QUESTIONS AND ANSWERS FOR HIGH DOLLAR CLAIM & APR-DRG CODE REVIEW

1. If an outlier claim meets DRG threshold after review, does Kern require that claim to also receive DRG up-coding review, or is that dependent on the claim meeting mutually agreed upon DRG concepts? I would expect that we would set outliers as one of the criteria requiring review.

2. Attachment A, Scope of Services (page 9/15). Please provide the following clarifications concerning the program scope of work:
    a. For calendar years 2020 and 2021, respectively, how many high dollar audits/reviews were performed by category/claim type? We had minimal high dollar audits/reviews performed by previous vendor. We had about 10 completed, and all were inpatient non-DRG.
    b. For calendar years 2020 and 2021, respectively, what were the total findings/dollars recovered by category/claim type? Under $50,000.00.
    c. How many third-party administrators (TPAs) are involved in processing claims? We do not use TPAs. We do use CES editing for NCCI Medi-Cal edits and a second pass by Zelis. However, we retain claim processing and adjudication inhouse.

3. Attachment B, Schedule of Fees (page 11/15). Please provide the following clarifications concerning the schedule of fees:
    a. Will KHS accept multiple pricing scenarios in the RFP response? Yes.
    b. Can KHS accept a contingency fee pricing model under CA regulation, as it pertains to this Medi-Cal patient population? Previous vendor was contingency based, however, all contracts will require approval through DHCS.
    c. For 2020 and 2021, respectively, what was total program value resulted from post-payment recoveries vs pre-payment savings? The prepayment was strictly via Medi-Cal NCCI edits. Other than that, minimal results on either.

4. General Contract Information
    a. What is the initial contract term? 3-5 years.
    b. Are there renewal options? If so, how many? And, for how long? Yes, for an additional 3-year term.
    c. To how many vendors do you anticipate awarding this contract? The desired award would be one. If needed, could be two.
    d. What is the anticipated contract start date? June 2022.
    e. Will KHS permit vendors to submit red lines of the contract documents with their proposals? Yes

5. Professional Services Agreement. Please provide the following clarifications concerning the professional services agreement:
    a. Section 6, Audits, Inspection and Retention of Records (page 5/41) states, "The books and records of Contractor relative to all its activities under this Agreement shall not be removed from the State of California without prior consent from DHCS and DMCH." What would prevent KHS from providing such consent? We do not allow records to be sent offshore. Medi-Cal doesn't allow. How is remote work impacted by this requirement? Remote work in the US is acceptable.
    b. Section 34, Standard for Plan Organization (page 11/41) states, "Contractor shall apprise KHS of recommendations, plans for implementation and continuing assessment through dated and signed monthly, quarterly, and annual reports which shall be retained by KHS for follow-up action and evaluation of performance." Would KHS please provide an example or template of these reports? See response to #92 – there is no template and we are open to discussions on what is available from the Vendor.
    c. HIPAAA Business Associate Addendum, Definition J, Security Incident (page 19/41) includes "attempted" security incidents. If a vendor only reports "successful" security incidents, will KHS accept a blanket acknowledgement of attempted/unsuccessful breaches in the Business Associate Addendum and only require reporting of successful breaches? Yes

6. Does the Interim Bill type 112, 113 and discharge status question apply High Dollar review or DRG Review? We do receive DRG interim claims 112,113- those are reimbursed at the per diem indicated by Medi-Cal. Once we receive final, we will work the APRDRG at that time. However, if the Vendor has a different process for DRG review or High Dollar review for these scenarios, we are open to listen.

7. Would any providers be excluded from a high dollar or DRG audit program? Possibly the Safety Net Facility. Also, if we do any LOAS that prohibit review.

8. What do you define as high dollar (both amount and is it Billed Charges or Allowed Amount)? Both can be used to define, depending on the contract. If there is a percentage of billed contract or a claim that hits stoploss, Billed charges would be important. We are open to negotiate the high dollar trigger. Initially, I would use 200,000 billed charges or 100,000 allowed amount.

9. Are there any restrictions on the number of appeals we can perform on Kern's behalf? Provider Dispute Resolution has a limit of 2.

