**Response to Bidder's questions**

1. Is there a desire to have a single vendor address all areas (if possible) or is UC Davis comfortable with multiple partners that best fit their needs?
   **R: Prefer single vendor to the extent possible.**

2. For focus areas 3, 4, and 5 in the RFP, do you have a scoring/ evaluation criteria? If so, can you share it?
   **R: Evaluation will be based on Exhibit B_Bidder submissions.**

3. For focus areas 3, 4, and 5 in the RFP, are there any specific 'hot buttons' or areas we should be aware of?
   **R: Unable to disclose at this stage. Recommendations will be included in the revenue cycle assessment summary.**

4. For focus areas 3, 4, and 5 in the RFP, what teams within UCDH will be evaluating our responses? Can you share their roles?
   **R: Various stakeholders will review the bidder responses.**

5. For focus areas 3, 4, and 5 in the RFP, are there any key integrations other than Epic required? (I.e. rev cycle systems, etc.)
   **R: Unable to disclose at this stage. Recommendations will be included in the revenue cycle assessment summary.**

6. How does UCDH currently provide estimates to patients?
   **R: Epic Estimates Module**

7. Do you require prepayment upfront?
   **R: Yes**

8. What is your current Point of Service (POS) collections process?
   **R: Primarily co-pay / estimate collection is user collection at point of service arrival area (*ie: clinic, admissions, emergency*). Self-service payment option (95%) Epic patient payment options via MyUCDavisHealth (5%) Guest Web payment portal.**

9. What is your current POS collection rate? Is there an annual improvement target/KPI?
   **R: Unable to disclose at this stage of process.**

10. Can you highlight the current challenges preventing improvement on DNFB/Unbilled Days and A/R Management?
    **R: DNFB/Unbilled Days – Need to minimize the amount of time a claim is in DNFB status. Details will be included in the revenue cycle assessment summary.**

11. For accelerated revenue, is it UC Davis' preference to have this as recourse or non - recourse?
    **R: Not applicable**

12. Does UCDH maintain in-house payment plans? If so, what plan terms are available currently?
    **R: UCDH offers in-house payment plans for up to 12 months. Patients have self-service option to set up their own payment plans with auto-pay in MyUCDavisHealth online portal if their balance meets a set criteria. UCDH Customer Service Representatives can extend in-house payment plans terms if needed after financial assistance screening.**

13. Who, if anyone, is UCDH's early out vendor? What are the rules of engagement to hand over collections to them?
    **R: UCDH has early out vendor who is assigned accounts for 45 days post discharge.**

14. Does UCDH currently work with a vendor that offers long-term financing options to patients? If so, what are their terms? (I.E. # of months, recourse/non-recourse, interest/no-interest, % of patients that are approved)?
    **R: UCDH offers patients interest free long-term financing for up to 36 months through vendor. All patients who complete applications are accepted. Payment default rates are less than 5%.**

15. Can you highlight the challenges with the current patient financial experience?
    **R: Patients currently have self-service options and online payment tools enabled in MyUCDavisHealth with additional features on roadmap. Recommendations for additional enhancements will be included in the revenue cycle assessment summary.**

16. Does the scope involve both Professional Billing (PB) and Hospital Billing (HB)?
    **R: Yes**

17. How many facilities within the Hospital?
    **R: Main hospital and 17 primary care clinics**

18. What is the current EHR system?
    **R: Epic**

19. Does every hospital have different EHR-EMR system?
    **R: No**

20. What is the name of current Clearing House? example SSI, Assurance, Change?

**R: Unable to disclose at this stage of process.**

21. Do you have single or multiple clearing house? by Facility please do name them?
    **R: Multiple**

22. What is the current PMS system [E.g.: Epic, Cerner, Meditech, etc.]?
    **R: EPIC**

23. Do you have single PMS or multiple by facility? please name them?
    **R: See response under question# 22.**

24. Do you have separate document system or embedded within EHR-EMR-PMS systems? if yes please name.
    **R: Onbase & Epic**

25. Is medical coding also part of the scope of work? If yes, what is Coding Application?
    **R: No, medical coding not in scope.**

26. Do you Provide Ambulatory Services?
    **R: Yes**

27. Do you have external Diagnostic Centers?
    **R: No**

28. Please share monthly/annual volumes estimates across all scope of work.
    **R: Unable to disclose at this stage of process.**

