QUESTIONS AND ANSWERS FOR MCAS SOFTWARE REPORTING TOOL

1. Whether companies from Outside USA can apply for this?
   Main headquarters and functions must be performed in the U.S.

2. Whether we need to come over there for meetings?
   Onsite meetings are not required. However, the ability to conduct virtual meetings with visibility of participants, screen sharing and during the client's business hours is required.

3. Can we perform the tasks (related to RFP) outside USA?
   (like, from India or Canada)

   Yes, unless these tasks involve HIPPA information.

4. Can we submit the proposals via email?
   3 hard copies of your proposal must be mailed and 1 electronic copy must be emailed to rfp@khs-net.com.

5. For the requirement to generate letters from the tool, would providing a file to KHS that includes letters for members and providers based on information provided by KHS suffice?

   The tool should have a correspondence feature that allows generation and printing or faxing. If your software does not have that feature, you should describe what correspondence functions exist, if any.

6. Regarding the 24-hour TAT for recalculation of measures for the SaaS model, do you mean a full data run in a 24-hour period, or the ability to have updated rates in the tool which would reflect the most current data run and abstracted data?

   Full refresh and or incremental refresh with delta changes – before and after rates.

7. Regarding the expectation of simultaneous synchronization of medical record results with administrative results, do you mean the integration of the abstracted data in our tool with admin data provided as of that date, or the expectation that the merge of data and admin data occurs, similar to the end of the HEDIS season, which for us is typically a 3-day process?

   Integration of medical record abstraction review data with administrative and supplemental data to derive the rate of compliance should be real-time or near real-time.

8. Please clarify what is meant by the reference to continuous and non-continuous mode for calculations and reporting.

Measures have specific enrollment criteria a minimum of X amount of months enrolled in the reporting year, we would like to see the measure performance rate in various modes of enrollment periods

9. What is the projected go-live date?

   2022

10. Who are your current vendors for medical record collection/abstraction and MCAS reporting?

    These functions are conduced in-house by KHS staff.

11. What is motivating you to change vendors? What are the pain points with your current software/process/vendor that can be improved?

    The RFP is to conduct an evaluation of other products available to determine what software and services are available. We are evaluating key areas such as software accuracy, progressive functionality of software for new direction and requirements anticipated (e.g. electronic clinical data system, EMR integration, etc.) client support, and pricing.

12. Were there any past audit issues noted?

    No audit issues were noted.

13. Will you run parallel processes as you complete a transition to a new platform?

    This is not a requirement. The vendor should be able to stand up their product without having to run parallel systems. However, we may opt to upload data from the previous year into the vendor's tool to evaluate if the same results are obtained.

14. What are the 3 most important aspects of a solution/vendor for you?

    Accuracy
    Client Support
    Ease of use for the Client

15. How many users do you expect to use the solution?
    25 - 50

16. Are you interested in "Full-Service" Medical Record Recovery (MRR) with an outsourced MRR/Abstraction Vendor Partner, "Self-Service" using your internal clinical abstraction resources, or a combination of both?

    Medical Record Retrieval and Abstraction Reviews are not part of this RFP.

17. Do you expect to use the platform for both Retrospective (members in the sample) and Prospective (year-round for supplemental data) projects?

    Typically, we use it for retrospective members in the sample. However, we would like to have the ability to utilize the platform prospectively.

18. What was the chase volume for the last two Reporting Years 2019 and 2020 (retrospective and prospective)?

    MY2020: 15,456
    MY2019: 9,979

19. How much do you expect the chase volume to grow over the next three years?

    We anticipate abstraction review and related chart chases to decline since the trend is toward electronic clinical data systems that leverage administrative data.

20. Do you prefer Onshore or Offshore abstraction resources?

    We are using our own abstraction resources currently. This RFP is not intended to include staff for chart chases and medical record reviews.