10. Are there any contractual limits on the number of DRG reviews that can be performed per month, year etc. ? No. Per DMHC we cannot request records for more than 5% of the claims. Our claims volume is over 200,000 claims per month.

11. Does Kern believe that they are contractually obligated to pay a claim (as is, regardless if it has errors) if they have given a provider a pre-authorization? No. We can require a corrected claim, however, ultimately the claim will need to pay the bed days at minimum or the specific service code that is authorized.

12.What is their membership and/or inpatient DRG spend annually? As stated in the Background information, membership is about 322,000

13.What percentage of their provider contracts allow for offsets versus those that require a recovery/returned payment/check? For all but one contracted provider, we can offset. We cannot offset for any non-Par without written permission.

14. Current contract details: N/A however prior contract was for 3 year increments and 20% of savings
    a. Effective date
    b. Expiration date
    c. Total contract amount

15.Current pricing structure:
    d. How is the KHS invoiced today? N/A – we are open to invoice per transaction or per month.
    e. What is the fee per invoice? – prior contract was contingency based. This is negotiable.

16.Anticipated go-live with a new vendor – within 60 days of awarding contract. We do have retrospective reviews ready to send.

17.Being privately held, can financial statements be provide outside the RFP upon request? Yes

18. What volume of claims require APR-DRG code review? Since we have not had an APR-DRG code review previously, we will look to Vendors to suggest triggers. Currently 4 of the 5 local facilities are DRG based.

19. We assume APR-DRG code review is part of the High-Dollar claims review and not separate, please confirm. No. APR-DRG coding is assigned by our system based on the order and listing of ICD10 DX and procedure codes. Many are leveling at 3 and 4's. We would like to review to determine if the coding on the UB04 is correct and in the appropriate order so that the correct APR-DRG code is being assigned. There may be some APR-DRGs that also would require a high dollar review, but not all.

20. What is the proposed contract duration? 3 years at minimum.

21. What is the expected go-live time frame for this engagement? – within 60 days of awarding contract. We do have retrospective reviews ready to send.

22. Are the following services in-scope for this engagement: Interpreter Services for Members, Coordination of Care. No.

23. What is the current core adjudication platform? QNXT

24. Is your current claims system installed on -prem in your data center or hosted on a cloud" If hosted on a cloud, who is the hosting vendor? On premises

25. What is the current workflow system used for High-Dollar claims and APR-DRG claims review? NA

26. Will vendor associates be provided access to KHS's current workflow system or is vendor expected to bring its on workflow tool for the process in-scope? Depends on the solution.

27. What is the Auto Adjudication %? Overall 84-87%. For facility claims closer to 75-78%.

28. What is the Adjustment Rate for the current claims operation? 1%

29. What % of claims are currently identified for Fraud and Abuse? Minimal less than 1%

30. What % of claims are processed in 30-45 days? For example, 90% in 30dys and 98% in 45days. Currently 99% within 30 and 45 days.

31. What are the accuracy targets across Financial and Procedural parameters? 98% for both.

32. What is the current process for identifying over payment and under payment? Internal random audits as well as identified through Provider calls and/or Disputes.

33. What tools/Analytics is used for the identification of over/under payment claims? We use CAT tool by L5 for auditing claims examiners. Prepayment – we also use Optum's CES for Medi-Cal NCCI edits and Zelis for 2nd pass.

34. What is the productivity target to be assumed (PPH) for the scope of services mentioned in the RFP? To be determined by Vendor and KHS. Anticipation of high dollar claims being over 6,000 per year and APR-DRG to be determined on criteria agreed upon through Vendor and KHS.

35. What would be the preferred model of delivery? Are you open to offshoring? Secured email or SFTP. No Offshore.

36. Please define the success criteria for the engagement, i.e, reduce your administration cost, improve your cost of care ratios, improve time services SLAS, etc. Improve cost of care/MLR and identify potential FWA billings.

37. Could you please identify the specific claim characteristics that define a High-Dollar Claim? Is the threshold value $100, 000? See response to #8.

38. What is your High-Dollar claims volume? See response to #34.

39. How are your High-Dollar claims processed today? Please share additional details. Claims are processed with review by management determined by payment amount and thresholds. We are looking to expand and have line item reviews and audit of appropriateness of charges.