29. Last six Month's Average Charges per month Visit | Dollar | Service Line?
    **R: Unable to disclose at this stage of process.**

30. Current Outstanding AR [90 + Days] by Visit | Dollar or Raw Data?
    **R: Unable to disclose at this stage of process.**

31. Average Monthly Collections for last 6 months (Insurance & Patient side)
    **R: Unable to disclose at this stage of process.**

32. Do you have DNFB's?
**R: Yes**

33. What are the total staff deployed currently for these services?
**R: Unable to disclose at this stage of process.**

34. Are the Payor Contracts embedded within system or outside? And are they updated every month?
**R: Currently managed through external vendor system with project plan to embed within EHR system.**

35. What is the expectation for the Denial Management component?
**R: Prevent revenue loss through implementation of proactive denials management measures.**

36. Does UCDH expect for an analysis for all write-offs conducted by UCDH to help determine if there is revenue leakage?
**R: Yes**

37. Does UCDH expect for the winning bidder to work with all areas that might be contributing towards the revenue loss and write-off?
**R: Yes**

38. What does UCDH expect from the selected vendor when the denial is because of insurance benefits or limited coverage, e.g. Non-covered Services", "Payment Included in Pmt for Other Services", "Exceed allowable visits"?
**R: Early identification of benefit limitations and opportunities for front-end payment collections process.**

38.1. This could be due to insurance limitation, registration or patient estimates identifying services not covered by the insurance. Does UCDH expect for the vendor to identify the issue, and make recommendation on how to address the problem? Or, does UCDH expect for the vendor to work with the individual areas negatively affecting revenue?
**R: Identify and make recommendations.**

39. What Is the scope UCDH looking for: Consulting, Services, or Technology?
**R: Depending on the workstream mostly it is Consulting. In couple of workstream it may require Technology services.**

40. For Denials Management, is UCDH looking for a vendor to appeal denials for payment or more of a consultative approach to reduce denials rates whereas UCDH would pursue denials internally?
**R: Consultative approach to reduce denials rates**

40.1. If vendor is to pursue the denials, what type of denials will be referred?
**R: Not applicable**

40.1.1. Can you please provide estimated monthly account volume for IP/OP/ PB and associated dollars.
**R: Vendor services will not include working denials**

41. Are offshore resources permitted if all data is domiciled in the United States?
**R: Not applicable**

42. For the other areas of Focus and Objectives for UCDH, it appears you are looking for a consultant to evaluate and provide insight and then proposed plans as opposed to a service/technology provider for optimization, can you please clarify?
**R: Scope will primarily be project management and implementation support for revenue cycle assessment recommendations.**

43. What work efforts have taken place ahead of placement?
**R: Unable to disclose at this stage of process.**

44. Will Vendor have access to all relevant patient accounting systems?
**R: Yes, upon completion of required documentation for user access and security**

45. Does UCDH allow vendors to access EMR data via FHIR Server Interoperability?
**R: No**

46. Can documents and/or billing data be pushed via structured HL7 communications via FHIR Server?
**R: No**

47. How many vendors do you anticipate responding to this RFP?
**R: Unknown at this time.**

48. Is there a current vendor in place and if so why the change?
**R: Unable to disclose at this stage of process.**

49. Can you share which firm was selected to perform the assessment? Will they be considered for the optimization support, as well?
**R: The firm that conducted the assessment will not be considered for implementation.**

50. Are the optimization initiatives inclusive of both hospital and professional fee revenue cycle? Inpatient, outpatient, and clinics?
**R: Yes**

51. Please provide an overview of UC Davis's technology environment as it relates to the revenue cycle (e.g., EHRs, patient financial systems, relevant bolt-on technologies)
**R: Epic integrated vendors include: credit card gateway, secure payment (DTMF), patient financing portal, and External Payment Page ( Epic MyChart).**

52. Can you please share UC Davis's current denial rate and top denial reasons?
    **R: Unable to disclose at this stage of process.**

53. Can you please share the current unbilled days and days in A/R?
    **R: Unable to disclose at this stage of process.**

54. Can you please clarify what is meant by "fixed fee"? Are you expecting the engagement to be priced based on professional fees only or would you consider and incentive-based structure?
    **R: All-inclusive pricing per the focus areas.**

