

ATTACHMENT A - DETAILED SCOPE OF WORK

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I. Detailed Scope of Work

The Center is a Community Mental Health and Intellectual Disability Center established under the Texas Health & Safety Code, Section 534 and as such a unit of local government. It provides Mental Health and Intellectual Disability services to residents living in nine Texas counties: Bowie, Cass, Gregg, Harrison, Marion, Panola, Red River, Rusk and Upshur. It also offers many specialty programs such as Adult Mental Health, Substance Use Disorder, Primary Care (FQHC LAL) in these and another 20 counties. The Center employs 450 employees and 150+ contractors. For Fiscal Year 2025 the Center annual adjusted budget is \$43 million.

The Center recognizes the need to pursue efficiencies and cost savings. Therefore, the Center is seeking a vendor to provide these Revenue Cycle Management services.

II. Instructions for Response

Please submit in your response the information requested below in the order presented below.

PROPOSALS IN RESPONSE SHOULD INCLUDE:

A Proposal submittal should include:

- Specifications for Service Delivery at all of the locations that produce revenue within the Center
- Experience / Personnel / Staffing (see Section II B for details)
- Cost (see Section II C for details)
 - For services provided-
 - Any additional cost for services.
- Acknowledge Invoicing
- Acknowledgement to meet all requirements
- Three References
- Acknowledgements of RFP and all RFP Addenda's
- Provide Declaration of Insurance
- Workers Compensation Policy
- Return signed Conflict of Interest Questionnaire - Attachment B
- Return completed Response INFO Sheet - Attachment D

A. Specifications for Service Delivery .

Using the Credible and NextGen Electronic Health Record platforms, and the designated Clearinghouse Vendor(s), the Vendor will:

I. Review and provide feedback on the current setup of locations, including validating and inputting the following:

- a. CPT Codes/Descriptions
- b. ICD 10 Codes
- c. HCPCS Codes (MAP Appropriate NDC Identifies)
- d. Place of Service Codes
- e. Type of Service Codes
- f. Taxonomy Codes
- g. Modifiers
- h. Insurance Companies
- i. Billing Transaction Codes
- j. Patient Statement Set UP
- k. Claims Edit Set Up
- l. Insurance Company Log In Set UP
- m. Payor ID Set Up
- n. Eligibility Set Up

II. Perform billing and collection services, including:

- a. Patient Eligibility & Benefits Verification
- b. Medical Coding
- c. Pre-Authorization
- d. Claims Submission
- e. Insurance Follow-Up
- f. Account Receivable Management
- g. Rejects/Denial Management
- h. Payment Entry
- i. Appeal Rejected/Denied Claims
- j. Payments Reconciliation & Posting
- k. Client Statements
- l. Productivity Reports by Provider, by Service Type etc.
- m. Revenue Reports by Payer, by Service, by Provider, by Location

III. Availability to have the following reporting criteria met:

- a. Ability to have reports provided that will detail Accounts Receivable at each month end by payer and by location.

b. Ability to have accessibility of reports based on history of closed claims, by payer, that can be used to calculate bad debt estimates monthly and can use a six-month rolling history of closed claims for the analysis.

c. Ability to have reports based on the following criteria: gross charges, contractual adjustments, and bad debt write-offs monthly. Fiscal services use these reports to post revenue, adjustments, and bad debt write-offs on the financial statements. Ability to reconcile back to the AR reports monthly.

d. Ability to track client detail to allow bad debt write-offs to be reported on the annual Medicare cost report for reimbursement from Medicare.

IV. Assist organizational operations, including:

- a. Obtaining CLIA number/CLIA Waiver
- b. Developing Policy and Procedure relating to Billing
- c. Provider CPT/ICD10 guidance for best practices coding while maintaining compliance (Limited)
- d. Billing for Performing Provider or Supervising Provider (Mid-Level Provider)
- e. Assist with training and provide technical assistance for revenue cycle management and front desk functions.

B. Qualifications / Experience / Staffing

Please acknowledge and respond to each of the specifications listed below and discuss your firm's abilities to meet or exceed these requirements

1. Provide your organization history and experience for the above scope of work. Please name and identify actual projects where such work has been done.
2. Does the billing company have experience in the following specialties? Explain with history and examples.
 - a. Primary Care Services
 - b. Behavioral Health
 - c. FQHC
 - d. Early Childhood Intervention (ECI)
 - e. Substance Use
 - f. Crisis Stabilization Unit (inpatient)
3. What Revenue Cycle Management (RCM) services do you offer?