21. What percent of provider sites or volume of charts can be retrieved via remote access into the provider's EMR?

    MY2020: 21.85%
    MY2019: 22.71%

22. What is your retrieval success rate?

	Retrieval %
MY2018	53.34%
MY2019	42.22%

23. What % of abstracted charts are overread?

    Approximately 50%

24. What component or aspect of your current record retrieval & abstraction process needs the most improvement?

    Shifting providers to allow EMR access and ultimately, moving toward electronic data capture.

25. Could you please provide a list of all required measures that are included in the scope of this RFP?

    The measures change based on the list required each year from the California Department of Health Care Services (DHCS).

26. Could you please elaborate on any custom, MCAS- like, or HEDIS-like state specific measures that are included in the scope of this RFP?

    Typically, these are measures developed by the Centers for Medicare and Medicaid.

27. What is involved in a typical measure customization?

    The California Department of Health Care Services identifies the technical specification for non-HEDIS measures. Those measures oftentimes are developed by the Centers for Medicare and Medicaid (Adult and Child Core sets) which are similar to the format of technical specifications used by NCQA.

28. Can you please share the technical specifications for all required MCAS measures?

    NCQA's technical specifications are proprietary and due to copyright laws, we cannot share those. Technical specifications for non-HEDIS measures are typically found in the Medicaid Adult and Child Health Care Quality Measures and the Child and Adult Core Sets. These are available to the public on the internet.

29. What is the projected number of retrospective runs per reporting population?

    Once the reported year is finalized, we will have no need to rerun prior years

30. What is the projected number of hybrid data runs per reporting population?

    Once the reported year is finalized, we will have no need to rerun prior years

31. How many submissions do you submit annually (please provide breakdown by LOB as applicable)?

We currently have only one line of business for Medi-Cal. There are typically two submissions per audit. One is a preliminary submission and the second is a final submission.

32. How many sources of supplemental data were used across your product lines for the last two Reporting Years 2019 and 2020?

    4-6 Supplemental Datasets were used

33. How many data sources were non-standard vs. standard?

    All Standard

34. What is the expected data refresh and measure runs processing frequency (weekly, monthly, quarterly)?

    Weekly

35. Is there a maximum time period (business days) that the measure refresh process has to be completed within once the incremental data is received?

    Expectation is that we have a 24-turnaround time for measures to reflect any incremental data load

36. What do you expect to be the total enrollment loaded into the solution in Year 1, broken down by line of business? What is the expected enrollment growth rate over the next 3 years?

    KHS enrollment increased this year due to the pandemic. It is anticipated that a similar decline will occur as the pandemic resolves. No one is able to predict the time that it will take for the pandemic to resolve.

37. What is your data volume based on available history (example: approximately 10 million medical claims, 2.6 million pharmacy claims, 1 million lab claims)?

    2 Year of Dates of Service: usually 3 to 5 years of data is provided

Medical Claims	6,073,432
Medical Claim Lines	16,542,465
Pharmacy	9,444,286
Lab	6,959,501
Immunization	438,697
Vision	214,806

38. What is your daily incremental data volume?

    Highest frequency of daily incremental load would be weekly for Medical Claims all other data sources would be monthly.

39. Do you have a preferred deployment mode: On-Premise vs. Cloud (for ex. Microsoft Azure) deployment?

    Preferred On-Premise, not limited to On-Premise

40. Do you currently have or are planning to have a site-to-site VPN connection from your network environment to Microsoft Azure or AWS? If so, please specify which one.

    We currently have a dedicated site-to-site VPN connection to Microsoft Azure

41. Can you please clarify what is meant by "provide reporting in a Continuous and Non Continuous mode" in Section C. Technical Requirements, C.3?

    Measures have specific enrollment criteria a minimum of X amount of months enrolled in the reporting year, we would like to see the measure performance rate in various modes of enrollment periods.

42. How is the data used?

    Data is used to report utilization data and compliance results of specific Managed Care Accountability Set measures as defined by NCQA and the California Department of Health Care Services.

43. Do you have a preferred output from the software-reports, raw measure calculation results, etc.?

    Ability to export to PDF, Excel with details supporting any level of summary or aggerated values

44. What prospective and predictive analytics capabilities, if any, are you interested in?

    This RFP does not include predictive analytics.