55. Is UC Davis expecting the firm to provide technical resources (e.g., system analysts) to make discrete changes to the system(s), or will UC Davis's internal resources be available to make necessary changes?
    **R: UCDH would like to explore all resources/skill sets offered by bidders.**

56. Will you be sharing the answers to questions submitted by other firms?
    **R: Responses to the questions will be posted on the website.**

57. What is the annual net revenue breakdown between HB and PB?
    **R: Unable to disclose at this stage of process.**

58. Are there revenue projections/estimates associated with improvements in each workstream? If so, can you share those?
    **R: Unable to disclose at this stage of process.**

59. Can you define which workstreams include HB, PB, or both?
    **R: Need additional information to answer**

60. The Charge Capture scope seems aligned to HB/Facility opportunities. Can you confirm this is HB only?
    **R: HB and PB charge capture opportunities**

61. Can you confirm that the departments listed within Charge Capture scope were all identified as having opportunity?
    **R: Yes, all have an opportunity; however there may be other departments identified for inclusion.**

62. Is there a single Managed Care / Payer Contracting function across the organization?
    **R: If this is referring to Contracting being centralized, the answer is yes.**

63. For the authorization workstream, is the majority of this workflow centralized? If not, please describe.
    **R: Authorization workstream is a hybrid model with multiple teams providing prior authorization support.**

64. For the patient access eligibility/RTE workstream, is the majority of this work centralized? If not, please describe.
**R: Pre-service eligibility verification is managed by batch jobs. Time of service and mismatched response reverification is completed manually using on demand submission.**

65. By what date would you like to begin this work?
**R: Upon completion of an approved SOW.**

66. Other than the services specifically mentioned as centralized within the PCC (scheduling, referral processing, etc), are any of the other focus areas standardized and/or centralized? To what degree?
**R: In the processes of centralizing prior authorization for elective services and specialty services. Outpatient authorizations are centralized for service lines that have centralized scheduling support.**

67. Do the focus areas outlined include hospital and professional billing components? For example, the Revenue Integrity focus area highlights high complexity acute departments, are you also interested in including any ambulatory practices?
**R: Yes**

68. Are there any in-progress or planned competing priorities related to the current revenue cycle transformation (e.g. vendor selection, implementation of bolt-on technology, etc.) that will need to be accounted for as part of the implementation for these focus areas?
**R: Updating GL Chart of Account string in EPIC, Large clinic and new surgery center opening in 2025**

69. Would we be expected to bring our coding expertise to facilitate improvement with the PFS focus area, specifically DNFB?
**R: No.**

70. Will we be provided with comprehensive root cause analytics (likely included in the historical assessment) or should we anticipate building these detailed analytics into the scope of work. For example, are the existing denials management analytics sufficient to understand denial type, location, etc.?
**R: Yes**

71. What are some of the biggest takeaways related to denials management from the 2023 end-to-end assessment?
**R: Unable to disclose at this stage of process.**

72. What are some of your challenges related to denials management today?
**R: Unable to disclose at this stage of process.**

73. Can you share any volume information UC Davis experiences with denials per/month?
    **R: Refer to response in question# 81.**

74. What is your current denials management workflow?
    **R: Monthly reporting and trending, denials management workgroups, and dedicated work queues and workflows.**

75. Who are your top payors?
    **R: Unable to disclose at this stage of process.**

76. Who are your most problematic payors?
    **R: Unable to disclose at this stage of process.**

77. Is UC Davis currently tracking: trends, top payors, success rate?
    **R: Yes**

78. What are some of your top denials category?
    **R: Medical necessity, authorization, registration/eligibility, and non-covered.**

79. What is your current contracting process with your payers?
    **R: Our Contracting dept secures modeling outcomes from our Decision Support team to be used when discussing rate changes during negotiations.**

80. How often are those negotiations done?
    **R: Depends on the payer. Some are annual, with CDM changes while others may be every 3 years.**

81. Could you provide additional specifics related to the focused areas outlined in the RFP? Such as, what is the current denial rate? What is the current POS collection rate?
    **R: Unable to disclose at this stage of process.**

82. Could you provide background regarding whether there are centralized business office, registration and revenue integrity functions across all locations or do the locations operate separately? This question is referencing the locations of the UC Davis Medical Center, the Cancer Center, Children's Hospital, Alzheimer's Disease Center, MIND Institute, Burn Center and Adult and Pediatric ED.
    **R: Registration functions are decentralized.**

