1	**Can you detail which 20 counties are seeking an EHR under this RFP?**
	Not at this time. We are still in the process of finalizing contracts with participating counties, as such we cannot notify vendors in advance of final county approval.
2	**Can you provide a breakdown of the number of users anticipated 12,000 users in the 20 counties by role (i.e. MD, PA, NP, nursing)?**
	No. This is variable across counties and organizations. If it impacts your pricing or solution approach, anticipate 15% administrative/billing staff, 80% non-MD clinical staff, 5% MD.
3	**Can you provide an estimate of concurrent users within the 12,000 anticipated users?**
	The large majority of County Behavioral Health operations observe normal business hours. As such, anticipate a peak concurrent usage of 75% - 85% during regular business hours.
4	**For those counties where the subcontractor users the county's EHR, will those users be included in the estimated 12k figure? If not, how can those users be accounted for with the selected vendor under this contract?**
	The 12,000 user count provided includes the Contractor staff anticipated to be using the semi-statewide EHR.
5	**Is CalMHSA looking for an IDIQ pricing model for any additional counties who seek to join the 20 initial counties?**
	Yes. The total anticipated number of counties that will use CalMHSA's semi-statewide EHR is anticipated to grow beyond the initial 20 identified. As such, during the initial term of the agreement, it is anticipated that many elements of the solution (most notably user counts) will increase through subsequent purchases.
6	**Do the 20 counties under this RFP use the same EHR currently or different ones?**
	The different counties currently use different solutions.
7	**What EHR/EHRs are in use today among the 20 counties?**
	Vendors interested in learning about the current market in California can review the External Quality Review county-specific reports which outline vendor relationships: https://caleqro.com/
8	**Will the CalMHSA organization be the primary vendor contact for the project and serve an implementation role or will each county be leading each county's implementation?**
	CalMHSA will be the primary vendor contact for contracting, implementation, Tier-1 support, and on-site technical/configuration activities.
9	**Will the CalAIM project to standardize some operations be complete before the first EHR site is live or will the system need to accommodate both the current billing code sets and the standardized billing data? How will this work for services paid for by the sites if external systems have not completed the CalAIM transformation?**
	Go-live of the new semi-statewide EHR will coincide with the go-live of CalAIM Payment Reform. As such, the newly implemented EHR will only need to meet CalAIM requirements (Please note that there are other historic state-specific requirements outside of CalAIM [such as various state reports] that will remain in effect and must be provided in the new solution).
10	**Can you elaborate on specific community outreach activities that an EHR would support? Will there be an MPI/eMPI record for those who attend such an event?**
	Two examples - Homeless Outreach and Suicide Prevention During Homeless Outreach, staff interface with the homeless population and attempt to connect them with appropriate resources. During these interactions, those contacted may not provide identifying information, thus an entry to the eMPI and Medi-Cal Eligibility verification is improbable. Nonetheless, recording the metrics associated with these activities and potentially creating a charge for each contact/unit to be reimbursed via a grant or other funding stream is required of the semi-statewide EHR. Suicide Prevention might be provided via a presentation to a large group at a local school. In this example, individual contacts are not recorded, rather the event would be the unit of service which would drive the charge to be reimbursed via a grant or other funding stream.

11	**Will the sub-contractor care providers access the new EHR and need to be accounted for as "users" in a Cloud hosted solution or will they use their own EHRs with an electronic data exchange process that will populate the data in the new CalMHSA EHR system?**
	Both approaches will need to be supported.
12	**For on-site demonstrations, will vendors be working with the use cases as they are described in the RFP or will additional scripts be developed and given to the vendors for demonstration?**
	Both. The use cases in the RFP were provided to provide context to the requirements being requested. At the point where "Treatment Episode Requirements" were discussed, it was stated that there was an expectation that any solution being proposed would provide common Behavioral Health Treatment functionality and limited use cases were provided. During on-site demonstrations, the use cases provided will be used as the basis for the "System Wide Requirements" and "Care Coordination Requirements" activities. For each requirement it is expected that the vendor will demonstrate the functions pertaining to the requirement directly or loosely using the provided use-case, and then demonstrate and explain the underlying design elements and/or tools that made the function perform as to meet the requirement. When the "Treatment Episode Requirements" are demonstrated, the vendor will have more flexibility to follow their own use cases allowing that all the specific requirements where details provided in the RFP are covered in full.
