 222. If i am a sub-contractor (providing enabling technology, but not leading a submission,) does my organization have to comply with the IP warrants and revenue sharing? Yes - The Prime Subcontractor is responsible for flowing down all applicable requirements to the Subcontractor.**  
*Yes - The Prime Subcontractor is responsible for flowing down all applicable requirements to the Subcontractor.*
- 223. You are encouraging TEAMING. How can Non-Members easily identify the right MTEC Members Teaming Partners that may have more experience with Govt Contracts ? Yes, per MTEC rules.**  
*Yes, per MTEC rules.*
- 224. Which task should "include IACUC, ACURO, IRB and HRPO review and approval" that may take up to 60 days (reference from Section 5.4)? That is base language in all MTEC RPPs. Please only include if it is relevant to your SOW.**  
*That is base language in all MTEC RPPs. Please only include if it is relevant to your SOW.*
- 225. Is FEMA / HHS the client of this or the military? The Government, but TATRC is working in partnership with HHS. Local caregivers, patients, service providers (remote experts), are also clients/customers.**  
*The Government, but TATRC is working in partnership with HHS. Local caregivers, patients, service providers (remote experts), are also clients/customers.*
- 226. I submitted these in email shortly before the meeting, but I wanted to make sure they are received:**  
**-How should we handle staffing in the RPP - In particular, cost modeling for staffing? Is a staffing model good enough or do we need map costs for the cost model, and if so, how do we address physician, support, technical staff? Also, there was mention of federal employees and what considerations do we make for this. If we propose a staffing model only, will MTEC assign rates (hourly wage, etc.)? · Can any current Telecritical Care model or site be used to fulfill tasks 1-3? For instance, a recent COVID-19 only hospital site? · Can we use a currently operating site to demonstrate the solution? · It was mentioned that 30% of funding should come from non-award monies. Does that mean that "in-kind" cost sharing**



**will work to off-set the 30%? · Do we need to include clinical staffing expenses in our cost estimate?**

**-Do we need to include operating medical groups or just installation in our cost estimate?**

*Offerors should include technical and clinical expertise in their teams. Reimbursement for services should not be part of offerors' applications.*

*Yes – current site can be used at the discretion of the contracting officer*

**227. Do we need to include operating medical groups or just installation in our cost estimate?**

**-Regarding Section 5.4. Restrictions on Animal and Human Subjects, under what circumstances do we need to apply for IACUC, ACURO, HRPO, and IRB approvals specific to this project?**

*That is base language in all MTEC RPPs. Please only include if it is relevant to your SOW.*

**Could you please clarify the technology requirements (e.g., entire billing solution v. data feed?) around: “Simplified billing and coding system for COVID-19 related emergency care is needed to encourage broader participation in program and to account for anticipated limitations of resources. Billing could be divided into following categories: 1. COVID Level 1: remote Assessment and Triage 2. COVID Level 2: Provision of critical care service with a time modifier 3. COVID Level 3: Billing for invasive procedures” The primary focus of NETCCN is care delivery and not billing. The focus should be delivery of a billing feed vs. development of an entire billing solution.**

**228. Is the integration of 3rd party software tools/applications into our proposal acceptable (with appropriate licensing requirements met or if open-source licensing is available)?**

*Yes. Offerors should partner as necessary to deliver a compelling solution.*

**229. While intended as a national emergency response, should solution address privacy protection of patient data and enforcement of state medical board / federal licensing requirements? Yes, as appropriate**

**230. Will the recording and not just the slides be available if DoD approves the slide release?**

*No, a recording will not be made available.*

**231. What cost will hospitals be incurring in order to access the network? This is up to offerors**

**232. Does the system need to Meet NIST800 standards and obtain ATO? No need to obtain an ATO within the scope of Tasks 1-3**

**233. The initial deployment would be best on a HIPAA compliant cloud server rather than a military - government server and only the data that is required to be kept at a national level**



should be kept there. The elastic cloud concept, even with HIPAA and encryption, is much better done outside federal data centers - something to consider. *Thank you.*

**234. What about solutions that leap ahead to the defense needs for pack up and deploy. Do you want any white papers know that highlight something already more adapted to military needs in deployments (CONUS and OCONUS)? Offerors should focus on be responsive to the current NETCCN requirements**

**235. Firm fixed price per task - how long is the delay in payment? We have many partners to pay during this project!**

*For firm fixed price, you need to complete the milestone, then the Government would need to concur that you completed it, and finally MTEC would pay you.*

**236. Must the supported students and staff be American citizens or Permanent Residents?**

*MTEC allows the usage of non U.S. citizens and companies, as long as there is no Security Clearance required under the solicitation.*

**237. If the base is mobile phone and a disaster, is this presuming a smart phone or any cell phone? Smart Phone**

**238. Is Security required for the proposed system or we do not have to focus on it and can use existing security approaches?**

*Security is important but the initial delivery needs to be secure enough in the context of care. No special security is required for Task 1.*