40. What is the claims threshold value based on billed value/payment value? See response to #8.

41. For any Post-Review of claims, what is the frequency that should be assumed? No more than 180 days from payment. All recoveries must occur prior to the end of the 12 month from payment.

42. Is "Grouper Pricer" used only to price the claim or is medical necessity also included? Medical necessity is determined by Utilization Management.

43. Is "Grouper Pricer" automation included in the scope of this engagement? Not necessarily. We currently have automation of Grouper through Optum. The review is not to ensure Optum uses the correct pricer, but rather, the services billed are correct for the pricer to do the correct grouping.

44. Please confirm if you use additional "Grouper Pricer's" beyond 3M? 3M via Optum.

45. Are these any know deficiencies in your claims system or operations that could impact the success of this engagement? None that we are aware of.

46. Could you please supply a Bill of Materials for you datacenter, specifically the claims engine and distributed tech stack? More details are needed.

47. Could you please confirm if your approved tech stack include "Kubernetes"? It does not.

48. Connectivity: How will vendor users be connecting to the KHS (Kern Health Systems) environments? E.g Client provided VDI, Site to Site VPN, Client provided Cloud Infra, etc. Depends on the solution/Vendor needs. Vendors are not allowed direct access to our systems. We usually send files via SFTP sites.

49. Could you please share the details around the client applications. How are client applications accessed, i.e, through open internet, Client VDI etc. See response to #48.

50. Telephony: Does KHS needs any telephony to be provided by the vendor as part of the scope of the RFP? Define Telephony

51. Please share if the are any end-point specifications that KHS recommends: System specifications, Monitor size, etc. This will be shared during vendor meetings.

52. Are there any other KHS's platforms or applications to be hosted at the vendor's side? No.

53. When does Kern expect to begin implementation for claim review? See response to #21.

54.When does Kern expect to go live with the claim reviews? See response to #21.

55. Kern shared estimated facility claim counts at and above $100,000. Is Kern interested in having claims reviewed at lower amounts (i.e. $25,000 or $50,000)? We are open.

56. If Kern expects to filter claims, what filters is Kern contemplating? LOAS, Safety Net Facility, potentially some PDRS.

57. If Kern is not expecting to send all claims at the given threshold, can Kern give a dollar estimate of the claims it expects to send? Depends on thresholds agreed upon between vendor and KHS.

58. Kern states most facility contracts are APR – DRG. What percent of facility claims are non APR – DRG? Estimation for just inpatient claims – 30%.

59. For non APR DRG claims, what types are claims - percent of billed charge, per diem, other? Yes. Some per diem, some case rates, some % percentage of billed, some % of billed with a not to exceed. Many have carve outs, including some of our APR-DRG. Carve outs such as high cost drugs/Implants.

60. Does Kern have a set administrative budget number for paying the supplier for its work identifying savings and Kern's utilization of savings such that once the budget number is met, Kern is no longer interested in utilizing identified savings within a budgetary period? Depending on structure of contract. If paying a set rate or per transaction, we are usually required to stay within budgetary guidelines. However, if contingency, or if can be offset by MLR savings, can be open to outside of budgetary limits.

61. Or does Kern desire to fund the work of the supplier on a non-capped basis as long as the supplier identifies, and Kern utilizes, claim savings? We are open to both types of contracting, as long as approved by DHCS.

62.Did you have a previous vendor conducting High Dollar Claim and APR-DRG Code review? Can you share total identified recoveries? We did, but the last 5 years has been

minimal – under $50,000. The threshold was over $300,00 paid with no Room and Board charges.

63.Section A Instructions and conditions number 17 Timeline bullet 4: Proposals due February 21, 2022. As this is a national holiday, will KHS observe this holiday with offices closed and affect the submission timeline? Offices will be closed and should not affect the online submission.

64.Attachment A scope of services First paragraph regarding "2% of the facility claims…" Please Clarify if these claims are inpatient? If not, what other claim types make up facility claims? Since the 2% were high dollar, these would be inpatient. You may occasionally have an outpatient claim billed greater than $100,000, but not paid greater than $100,000.