13	**If a vendor can provide a data warehouse that incorporates all data elements/tables from the EHR, is the second use case satisfied without the need for updating the data set available within the data warehouse?**
	Electronic Health Records are usually comprised of dozens/hundreds of data tables. Not all these tables are needed in a data warehouse for common reporting needs. Therefore, a data warehouse design that replicates all tables with all data is potentially inefficient. If a vendor is able to provide a data warehouse that replicates all tables with all data and the replication effort that is anticipated to be executed nightly can be completed within a reasonable timeframe, then the second use case would be satisfied without updating the data set.
14	**Does CalMHSA require separation in the data warehouse between clinical and financial data or do reports potentially draw on both sources simultaneously?**
	Reports will draw on both sources simultaneously.
15	**If a vendor system has customizable business rules that can replace the existing process to "script" are the use case requirements satisfied since this would eliminate or significantly reduce the need for local development using configuration tools within the new EHR?**
	It depends upon the scope and limitations of these "customizable business rules". We have provided use cases and if your "customizable business rules" can address these examples, then respond accordingly. During the demonstrations, anticipate that we will ask questions as to the scope and limitations.
16	**Is CalMHSA seeking an integrated telehealth solution as part of this EHR procurement or an interface to an existing telehealth system that is already deployed? If a new telehealth solution is being sought, can you provide the number of anticipated users by role?**
	Yes, an integrated telehealth solution is part of the requirements within this RFP. It is not an interface to an existing telehealth solution. We cannot provide the number of anticipated users by role. For pricing related to telehealth, provide pricing based upon a number of users of the telehealth solution your organization would expect given the overall user distribution described in question #2.

17	**Is CalMHSA seeking a voice recognition solution as part of this EHR procurement or an interface to an existing voice recognition system that is already deployed? If a new voice recognition solution is being sought, can you provide the number of anticipated users?**
	Yes, a voice recognition solution is part of the requirements within this RFP. It is not an interface to an existing voice recognition solution. We cannot provide the number of anticipated users by role. For pricing related to voice recognition, provide pricing based upon a number of users of the voice recognition solution your organization would expect given the over-all user distribution described in question #2.
18	**Does CalMHSA have existing patient signature pad hardware/technology for patient consent/sign off? If not, are wet signatures that are scanned acceptable or is patient signature pad part of this RFP?**
	Collection of electronic patient signatures are part of this RFP. Given the number of devices and mobile nature of many of the staff, use of touchpad rather than separate signature pad hardware is preferred.
19	**Are there existing on-site pharmacy services? If yes, are these county staff or contract and is the agency seeking an integrated retail pharmacy solution as part of this procurement or will eRx scripts be generated to retail and on-site pharmacies?**
	Across the 20 counties the majority of operations/programs are outpatient. As such, the vast majority of medication/eRx/pharmacy requirements are associated with eRx scripts generated to retail pharmacies. There is a limited need for inpatient, closed loop medication functions. For pricing purposes, vendors should provide pricing for one (1) inpatient facility with 16 beds with an on-site pharmacy, with one Pyxis dispensing machine. This would entail Computerized Provider Order Entry (CPOE) functions within the EHR, an HL7 outbound feed to an existing Pharmacy system, and an electronic medication administration record (eMAR) within the EHR to be fed by an inbound HL-7 feed from the existing Pharmacy system.
20	**Can you provide details for any existing on-site medication dispensing machine solutions?**
	Specific number is not available at this time. For pricing purposes, vendors should provide pricing for one (1) inpatient facility with 16 beds with an on-site pharmacy, with one Pyxis dispensing machine. This would entail Computerized Provider Order Entry (CPOE) functions within the EHR, an HL-7 outbound feed to an existing Pharmacy system, and an electronic medication administration record (eMAR) within the EHR to be fed by an inbound HL-7 feed from the existing pharmacy system.
21	**Can you elaborate on what medications are to be administered on site? Is this limited to vaccines & injectable long acting anti-psychotics or are oral medications also administered? Does CalMHSA have medication administered therapy (MAT) programs including methadone dispensing on-sites? If yes, is the agency seeking MAT solution replacement or integration as part of this RFP?**
	Medications administered on-site are predominantly oral medications with limited administration of injectable long acting anti-psychotics. MAT/Methadone dispensing is not part of this RFP.
	Can you provide the list of lab service vendors that will need to be integrated or is it only the two listed (Quest & Labcorp)?