83. Do the Objectives and Focus areas outlined in the RFP include Ambulatory Services and the Medical Group? If yes, are the focus areas noted centralized under the UC Davis Medical Center umbrella or do they have separate revenue cycle leadership.
    **R: Yes, Ambulatory services and Medical Groups do not report up to revenue cycle leadership.**

84. Could you provide the number of FTE's in patient access, prior authorization and revenue integrity?
    **R: Unable to disclose at this stage of process.**

85. Do you anticipate or prefer the work to be completed on-site, remotely or a combination?
    **R: This will be based on project dependencies.**

86. Does UCDH anticipate all services requested be accomplished in the initial year or is it anticipated that certain areas would be performed over a multi-year period (i.e., for example, 2024 and 2025)? What are the expectations for completion timeframe and/or duration?
**R: Multi-year will be determined prior to project implementation.**

87. As a partnership, we do not have audited financial statements, and it is the firm's policy not to disclose financial statements or tax returns of the firm. We are able to provide a letter of verification from our bank, a five-year history of net fees, as well as a current D&B summary report to assure our financial stability. Will these satisfy the requirement?
**R: Yes, the documents will satisfy.**

88. In addition to its complete proposal, is it acceptable for a bidder to submit a redacted version of their proposal from which confidential information (as defined by UCDH) has been stricken? If not, how would UCDH like xxxxx to mark confidential information?
**R: Along with complete proposal, submission of redacted version is acceptable. All confidential information need to be noted.**

89. Will you conduct in-person oral evaluation of any finalists?
**R: Yes. In person and virtual**

90. Can you provide an estimated / anticipated start date for this work?
**R: Upon completion of the SOW**

91. What is the expected contract length?
**R: Unknown at this time.**

92. What falls within the UC Davis Patient Contact Center (PCC)? Ambulatory, Medical Group, all Pre-Registration Services?
**R: PCC supports scheduling, outgoing service authorization (when patients are being referred outside of UCDH), internal referral preparation before manually flagging the referral to the financial clearance unit for authorization. Ambulatory specialty services support scheduling, prior authorization and all onsite time of service registration. UCDH does not have a centralized pre-registration process.**

93. For Focus Area #5: Does financial clearance fall into the responsibilities of the Patient Contact Center?
**R: No. Financial clearance is supported by the Financial Clearance Unit which reports up to Finance Division. The Patient Contact Center reports up to Ambulatory Operations.**

94. For each component of the implementation, is the scope limited to either HB, PB, or both?
**R: Some improvement opportunities are HB or PB specific.**

95. Focus Area #1: Do you have reporting established and are you able to share top denial and AWO categories by annual net or gross financial impact?
**R: Yes. Unable to disclose at this stage.**

96. Focus Area #2: Do you currently use an RTE tool or is that part of the implementation?

**R: Current RTE tool already active.**

97. Focus Area #3: Do you utilize a self-pay vendor for patient collections?
**R: Competing vendor model with 2 vendors assigned by alpha split**

98. Focus Area #6: Would prior authorization workflows include both acute & ambulatory authorizations?
**R: Yes**

99. Focus Area #6: Are responsibilities for obtaining authorizations centralized or decentralized at UC Davis?
**R: Decentralized, project will focus on work centralized within the Financial Clearance Unit.**

100. Focus Area #6: Is UC Davis using any technology/ automation focused on streamlining the prior authorization process?
**R: No current automation for prior authorization**

101. Focus Area #7: Would the charge capture review and implementation focus target clinical workflow improvement or backend reconciliation workflows?
**R: Clinical workflows improvement to mitigate denials, ABN processes, covered diagnosis codes.**

102. Focus Area #7: These service lines are primarily focused on HB, is that correct? Are other service lines out of scope?
**R: Other service lines may be in scope**

103. Systems & Vendors:
103.1. Is Epic used across all service lines (including acute and ambulatory)?
**R: Yes**

104. Are any of the core revenue cycle responsibilities or subsets of responsibilities outsourced to vendors (i.e. Responsibility: Follow-up. Subset: Follow-up for third party liability)
**R: Yes**