45. Can you provide a pre-defined list of required reports and some examples of current report layouts?

    By measure, denominator, compliant (numerator), non-compliant, rate

46. Do any custom or ad-hoc reports need to be developed, and what is the frequency for these?

    Because these are ad hoc, the intent is that they are ones that come up due to an unplanned or unexpected need. There is no set frequency for when they may be needed.

47. Our assumption is that the NCQA Roadmap will be completed for the NCQA measures under MCAS only. Please confirm.

    While the Roadmap is geared toward NCQA HEDIS measures, it applies to all of the MCAS measures.

48. Will KHS provide the most current MPL and HPL for the MCAS measures for reporting and tracking performance against these levels?

    KHS does secure the most current MPLs and HPLs. Typically, these are available for the HEDIS measures and are available by purchasing the Quality Compass data through NCQA. Because that data is proprietary to NCQA, KHS does not provider that for to the software vendor.

49. Does Kern Health currently have template letters for members and providers? If so:

    1) How many template letters do you currently use?
       Three
    2) What is your preferred format for the letters?
       Not sure what is being asked. We typically fax the letters.

    3) Are the letters emailed or mailed to providers and members?
       No. Fax only, currently. However, we would like the ability to email and print.

    4) How frequently are the letters sent to members and providers?
       This varies. We do not send letters from the MCAS software system to members.

50. As reporting is year-round, can you confirm the frequency of data updates?

    Weekly, Bi-Weekly or Monthly

51. Since reporting is year-round, we are assuming that chart abstraction is year-round. Please confirm.

    No. KHS does not conduct chart abstractions year-round. That is done once a year during the annual MCAS audit and rate submission.

52. Can you clarify what is meant by maintaining parallel databases with the ability to run monthly reconciliation? Is the intent to reconcile P4P MCAS like measures with the organization MCAS measure set?

    Internal reporting on measure performance compared to your solutions measure performance, comparisons between denominators, compliant (numerators) and non-compliant

53. Regarding the 24-hour TAT for recalculation of measures for the SaaS model, does having updated rates from the most current data run and abstracted data meet the intent of this requirement?

    Yes, as data is loaded or abstracts take place, reviewing measure performance reflecting the latest changes is what we expect to see within 24-Hours.

54. Regarding the expectation of simultaneous synchronization of medical record results with administrative results, are you referring to scoring updates following data entry within the chart abstraction tool? If not, can you clarify this expectation?

    Yes. Compliance rates and report data should reflect real-time or as near real-time integration of administrative and abstraction review data.

55. Please clarify what is meant by the reference to continuous and non-continuous mode for calculations and reporting.

    Measures have specific enrollment criteria a minimum of X amount of months enrolled in the reporting year, we would like to see the measure performance rate in various modes of enrollment periods

56. Would a monthly data extract meet your needs for ad hoc reporting outside of the reports listed under the reporting section of the RFP?

    No. This requirement refers to your ability to provide non-standard reports as needed versus regularly scheduled and defined reporting.

57. In the Attachment A Scope of Services section, number 2L, can you clarify if we need to have an intake that matches the data types listed or so that we have a place for you to map your data to?

    We will provide data files meeting your data specification for the various data sources

58. Can you clarify which measures are the MCAS measures? Do you require all HEDIS measures?

The measures change each year based on the list required each year from the California Department of Health Care Services (DHCS). Only a subset of the HEDIS measures are used by DHCS and they may include non-HEDIS measures that typically are from the Medicaid Adult and Child Health Care Quality Measures.

59. Do you also require CA AMP measures?

    We stopped using any P4P reporting from Cotiviti's software last year.

60. In the Attachment A Scope of Services section, #7, can you clarify what you mean by MCAS-like measures?

    These are measures that are closely aligned to technical specifications for the CA DHCS measures but may have some variation to accommodate for provider P4P initiatives.

61. Would you be willing to move to a hosted model of software?

    We are willing to consider that model.