4. How does your billing company handle claim changes (e.g. changes in CPT codes or regulations)?
5. What type of RCM reporting will your billing company provide the Center?
6. Is the RCM offering reporting and any additional value-added dedicated revenue reporting for the organizations to keep track of their revenue whenever needed?
7. Do you have a dedicated team that will manage the ongoing Accounts Receivable?
 - a. Would you be providing us with a periodic analysis of A/R and assisting us with recommendations based off your analysis?
 - b. Do they provide a summary of your current 'Accounts Receivable'?
8. How often does your company/Billing Team Process Insurance Claims i.e. from coding to submission?
9. How do you keep track of denials/rejected claims?
 - a. Do you have dedicated platforms to managing payer denial or dedicated staff?
10. Do you utilize 'Specialty Specific Coders' and or have 'Certified Coders'? Does your company offer a 'Code Analysis' based on your existing medical practice's history? (i.e. Top used codes; Top Paying Codes and Most denied Codes etc.
 - a. Would you be providing us with a periodic analysis of Coding Analysis and assisting us with recommendations based off your analysis?
 - b. Do they provide a summary of "Top Codes Utilized in the last 90 days: Top Paying Codes in the last 90 days and Most Denied Codes in the last 120 days"?
11. How are your teams well-versed at mapping codes from ICD9 to ICD10?
12. What kind of training does your staff have and how often are they required to renew?
13. What is the procedure to protect the privacy of information, i.e. HIPAA Compliant?
14. Do you offer 'Patient Eligibility Verification' services, if so how often and which resource do you use to verify this information? What is the communication process for any discrepancies and changes?
15. Can you provide 'Relative Value Unit (RVU) Analysis' specific to your healthcare organization? Do you offer any benchmarking services to track your doctors' productivity levels with other doctors in the area? Please provide examples

16. Do you offer any recommendations to the practice re Credentialing and Contract Negotiations as it relates to denials or rejected claims' i.e. Provider Enrollment, Provider Network, ...?
17. Do you schedule weekly/monthly governance meeting with your client?

C. Cost and Invoicing

Please answer question 1 in detail, add an additional document as necessary.

1. The Center expects to pay the selected vendor a percentage of the total collected revenue each month, what percentage would you propose? Give examples for how you would calculate and invoice for this percentage
2. How will you invoice Community Healthcore for this percentage? Provide an example document

D. Additional Requirements

3. The successful RESPONDER will use the CENTER contract (ATTACHMENT C). The final version may be modified with consent by the CENTER. RFP 1004-26, all addendums, and RESPONDER's proposal will be a part of that contract.
4. The CENTER's Staff and Vendor team agree to notify each other, either verbally or in writing, as soon as appropriate, of absences of critical positions and to identify a team member who will be attending to the responsibilities usually attended to by the person in the critical position to minimize program impact.
5. The Vendor will participate in a minimum of one meeting per quarter with CENTER, including business office to review performance, concerns, and any updates necessary to continue efficiently

E. References

Community Healthcore requests to RESPONDER to supply the following with this RFP:

1. Provide three (3) references where similar services have been received by their firm.
2. Must be professional references of similar.
3. RESPONDERS who have the best scores will have their references checked.

Include name of firm, address, telephone number, email and name of representative.

Note: It is the practice of Community Healthcore to score a "Zero" after 3 attempts are made for a Reference Check without success and no call back or other communication by the reference.

Also submit with your proposal

1. Acknowledgements of RFP and all RFP Addenda's
2. Provide a complete copy of insurance policy including all addendums
3. Workers Compensation Policy
4. Return signed Conflict of Interest Questionnaire - Attachment B
5. RESPONDER shall provide in their proposal all documentation required by this RFP.
6. Response INFO Sheet - Attachment D

Failure to provide this information may result in rejection of proposal.

III. Scoring of the RFP

A. Factors to be considered include:

1. Delivery terms.
2. Quality and reliability of respondent's goods or services.
3. The extent to which the goods or services meet Community Healthcore's needs as described in this RFP.
4. Past RESPONDER performance, respondent's financial resources and ability to perform, the respondent's experience and responsibility, and the respondent's ability to provide reliable service agreements
5. The impact on the ability of Community Healthcore to comply with laws and rules relating to historically underutilized businesses or relating to the procurement of goods and services from persons with disabilities.
6. The total long-term cost to the local authority of acquiring the respondent's goods or services.
7. The cost of any Community Healthcore employee training associated with the acquisition.
8. The effect of the acquisition on Community Healthcore's productivity.
9. Price
10. Whether the respondent can perform the contract or provide the service(s) within the contract term, promptly provide the services, without delay or interference.
11. Respondent's history of compliance with the laws relating to its business operations and the affected service(s) and whether it is currently in compliance.
12. Whether the respondent's financial resources are sufficient to fulfil the contract and to provide the service(s);
13. Whether necessary or desirable support and ancillary services are available to the respondent.
14. The character, responsibility, integrity, reputation, and experience of the respondent.
15. The quality of the facilities and equipment available to or proposed by the respondent.
16. The ability of the respondent to provide continuity of services.
17. The ability of the respondent to meet all applicable written policies, principles, and regulations.
18. Any factor is relevant to determining the best value for Community Healthcore in the context of this procurement.

B. Proposals will be scored using the following criteria:

These factors will be considered, Some may be given greater weight than others

Description	Max Score
Service Delivery	
Specification for Delivery-Describe the services and explain how you meet specification provided.	400
Qualifications / experience/ staffing-described how most qualified/ experience with similar/ and staffing to meet needs.	300
Cost and Invoicing- Best value for organization	200
References-as requested	100
Additional Requirements	Acknowledge

Center reserves the right to invite more or fewer finalists.

Please direct any questions you have about this specification to

rfp.questions@communityhealthcore.com.