105. Patient Experience - do you currently have reporting established to understand the top patient complaint reasons when contacting Customer Service (i.e. "balance dispute" or "estimate accuracy")?
**R: Call reason report is generated to track patient complaints. Balance dispute is top category for patient complaints which primarily consists of patients calling due to lack of understanding of their benefit plan and out of pocket costs.**

**Page 8 – Denials Management**

106. Could you provide your current Denial Rates?
**R: Unable to disclose at this stage of process.**

107. What are your top 10 denials reasons?
**R: Unable to disclose at this stage of process.**

108. Are your denials clinical, technical or both?
**R: Both**

109. Could you provide the top 10 payers that deny claims?
**R: Unable to disclose at this stage of process.**

110. Could an awarded bidder provide the operational work, i.e., write and appeal the denied claims, etc, following this consulting engagement?
**R: No**

**Page 10**

111. Do you have any page limits for our proposal or supporting documents?
**R: Precise and concise information is recommended. No page limits.**

112. Do you have any file size limits for any supporting files that are submitted as a PDF file?
**R: No limit but must be able to be forwarded via email.**

**Exhibit B – Tab A Question 2.1**

113. We are a private corporation that does not have any legal requirement for audited financial statements. Could we provide financials that have been reviewed but not audited by our CPA?
**R: R: Yes.**

114. How many years of financial statements do you require?
**R: Recommended for last 3 years.**

*RCM Assessment Findings*

115. Is it possible to share the recent RCM assessment findings or receive a summarized version? Understanding the findings in more detail will help us facilitate a more effective proposal. Please note, we are open to signing a Non-Disclosure Agreement if necessary.
**R: No. As necessary, may share with the awarded bidder**

116. If it is not feasible to share the RCM assessment material, could you provide an estimated financial opportunity range for each of the seven Focus Areas outlined on page 8 of the RFP, assuming it was calculated during the assessment?
**R: Unable to disclose at this stage of process.**

*Funds Flow*

117. In the 2022-2027 clinical strategic plan, "Aligned Incentives (New Funds Flow)" was cited as an enabler of Transformation. How will this impact revenue cycle operations?
**R: Funds flow is an internal distribution of collections. Revenue cycle operations is part of how the money comes into the organization, but not involved in our internal distribution methodology.**

*Goals / Performance Metrics / Reporting*

118. Currently, what revenue cycle metrics are being tracked and can you share recent baseline performance?
**R: Cash Factor, Cash Collected %, AR Days, CFB Days, Min Days, DNFB Days, Denial Rate, Charge Lag, Charity Care as a % of Revenue, Bad Debt %, and Admin Write Off as a % of Net Revenue.**

119. What goals have you set for the revenue cycle teams (e.g., AR Days, POS Collections, Denial Rates, etc.)?
**R: Cash Collected %, AR Days, CFB Days, Min Days, DNFB Days, Denial Rate, Charge Lag, Bad Debt %, and Admin Write Off as a % of Net Revenue.**

120. What reporting mechanisms are used to drive performance (e.g., 3rd party BI software, Epic Custom Reports)?
**R: EPIC and/or Tableau dashboards and custom reports**

*RCM Department / Vendors / Technology*

121. Which Epic modules are installed and implemented? Could you describe the current state of utilization?
**R: HB and PB Resolute, Cadence, Caboodle, Clarity, ClinDoc, Grand Central, Prelude, Tapestry, Willow, Kaleidoscope, Beacon, Stork, Radiant, EpicCare, Phoenix, OpTime, Beaker, and ASAP, Epic Anesthesia, EpicCare etc are in use.**

122. What clinical services, if any, are functioning outside of Epic (e.g., radiation oncology, lab, pathology, etc.)?
**R: None**

123. How are the Hospital Billing (HB) and Professional Billing (PB) RCM teams organized? Are they consolidated into one department or separated?
**R: Separate hospital and professional billing teams. Self-Pay is single billing office (HB and PB).**

124. What RCM teams or functions, if any, are outsourced, and to whom? Which are in-person or remote?
**R: Unable to disclose at this stage of process.**

125. Would it be possible to provide an inventory or description of purchased services within the revenue cycle department (i.e., technology and outsourcing partners)?
**R: Unable to disclose at this stage of process.**