65.Attachment A Scope of services states "ALL claims are paid/denied within 45 working days of the initial receipt of the claim". If for pre-pay review, will the clock stop if a complex medical record review is deemed necessary? We do not stop the clock. We may be able to have an agreement with the provider for the review and do a % of payment prior to completion of audit.

66.Attachment A scope of services item 3: "Suggest which claims to review based on bill charges, contract rates, or coding methodology". Does KHS require final approval for claims selection? If so, what is the timeline/process for approval? All to be determined and identified with the selected vendor in the SOW.

67.In the contract it states: "Billing is based on time spent." Will you consider a contingency fee payment for identification and recovered claims? Yes. However, all contracts based on contingency must be approved by the DHCS.

68.Instructions and Conditions A(5)(a): Please confirm that electronic copies will not be opened before the bidding deadline. Yes.

69.Instructions and Conditions A(5)(e): Please confirm that a proposal will be late if KHS does not receive **both** the hard copies and the electronic copy by the bid deadline. Electronic copies will have to meet the deadline. Hard copies can come after as long as hard copies match electronic submission.

70.Instructions and Conditions A(5)(d): Paragraph A(2)(e) permits bidders to "object" to contract terms and conditions. If bidders propose alternate language, is that considered a prohibited "alternate proposal"? Are bidders required to confirm that they will enter into the agreement in the form provided if they do object to any contract terms and conditions? (Please note that, in the event alternate language is considered an "alternate proposal," we have identified certain questions/requested changes to the draft contract.) Contract negotiations and alternate language will be reviewed by KHS' legal.

71.Instructions and Conditions A(9)(c): Please explain what is meant by providing "special consideration" to vendors located in Kern County. How much weight does KHS intend this factor to carry? 10% of final scoring.

72.Instructions and Conditions A(14)(b): This paragraph indicates that payment is Net 30 after receipt of an invoice. However, the draft contract paragraph 3.2 indicates that payment will be made 45 days after receipt of an invoice. Please confirm which applies. Net 30.

73.Attachment A: The "summary" states that the purpose relates to "high dollar claims," but the paragraph numbered 1 below that indicates that claims are to be selected based on "high dollar, random sample, or other industry standard methodology." Should bidders assume that KHS only wants review of high dollar claims and, if so, please specify the threshold of what you consider to be "high dollar." See response to #8.

74.Attachment A: The paragraph numbered 8 starts with "Provider." Is that intended to be "Provide"? If so, what are the "Claim Dispute resolution statistics" sought?It should be provide. The statistics would be based on your adjustments to claims, what is your provider dispute rate and how often do you over turn your decisions.

75.Attachment B: This attachment asks bidders to define their proposed method of reimbursement. However, the draft contract (paragraph 3.1) states that "Contractor shall be paid on a time and material basis." The next sentence in the contract says that KHS "prefers itemized billing on a project basis," which seems to indicate that KHS would prefer billing a flat rate per claim review.

- ***A.*** Please confirm whether bidders are to bid based on a time and material basis. No. billing should be based on percentage, monthly fee, or per transaction fee.
- ***B.*** If bidders are not required to bid time and materials, please confirm whether KHS prefers billing a flat rate per claim review. See above.
- ***C.*** If bidders can bid on a basis other than time and materials, please explain how KHS intends to compare pricing. For example, if one bidder bids on an hourly rate and another bids on a rate per claim review, and another bids on percentage of recovery, how will KSH be able to compare those prices? These questions also relate to **Attachment D** "Grand Total of 'Attachment B.'" Comparison will extrapolate estimated volume for a year for comparison.

76.Attachment C, paragraph B: Which financial statements does KHS want, e.g., income statement and/or balance sheet? Do you want audited financial statements? Does KHS consider the 2020 financial statements to be the "present" financial statements if the 2021 financial statements have not yet been prepared/audited? Audited financial statements.

77.We understand that KHS intends to establish an ongoing relationship with a claims reviewer. Please specify an anticipated term of this agreement (e.g., three years, with two one-year extension options) to set bidder expectations and allow for allocation of set-up costs across a reasonable period, assuming that KHS does not intend to terminate for convenience or default. 3-5 years with option for an additional 3.

