C·B·H
Community Behavioral Health
A DIVISION OF DBHIDS | CBHPHILLY.ORG

Request for Information

for

Behavioral Healthcare Claim Adjudication Software

issued by

Community Behavioral Health

Date of Issue:
September 4, 2020

Responses must be received via email no later than 2:00 p.m., Philadelphia, PA, local time, on September 30, 2020.

EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER;
MINORITY, WOMEN, AND DISABLED ORGANIZATIONS
ARE ENCOURAGED TO RESPOND

Table of Contents

1. INTRODUCTION

The Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), an agency within the Department of Health and Human Services of the City of Philadelphia, is issuing this Request for Information (RFI) to gather high-level information about options for meeting its need to adjudicate, and prepare for payment, claims submitted by providers for payment for behavioral healthcare services. DBHIDS seeks responses describing the general functionality, benefits, limitations, and cost of solutions available over the coming year. Interested parties should respond, following the instructions below, by September 30, 2020.

2. BACKGROUND

DBHIDS provides services addressing mental health, addiction, and intellectual disability to the citizens of Philadelphia. It oversees several sub-agencies, the largest of which is Community Behavioral Health (CBH), a managed care organization that pays claims for the Pennsylvania HealthChoices (Medicaid) behavioral health program for eligible Philadelphia residents.

CBH manages care funded through Medicaid and is at risk for the cost of the care. Eligibility for CBH-managed services is based on Medicaid eligibility at the time of service. CBH manages care for approximately 650,000 clients at any one time, processing approximately 400,000 claims per month resulting in approximately $64 million in monthly payments to providers. Other DBHIDS sub-agencies serve smaller client bases and process fewer claims. The services they manage are program-funded and directed toward Philadelphia citizens without Medicaid or other coverage available for those services.

CBH and other DBHIDS sub-agencies currently use the same solution for claim processing. The incumbent vendor operates its software at a remote site, adjudicates claims and performs related input/output processing and reporting, and provides DBHIDS staff with access to claim inventory. Necessary manual processing (paper claims, special claim processing, etc.) is performed by DBHIDS, not vendor, staff.

Incoming claims generally comply with the 837P and 837I standards; however, a solution must also accommodate paper claims and non-electronic claim attachments. Generally, claims describe the rendered services using CPT/HCPCS codes, including the standard codes and modifiers used by state Medicaid programs.

3. PURPOSE OF RFI

Through this RFI, DBHIDS and CBH seek to gather high-level information about options for meeting their need to adjudicate, and prepare for payment, claims submitted by providers for behavioral healthcare services. The RFI asks for responses describing the general functionality, benefits, limitations, and cost of solutions available to DBHIDS over the coming year.

The RFI does not describe an exhaustive set of requirements. Instead, it seeks to survey the range of solutions available on the market, pose some basic questions which responders should answer, and invite responders to offer considerations in the eventual choice of a solution that might not have come to mind in these early stages of a potential procurement.

DBHIDS and CBH seek information about solutions able to process claims for all relevant DBHIDS sub-agencies, drawing on different funding sources and operating under different provider contracting and adjudication rules, from overlapping sets of providers, and to apply flexible, automated rules to support payment accuracy.

While DBHIDS expects to gather information on solutions that follow the model it currently uses (software as a service, with DBHIDS staff providing needed manual processing), responders are invited to describe all models/approaches they think might be of value.

4. TERMS OF RFI

This RFI is not a request for proposal nor is it a statement that the issuing entity is committed to replacing its claim system. This is a RFI pertaining to functionality offered through available solutions. While it asks for pricing ranges, responses are not considered binding or limiting in any subsequent procurement process.

Potential vendors and other responders will bear all costs associated with responding to this RFI. Lack of response to this RFI does not preclude participation in any future procurement process.

Interested parties should respond, following the instructions below, by September 30, 2020
All information in this RFI and submitted in response is the sole property of DBHIDS.

5. RESPONSE FORMAT

Parties responding to this RFI should answer the questions in the section below and provide additional information of value to DBHIDS. Please limit responses to 10 pages, single spaced, 12-point font.