126. What kinds of automation technologies (e.g., RPA, machine learning, generative AI, etc.) are in place today and for what functions/workflows? Are any being contemplated for the future?
**R: Unable to disclose at this stage of process.**

127. Are there existing, long-term vendor commitments we should be aware of for implementation purposes?
**R: Unable to disclose at this stage of process.**

*Payer Contracting / Relations*

128. Currently, how is payer contracting managed? What tools are utilized to manage contracts and track payment variances?
**R: HB is currently using a 3rd party vendor to build contract profiles and send expected reimbursement information to Resolute (to be used to contractualize liability buckets). Future state plan is to move to EPIC Contracts. Variances are identified and managed within EPIC. PB is currently migrating to EPIC Contracts.**
**PB contracts have been loaded into EPIC, HB contracts will be loaded into EPIC by March 2025**

129. Are there current payer issues affecting timely payment? If so, what is driving this and which payers?
**R: Yes. Most common issues involve both the health plan and med group denying risk.**

130. What is your current payer mix? Do you have any incentive-based contracts?
**R: Unable to disclose at this stage of process.**

*Patient Financial Experience*

131. Is Hospital Billing (HB) and Professional Billing (PB) consolidated when calculating and collecting patient responsibility amounts?

**R: Yes**

132. Is it possible to receive the most recent patient experience survey results?

**R: Refer to revenue cycle assessment summary for Patient Billing office.**

133. What channels are provided to patients for payment (e.g., patient portal, text to pay, etc.)?
**R: MyUCDavisHealth (with and without login), IVR Pay-by-Phone, DTMF collections with call center representative, walk-in, and lockbox (text to pay, apple pay, and google pay on roadmap for implementation)**

*Engagement Fee Structures*

134. Would you prefer the all-inclusive fixed fee pricing include travel expenses, or should it be estimated separately? What is the expectation for in person and virtual support?
**R: Fixed fee pricing and mostly will be virtual. Estimate separately for travel expense. Travel expenses will be paid according to UC policy.**

135. Is UCDH open to an incentive-based engagement (e.g., milestones, gain sharing, etc.)?
**R: The current engagement is a fixed fee pricing. If a milestone payment is required for Focus Areas, the milestones should be based on fixed fee per milestone.**

136. What level of automation is currently being employed within Epic?
**R: Unable to disclose at this stage of process.**

137. What is the current breakdown of AR by category (ie. Unbilled, CFB, Outstanding, denial, Credits?)
**R: Unable to disclose at this stage of process.**

138. What percentage of patients utilize My Chart for Scheduling? Payments?
**R: 6-month MyChart payment averages (January 2024 – June 2024)**
- **Self-Service Payment % - 57.7%**
- **Self-Service Payment Plans Created % - 75.3%**

139. It appears that the PCC owns AMBULATORY scheduling, referrals and Template management. Who owns INPT Scheduling?
**R: Unable to disclose at this stage of process.**

140. Are they utilizing RTA?
**R: No**

141. Does PCC do "pre-visit" calls/reminders? Collections on outstanding accounts before non-emergent visits?
**R: Telephonic and text pre-visit calls. No pre-service collections performed.**

142. What are the top 5 denials (including Volume and $$$) for Hospital? Professional?
**R: Refer to response for question number 107.**

143. Are payer contracts loaded into Epic Contract Management? IF YES, Which Payers? IF NO, How are contracts managed?
**R: Currently managed through vendor system with plan to transition to EPIC contracts.**

144. Has CDM and CGT standardization occurred?
**R: Need further clarification around CGT.**

145. What is the value of the findings and recommendations from the initial assessment for each of the Focus Areas? (The RFP says… "Some of these focus areas may utilize the findings and recommendations from the initial assessment."…asking this question to estimate the value of the opportunity and required effort to achieve it.)
**R: Unknown at this time.**

146. Is charge reconciliation decentralized?
**R: Unable to disclose at this stage of process.**

147. Are referrals, decision trees and/or visit types in scope? (One objective states, "Reduced revenue leakage," but there is no reference to any of these items.)
**R: No**

148. Do you utilize any third party vendors to support revenue cycle operations? If so, is there work in scope?
**R: Yes**

149. Facility Structure:
149.1. # of Service Areas
**R: See response under question# 17.**

149.2. Single Billing Office (SBO)?
**R: SBO has vendors for bad debt collections, international collections, comprehensive eligibility screening services, and legal support for third party liability cases.**