22	Not at this time. Throughout each of the Counties, Quest and Labcorp are the predominant laboratory services providers. Nonetheless, different counties may have other commercial providers or send labs to local hospitals. For pricing, please provide an estimate based upon a "per connection"/"per interface" basis.
23	**For data conversion from legacy systems, will change orders be generated outside the RFP for data conversion since the RFP indicates this is outside of the central scope? If not and some data conversion must be built in, how should cost be included in the response to indicate this is optional and pending final requirement elucidation from CalMHSA?**
	THIS IS A VERY IMPORTANT QUESTION/POINT OF CLARIFICATION **Under the requirements of this RFP, it is expected that the conversion of data needed to "seed" the new semi-statewide EHR to immediately continue the treatment and operations associated with current clients/census will be included.** It is understood that the scope and capabilities related to converting data is highly variable across different solutions. As such, in their response, the vendors will need to identify what records types are supported through their "standard" conversion processes. We will also look for the vendor to provide the pricing for their part of such services across the 20 participating counties. In addition to the standard conversation efforts, each of the 20 counties will need to convert extensive data from their legacy system. This effort is not part of the requirements of this RFP and will be addressed through a separate effort.
24	**Can you elaborate on why go live dates in July 2022 are firm? Is this for the purpose of the RFP response or are there constraints that must be met due to legacy system sunset dates?**
	The proposed timelines are fixed and reflect the business needs of the participating counties. Our current understanding is that 2-3 of the 20 participating counties will need to go-live on the semi-statewide EHR on July 1, 2022. These Counties will be used as a beta for the overall implementation. The remaining counties will then go-live July 1, 2023 to coincide with the go-live of new CalAIM requirements.
25	**Can you elaborate on the evaluation criteria within each section that rolls up to the total score? For example, is the score higher for features that are client configured versus vendor configured? If a feature is vendor configured so that it meets regulatory standards such as ONC MU functionality, is that more desirable than using staff time to configure the feature? If something can be vendor configured and altered subsequently by client–led configuration, which response should be selected based on the scoring model being used?**
	Each vendor response section will be scored as a whole. The narrative response will be taken into consideration with the responses to the functional requirements. In general, features that are configurable, whether by the vendor or the customer are more desirable as compared to features that must be integrated via 3rd party or vendor developed. However, specific point values are not being assigned to each of the functional requirement's rows/responses. To answer specifically, if the answer involves a vendor configuration that will allow a client configuration, use the one that is most important. Either one will be considered desirable and will positively impact the score for that "section".
	Section 3.2/EHR Vendor Response Sheets XLS - If a feature is implemented in production using a legacy version of a vendor's software but also included in the web-native Cloud solution being proposed for CalMHSA, should it be marked as "In Use in Production Now"?

26	If a vendor's solution is in the process of a major upgrade wherein there is legacy functionality that addresses an identified requirement, but there is no example where that legacy functionality is in productive use in combination with the upgrade, please mark "Yes" in "In Use in Production Now". But, if there is a reasonable chance that the legacy functionality may be negatively impacted by the upgrade, then mark "No" in "In Use in Production Now". For example, if a solution is having a major upgrade to its UX, this may impact functions such as calendars in Appointment Scheduling functionality, but it may not impact the processes that generate Claims EDIs. In this example, "Appointment Scheduling" functionality should be marked "No" in "In Use in Production Now" whereas "Claims Creation" should be marked "Yes" in "In Use in Production Now". In any/either case, additional explanation can be provided in the "Comments" for each response.
27	**Section 3.2/EHR Vendor Response Sheets XLS - For sections of the response that are not applicable for the question "In Use in Production Now" such as "prod/test/dev environments" or questions specific to the bid and not the solution that would be set up for CalMHSA should the response be "NA", "blank", or "yes"? How will the response impact scoring?**
	Please enter "NA". There will be no impact on scoring.