77.Paragraph 3.1: See question above regarding confirming whether compensation is to be on a time and materials basis, as stated. See response above.

78.Paragraph 3.2: See question above regarding time for payment. Net 30.

79.Paragraph 4: We believe that "the Secretary of" in the third line should be stricken. If not, please specify which Secretary is referenced (in addition to the Secretary of Health and Human Services, which is the next referenced person). Please also correct "General Accounting" to "Government Accountability." Redlined during contract negotiation.

80.Paragraphs 6 and 26: Please confirm that these paragraphs apply only to entities covered by 42 CFR section 438.3. If the answer is no, please clarify why that section is referenced. Yes

81.Paragraph 17.1: This paragraph (including sub-bullets) does not appear to apply to the services being procured. If KHS intends this paragraph to apply, please explain the "Members" (which is not defined) and "enrollees" to which it refers. Redlined during contract negotiation.

82.Paragraph 21.2: This paragraph references "agents" twice, and does not reference Subcontractors. Will KHS change the second "agents" to "Subcontractors"? Yes

83.Paragraph 31: Will KHS accept notice by email? Yes

84.Paragraph 35.2: Generally, an entity can only terminate for cause if, for a curable breach, it first provides a notice of the breach and opportunity to cure. Will KHS add such notice and reasonable opportunity to cure? Yes

85.Paragraph 35.4: In the third line from the end of the paragraph, clause (c), should the reference be that KHS (not "Contractor") will notify DHCS and DMHC of a termination? Yes

86.Paragraph 38: In the second to last line, please make the following change: ". . . OR LIMIT ~~CONTRACTOR'S~~ EITHER PARTY'S DUTY TO INDEMNIFY ~~KSH~~ THE OTHER PARTY IN ACCORANCE WITH THIS AGREEMENT AND/OR (II) ANY THIRD PARTY CLAIMS." Contract negotiations and alternate language will be reviewed by KHS' legal.

87.Can KHS provide a more specific breakdown of the number of bills, and their corresponding charges, received outside of the contracted hospital and tertiary facilities and outside the State of California? We would be happy to share general numbers with finalists. We do use tertiary facilities and have agreements with a few and do LOAs for others. Non-contracted facilities require authorizations for services above ER, and would be subject to review as others.

88.Under Attachment A, section 1, is there a preferred methodology that KHS would like to use for determining the volume of bills to be audited? What methodology is being used today? We are looking to the Vendors to provide their expertise in the area, and depending on the solution, will come to an agreement between KHS and the Vendor. A general response would be based as follows: APR-DRG review for those leveling at 3 and 4 with a certain dollar payment threshold. For non-APR-DRG high dollar review it would be billed charges over $200,000 or payments over $100,000. Again, open to other suggestions by the selected vendor.

89.There can be several different turnaround times within an audit process, and different organizations varying definitions. Can KHS provide specific definitions for the turnaround times they would like details on and/or measured? We require all initial claims to be processed within 45 working days – or 62 calendar days. If a provider dispute, we can pause the clock for records.

90.Can KHS provide additional insight into their current process for pre-payment and post-payment reviews? Our internal processor and contractual audits occur pre-payment. For high dollar review and APR-DRG review, we prefer claims to be audited on a pre-payment review. If more time is needed for the review, we will pay the claim and continue the review on a post-payment basis. We are allotting up to 180 days from the adjudication of the claim for the review, to provide time for recovery prior to the 12 month from date of adjudication.

91.Is there a history/trend/pattern of Fraud Waste Abuse (FWA) that has been of particular concern to KHS? No. But we are looking to RFP later this year for a FWA vendor to increase our reviews and identification.

92.What sort of detailed reports is KHS receiving today and what additional information would they like to receive as part of a stewardship package? No vendor at this time so no reports. While we are open to adding reports that help identify, manage and educate providers and staff, at minimum, we would expect monthly reports of volume of claims being reviewed and status of those reviews.
identified for review
#reviewed at different levels of review
in process
completed
#savings identified
#patterns identified by type or provider

93. Under the California Public Records Act and to provide the most competitive bid possible, what is your current pricing? This request must be submitted officially via the purchasing department.