**239. Can the application include a bibliography? I suspect that a strong application might have an extensive bibliography, particularly to demonstrate prior work done in this area, which speaks to feasibility.**

*Yes, but please include it within the page limitations of the Enhanced White Paper specified in the RPP.*

**240. What are the expectations about redundancy for the network? Is global capability important? Offerors should not assume network redundancy. The focus for this project is the United States for Tasks 1-3**

**241. How will the T=15 days be reviewed if it is local? If you make a decision to continue or discontinue at that gate, does that mean we stop work until we hear that we have passed, or does the project continue and are we paid for the part of T=30 that continues after Day 15? The project would stop at that Gate until further direction is received.**

**242. You have used the word "austere" several times. Do offerors need to propose a solution**



**with store and forward features where there is no internet like we do in a theater environment?** *Offerors should plan on mobile access but not 24/7 high speed internet access.*

**243. For the Task 3 requirements of "Deploy System to Multiple Sites", should cameras, tablets and broadband or cell connectivity be included in the proposal?** *Offerors should include what is necessary to support development and use of their platform. Broadband or cell connectivity (e.g. towers) for facilities should not be part of the budget.*

**244. For the Task 4 & 5 requirements, how many sites and beds should be included in the cost estimates?** *The number of sites is to be determined, and unknown at this time.*

**245. Will there really be "Dozens of sites for deployment" under task 3 (within 45 days)?** *Depending on number of awardees and the number of sites per awardee.*

**246. Need clarification on animal/IRB testing approval requirements. This is likely to extend timelines beyond the task window.** *Applicants should plan to work with HRPO and the project COR to determine human subjects protection requirements.*

**247. FedRAMP cloud security platform/capability - what are the requirements for answering yes? Do we need HiTrust? Need to move to HiTrust cloud services provider?** *Initially offeror platforms may not comply with FedRAMP of HiTrust but should have a clear plan for achieving these by Stage 3.*

**248. What does credentialing mean? If it's being developed by the govt is it initially identity management with the goal of eventually supporting credentialing?** *Credentialing is the process of establishing the qualifications of licensed medical professionals and assessing their background and legitimacy.*

**249. Are there ELOs for training content? What is the expected timeframe for content development beyond the 15 days for a training plan in task 2?** *Offerors should develop training content that they feel is appropriate for the users of their platform(s) throughout the project stages. The government will not develop ELOs for the offerors' systems.*

**250. The scenarios describe care environments including a temporary field hospital and home health care. Does METC know if there are specific medical devices that would be deployed in these scenarios that would benefit from IoT integration?** *The offerors should propose what they believe is appropriate*

**251. How should we handle staffing in the RPP - In particular, cost modeling for staffing? Is a staffing model good enough or do we need map costs for the cost model, and if so, how do we address physician, support, technical staff? Also, there was mention of federal employees and what considerations do we make for this. If we propose a staffing model only, will MTEC assign rates (hourly wage, etc.)?** *The project team should include medical staff as appropriate.*



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*The project should not include reimbursement for medical services delivered as part of project costs.*

**252. Can any current Telecritical Care model or site be used to fulfill tasks 1-3? For instance, a recent COVID-19 only hospital site? Yes with approval from the project COR**

**253. Can we use a currently operating site to demonstrate the solution? Yes**

**254. Do we need to include clinical staffing expenses in our cost estimate? *The project team should include medical staff as appropriate. The project should not include reimbursement for medical services delivered as part of project costs.***

**255. Do we need to include operating medical groups or just installation in our cost estimate? *The project should not include reimbursement for medical services delivered as part of project costs.***

**256. Regarding Section 5.4. Restrictions on Animal and Human Subjects, under what circumstances do we need to apply for IACUC, ACURO, HRPO, and IRB approvals specific to this project? *Applicants should plan to work with HRPO and the project COR to determine human subjects protection requirements.***

**257. Could you please clarify the technology requirements (e.g., entire billing solution v. data feed?) around: "Simplified billing and coding system for COVID-19 related emergency care is needed to encourage broader participation in program and to account for anticipated limitations of resources. Billing could be divided into following categories: 1. COVID Level 1: remote Assessment and Triage 2. COVID Level 2: Provision of critical care service with a time modifier 3. COVID Level 3: Billing for invasive procedures" *The primary focus of NETCCN is care delivery and not billing. The focus should be delivery of a billing feed vs. development of an entire billing solution.***

**258. Should our cost proposal include the cloud hosting requirements for a FEDRAMP solution...like AWS? If so, are we allowed to estimate would the DoD or Federal cost will be, or will we need to have a negotiated hosting agreement with our Enhanced White Paper submission? *Hosting of the platform(s) used in the project should be part of the cost proposal***

**259. Is it anticipated that non-government users would need to register and use this cloud based solution and therefor the system would be accessed without a Common Access Card authentication? *Yes – it is anticipated that this system would have users that do NOT work for the government.***