150. What is your current cost to collect? (One objected states, "Cost reduction opportunities through enhanced revenue cycle efficiency and resource allocation." Asking this to estimate value of opportunity and required effort to achieve it.
**R: Unable to disclose at this stage.**

151. xxxxx is a member of Epic's new Revenue Cycle Partners program - xxxxxx– and as such, are permitted access to previously unavailable system and performance tools. Will UCDH approve permission to have Epic provide their standard performance comparisons/analytics to better inform our response?
**R: Unable to share at this stage.**

152. What type of denials do you intend to outsource?
152.1. IP/OP?
152.2. Hospital only?

152.3. Authorization, Medical Necessity, Level of Care, Readmissions?
152.4. Will administrative and technical denials be included?
**This RFP is not related to outsourcing**

153. What is the timing on placement of the denial? i.e. Day 1 after remit?
**R: Unable to share at this stage.**

154. Will estimated monthly or annual data be provided for pricing?
**R: Unable to share at this stage.**

154.1. Est Monthly Volume of denials
**R: Unable to share at this stage.**

154.2. Est Monthly $ of Denials
**R: Unable to share at this stage.**

154.3. Average balance for denials
**R: Unable to share at this stage.**

155. Does the $ in the data represent Billed Charge or Estimated Net expected?
**R: Unable to share at this stage.**

156. Will the placements be go-forward only or will there also be a back log include?
**R: Unable to share at this stage.**

157. If backlog included – will the data be provided separately for back log vs anticipated volume going forward?
**R: Unable to share at this stage.**

158. Will there be a bottom threshold expected?
**R: Unable to share at this stage.**

159. Denial Management can be a separate service. I wanted to ask if UC Davis has a vendor for Underpayments, zero balance, etc. xxxxxx solution is currently being considered for 2nd position behind xxxxxxxxxxxx. xxxxxxxxxx, with our 21 separate special teams made up of over 1200 coding RNs have had particular significant recoveries with infusion therapy due to the intricacies of cancer and related coding.
**R: This RFP is not related to outsourcing**

160. IF UP are not part of the RFP, can we keep in contact with xxxxxxx, xxxxxxx and any other interested parties on the outcome of the pending evaluation at UCSD?

**R: Not related to UC Davis. Follow UCSD guidelines.**

161. In a presentation that was recently given by UC San Diego Health (attached) at HFMA, the team shared that due to a union contract arrangement, the UC Regents issued a mandate that all work be

performed by UC employees. The following links support this (https://www.ucop.edu/procurement-services/uc-procurement-newsletters/winter-2021/contracting-for-covered-services.html and https://afscme3299.org/media/news/uc-regents-release-implementation-guidelines-to-generally-prohibit-outsourcing/). Is UC Davis Health exempt from following this mandate and plan to outsource the work described in the RFP?
**R: This RFP is not related to outsourcing.**

162. If outsourcing is not an option due to the Board of Regent's mandate, can we propose automation solutions that will enable UC Davis Health team members to be more efficient?
**R: Respond as per Focus Areas.**

163. Appendix A UC Terms and Conditions, Section "7.6 No Offshoring. Supplier's transmission, transportation or storage of institutional information outside the United States, or access of Institutional Information from outside the United States, is prohibited except with prior written authorization by UC."

163.1. Will UC provide written authorization for offshore access using a Virtual Desktop Infrastructure that is HIPPA compliant?
**R: No offshore access.**

163.2. Will UC permit access to UC account data from our secure US-based datacenter and tools?
**R: If required, the responsible teams or department upon review will determine regarding granting access.**

164. For each line of service referenced in the RFP, please provide monthly and/or annual volumes anticipated to be supported through this RFP. This is needed to provide the most competitive pricing.
**R: Unable to disclose at this stage of process.**
**2023 data:**
**License beds – 646, Admissions - 33,123, Discharges 33,193, Outpatient visits 1,034,377, Case mix 2.16,**

165. The RFP requests "all-inclusive fixed fee pricing". Please clarify or confirm this is a fixed FTE rate by service. Can fixed transaction rates be proposed?
**R: This engagement is a Fixed fee pricing per Focus Area. Estimate separately for travel expenses. Travel expenses will be paid according to UC policy.**