28	**Section 3.2/EHR Vendor Response Sheets XLS - In Tab 1 instructions, "the vendor is to provide a short (up to a few pages) description of its plans to implement a solution that addresses the requirement being defined in that section" but on the individual tabs, the free text area requests "Please provide a short description of how your solution satisfies this requirement (below):". Should the responses be tailored as they apply to implementation as stated in the instructions or geared toward the functionality being sought?**
	Both. This engagement and its component requirements are broad and complex. Generally, individual questions about whether one function or another is supported does not provide clear indication of a solution's ability to support an organization's workflows/operations. Nor does a list of Professional Services and their associated pricing indicate an organization's history of managing similar engagements or ability to undertake such a large-scale project with such tight deadlines. As such, CalMHSA is providing an opportunity for vendors to describe in their responses how their solution supports the requirements in a manner that may not be reflected in the scoring questions. Additionally, a description from the vendors as to how they would envision supporting CalMHSA throughout this complex, aggressive, multi-phased implementation will provide additional context not immediately obvious based upon the Professional Services pricing model.
29	**Section 4.0 - Has a budget been established for the EHR? Is funding by county or as a whole? Is CalMHSA seeking to front load costs including implementation or spread out costs evenly over time?**
	The budget has not yet been established for this project. We are interested in front loading costs to drive down ongoing costs.
30	**Can you provide an estimated # of subcontractor provider users (named) per county?**
	Not at this time. This is highly variable across Counties and such values are not currently available.
31	**How many prescribers do you have across the enterprise and / or per county? How many non-prescribers do you have across the enterprise and / or per county? How many EPCS prescribers across the enterprise and / or per county?**

	This information is not available at this time. For pricing information, assume 600 Prescribers and 9,600 Non-Prescribers.
32	**Can you provide the # of psychiatrists/doctors that complete E&M documentation (across the enterprise and per county)?**
	This information is not available at this time. For pricing information, assume 600.
33	**Can you provide the # of users that would need to have disconnected access to the EHR (across the enterprise and per county)?**
	None. The need to deliver a disconnected solution is not a requirement of this RFP.
34	**How many lab vendors do you need to connect to and can you provide a list of specific vendors (I.e. Labcorp, Quest, etc.)**
	Please see question #22.
35	**Will any counties need to connect with their own internal lab system/company? If yes, can you provide the # of facilities and specific lab company name?**
	Please see question #22.
36	**For any local lab company, do you need an LIMS (Lab Information Management System)?**
	No, this is not a requirement of this RFP.
37	**Do you have any POC (Point of Care) testing needs (i.e. glucometer, rapid strep/flu, rapid COVID, A1C devices, etc.)? If yes, please # and type of devices and locations.**
	No, this is not a requirement of this RFP.
38	**For Cal-HOP, will counties need to connect to all 9 HIEs? If not, please list those requiring a connection.**
	For the interoperability requirements within this RFP, the proposed solution needs to have proven capabilities to connect with Health Information Exchanges (HIE). Under the initial agreement, there will be no HIE implementation projects. Rather these will be identified on a case-by-case basis and covered under a separate purchase agreement between CalMHSA and the selected vendor.
39	**Regarding Care Coordination Activities Interoperability, Section 2.3.7, does CalMHSA know which HIEs you will need to receive data from?**
	Section 2.3.7 does not specifically mention/identify a connection with HIEs. Regardless, there are a number of HIE interoperability projects throughout the state. Within this RFP, connection with HIEs are not part of the identified deliverables, rather the proven capability to connect with HIEs and other outside data sources is the requirement at this time. It is anticipated these capabilities will be leveraged in future projects covered under future agreements/purchases
40	**How many inpatient facilities (Crisis Stabilization and/or Inpatient Mental Health Treatment Centers) are there across the 20 counties?**
	Specific number is not available at this time but the very large majority of the operations across the 20 Counties are outpatient/community-based programs. For pricing purposes, vendors should provide pricing for one (1) inpatient facility.
	How many inpatient beds do these facilities have (across the enterprise total and / or per county)?

41	For pricing purposes, vendors should provide pricing for one (1) inpatient facility with 16 beds.
42	**How many facilities (Crisis Stabilization / IMHTC) operate an onsite pharmacy?**
	For pricing purposes, vendors should provide pricing for one (1) inpatient facility with 16 beds with an on-site pharmacy.
43	**Is an inpatient pharmacy management system part of the scope of the Enterprise Health Record? This would be a system to manage the pharmacy, above and beyond the CPOE that would be part of the EHR.**
	Specific number is not available at this time. For pricing purposes, vendors should provide pricing for one (1) inpatient facility with 16 beds with an on-site pharmacy, with one Pyxis dispensing machine.
44	**How many outpatient facilities are there across the 20 counties?**
	Specific number is not available at this time but the very large majority of the operations across the 20 counties are outpatient/community-based programs. Therefore the total number is in the 1,000s.