The cover page does not count in page total and should include:

1. Name of the responding company
2. Name, phone number, and email of the contact person for the response, particularly for the person or persons who can answer questions about the response
3. Note if the responding company is a Pennsylvania Minority, Women or Disabled-Owned Enterprise MWDBE. Note any similar or related other designations (e.g., Philadelphia MWDBSE, etc.)
4. Number of years the company has been in business
5. Number of customers that use the responder's solution for claim processing

6. Number of covered lives of the largest client of the company
7. Total number of claim lines processed in the month of October 2019 (if the respondent offers a SaaS solution)
8. A list of claim clearinghouses with which the responder has business relationships

6. QUESTIONS FOR INTERESTED POTENTIAL VENDORS

1. General service models
    a. Describe all models/arrangements through which your solution is available (e.g., software executing on the payer's hardware, software as a service, complete process outsourcing, etc.).
    b. Do you prefer to have your staff process claims (perform needed human intervention to support entry and adjudication) or the payer's staff process claims? What is your experience with both models? Other models?

2. Describe your process for accepting received claims for processing.
    a. Criteria for accepting claims for processing (often marked by creating a system claim number)
    b. Mechanisms for counting and rejecting claims that cannot be accepted and for responding to the submitting providers
    c. Reporting about rejected claims by various categories, including by the type of error causing rejection
    d. Mechanisms for identifying duplicate claims
    e. Mechanism to identify resubmitted claims
    f. Can you accept COBA claims directly from CMS?
    g. Process for dealing with paper claims and claims with paper attachments

3. Describe your use of reference files in processing, and your requirements for files from the payer.
    a. Member eligibility (e.g., daily 834, 270, 271, etc. noting that eligibility for program-funded, non-Medicaid, services is stored in other formats)
    b. Information about the primary insurance company
    c. What information do you need to determine if the provider or facility is in network?
    d. What information do you need on a pricing file? How are services described for pricing purposes?
    e. What information do you need to apply an authorization to a claim? Can you reject a claim that requires an authorization if it is missing? Do all claims need an authorization to pay? How are services described in authorizations and how are they translated to services in claims?
    f. What other data do you need from the payer to process claims?
    g. Describe your mechanism for secure transmission of reference files?
    h. Do you have written specifications the payer can use to assure all required information is provided?

4. General claim processing performance
    a. Please provide your average time from claim receipt to acceptance for processing (claim number creation).
    b. Please provide your average adjudication time (receipt of claim to full adjudication and 835 creation).
    c. When human intervention is necessary for data entry or adjudication, how is that achieved? If the responder is proposing a model in which responder's resources do manual processing, describe how performance is measured and typical results.

5. Processing output and access to data
    a. Can you send various files, e.g., Ta1, 999, 277, 835, etc. directly to the provider/clearinghouse after adjudication? How often can you send them (hourly, daily, weekly, etc.)?
    b. Do/can you send to the payer all data about all claims in inventory, including data on the results of adjudication, paid or denied? How often? Do you have a data dictionary/file specification?
    c. How long do you store information about the claims accepted/processed? Describe your mechanism for payer staff to look up history.
    d. Do you have a self-service portal for providers to check claim status? Do you have a portal for payers to check claim status on behalf of providers?
    e. Describe how you enable access by payer staff to all claim data for analytical and reporting purposes.
    f. The incumbent vendor submits Medicaid encounter records to the State for CBH, following prescribed formatting and validation rules. Describe your capability to perform this task, if available.

6. Flexibility
    a. Describe generally how adjudication rules and other important logic components are set up in your solution. I.e., how difficult is it to change the rules that govern adjudication, modify standing input reference data/codes, etc.
    b. Increasingly, payments for healthcare services adhere to models other than traditional fee-for-service. Some of these "value-based" models require integrating claim processing with payments made outside claim streams, perhaps linking claims to specific provider contracting arrangements calling for payments outside the claim stream—sometimes in addition to claim payments, sometimes in place of claim payments but with the requirement that (zero-paid) claims serve as a record of the related encounters. Please describe the support your solution offers for these evolving models.

7. Please describe who owns each component of the data gathered and created in your solution.

8. Please describe the pricing models you offer for your solution, including relevant software licensing arrangements (perpetual or periodic) and/or volume-related charges based on membership and/or transactions. What is your preferred model? What are typical prices for a volume of claims similar to CBH's under these models?

9. Please describe how the security of your data center, storage, and transmission complies with HIPAA and other relevant standards.

10. Please describe any hardware or software the payer must have to use your solution.

11. Please describe the configuration process and testing performed before your solution is delivered for client acceptance. What objective data do you provide to show the types of testing performed, types of test cases run, and test outcomes for each function?

12. Please provide us with other information you believe might be useful to us as we consider solutions to our claim processing challenges.

7. RESPONSES

Please submit your responses to hans.leach@phila.gov by 2:00 PM EDT on September 30, 2020. All responses become the property of CBH upon submission.