62. Can you clarify what you mean by "reporting in a continuous and non-continuous mode" (under #C in the Technical Requirements section)?

    Measures have specific enrollment criteria a minimum of X amount of months enrolled in the reporting year, we would like to see the measure performance rate in various modes of enrollment periods

63. Which measurement year does this RFP pertain to (e.g., 2022)?

    It pertains to measurement year 2022 and report year 2023

64. Do you report on CMS measures for Medi-Cal?

    The CA DHCS selects the measures Medi-Cal health plans are accountable for and that list typically includes a mix of measures from NCQA's HEDIS measures and Medicaid's Adult and Child Health Care Quality Measures.

65. Do you use third parties for retrieval and abstraction, or do you perform those functions with internal employees?

    We use internal staff. Inclusion of staff to perform chart chases and medical record abstraction reviews is not part of this RFP.

66. Could you please clarify if the vendor will be expected to perform any of the following? A. Medical record collection/retrieval B. Medical record abstraction.

    No for both services.

67. If you do expect the vendor to perform any of these activities, what volumes should the vendor expect for each?

    N/A

68. Which measures outside of standard MCAS measures do you anticipate needing, if any?

    We only anticipate needed the current MCAS measures as defined by the CA DHCS.

69. Requirement a. states "Ability to perform over read." Is the expectation that the vendor's software tool has the ability for Kern staff to perform overreads in the tool or that the vendor will perform overreads?

    The ability for KHS staff to perform and document overreads within the software should be a feature of the software.

70. Will you require reporting for defined segments of the member population? If so, how many segments will be required?

    Yes. They are Medicaid, SPD and Non-SPD populations.

71. What is the standard expected frequency of producing rate reports, for both YTD performance and prior periods?

    Internal solutions in place that provides insights to measure performance throughout the year, using your platform we would run necessary process on a bi-weekly basis to monitor YTD Measure Performances

72. Can Kern provider more detail on what or how many measures DHCS is requiring above NCAQ?

    This is determined by DHCS and the list of MCAS measures they define each year. Their list is available to the public.

73. Can you describe the current P4P program any planned changes?

    Core measure criteria is leveraged for P4P measure analytics, scenarios are modeled as if we had P4P to identify financial liabilities.

74. When would Kern like to target a go-live date?

    This RFP is for initiation of services for MY2022 and RY2023.

75. As most companies are still having employees work remotely, can vendors have an exception to submitting a paper submission (only submitting electronically)?

    No. 3 hard copies of your proposal must be mailed and 1 electronic copy must be emailed to rfp@khs-net.com.

76. Please share information related to the current technology being used for: 1. Reporting (and directly to DHCS) 2. Database 3. Visualization 4. Analytics

    Information is extracted through template reporting and or data extract from the database for analytics that will provide the necessary reporting information.

77. Does KHS currently have a vendor (or vendors) providing the services described in the RFP? If so, who is/are the vendor(s)?

    This question has no relevance to the RFP.

78. Can KHS provide which EMR systems and versions?

    Providers use a variety of EMR systems and the version they use vary by provider.

79. Would KHS confirm that certification requirements include in-progress NCQA certifications that will be completed prior to the MCAS report year?

    Current NCQA certification is a requirement.

80. Would KHS share the historical and expected number of record reviews and over reads expect? Could you also share the specialty areas?

    Based on KHS' enrollment size, this should not have a bearing on the RFP response.

81. Would KHS share what year/years will be required for prior reporting? Also, could you please confirm the first reporting cycle Measurement Year/Reporting Year required?

    Prior reporting is not required. The proposal is for MY2022 and RY2023.

82. Will KHS take in to consideration for evaluation purpose a teaming partner's (subcontractor's) experience and references?

    No. This RFP is for direct contracting and not for subcontractors.

83. Is KHS currently contracted with IPAs? If so, would KHS prefer that vendors have a background providing services to this type of organization?

    No

84. Please share this initiative's anticipated budget range for the anticipated life of the contract (three initial contract years and tow optional years?

    Interested bidders are expected to provide their best pricing options.