45	**Do any county operated sites dispense methadone or other MAT medications (i.e. suboxone, vivitrol) where the medication inventory is managed onsite and ordered, dispensed and administered onsite? This does not include scenarios were medications are brought to a site by a pharmacy or a client for administration/admin observation. If yes, how many sites do this?**
	Please refer to question #21
46	**Will the use of a clearinghouse be needed?**
	Clearinghouse is not a requirement of this RFP.
47	**How many billable NPIs across the 20 counties? How many claims produced across all counties on an annual basis?**
	The billing for services provided across the 20 facilities will incorporate hundreds of Provider Agencies (NPI-1) and thousands of Clinicians (NPI-2)
48	**How many sites utilizes ADMs?**
	Please clarify "ADMs"
49	**Can you provide an estimate of ADMs per site?**
	Please clarify "ADMs"
50	**Will the MPI referenced in Section 2.2.14 need to be integrated with any other agencies, i.e. Jail, Sheriff etc., across the different Counties?**
	The eMPI described in 2.2.15 is anticipated to be exclusively used for the semi-statewide EHR.
51	**Please explain how the counties would use the scale up and scale down on demand self service capabilities referenced in Section 2.2.2 Cloud Based.**
	No individual county (or even CalMHSA) would “scale up or scale down on demand”. Rather this is aimed at the vendor describing their ability to seamlessly scale up or scale down within their cloud environment to meet customer demand.
52	**Could you provide a list of the counties that are currently part of this project?**
	Please refer to question #1.
53	**How does CalMHSA envision the interaction between contract providers and the county's managed care organization? Will contract providers login into EHR? Or open to other methods?**
	Please refer to question #11.
54	**Does CalMHSA envision a CalMHSA or vendor led Phase 2 implementation?**
	Phase 1 and Phase 2 will be a partnership between CalMHSA, County Resources, and Vendor(s).

55	**Could you provide additional details regarding how CalMHSA plans to support the implementation effort? Joint project team with representation from each county? Other?**
	Joint project team with representation from each county. CalMHSA will be the principal partner with the vendor throughout all phases of the implementation.
56	**Could you provide additional details regarding how CalMHSA plans to support the counties post Phase 1 and Phase 2 Go Live?**
	CalMHSA will be responsible for providing Tier-1 support. As the contract holder and the Tier-1 support resource, CalMHSA will be the primary contact for the semi-statewide EHR and the vendor for all support efforts.
57	**Can you share any thoughts on what the governance structure/model would look like for this project? During implementation and on an on-going basis?**
	CalMHSA will be the lead project manager and facilitate cross county decision making.
58	**How will decisions be made regarding the definition and scope of the CalMHSA core system?**
	CalMHSA will be leading the discussions and brokering decisions regarding the scope and configuration of the core system.
59	**Following the bidders conference, can vendors submit additional questions or follow up inquiries regarding the provided responses?**
	No.
60	**In our review and comparison of the RFP and the EHR Questionnaire, we noted that Section 2.2.11 Data Hierarchy in the RFP does not have a corresponding tab in the EHR Questionnaire. Please confirm that this is a deliberate omission; and that Section 2.2.11 should not have a corresponding tab in the EHR Questionnaire.**
	Section 2.2.11 Data Hierarchy does not have any "high level requirements" so it did not get a "section". This was intentional.
61	**Section 9.10: Section 9.10 Format of the Proposal specifies that the "Submission materials should be prepared in the file formats listed under Requested Information for this opportunity in the Bonfire Portal." That is currently limited to a single XLS Workbook. Can we provide supplemental materials supporting the spreadsheet answers, for example sample screen shots or reports, or are we limited to the Workbook?**
	We are working to cross-reference all materials and will have minor updates posted to Bonfire by the end of week, October 4th. No additional materials will be accepted.
62	**Section 2.1.13: High level requirements call for 4 levels, specifically all calling out User, clinician, and staff. Please outline the 4th level to be included. Only three are listed.**
	This is a typo--we apologize for the confusion. The three levels as identified in section 2.2.13 (User/Clinician/Staff) are all that is required. We are working to cross-reference all materials and will have minor updates posted to Bonfire by the end of week, October 4th.
63	**Section 2.1.3 calls for both Development and Test Environments in addition to production. It further stipulates that all environments must have fully functioning interfaces, APIs, interoperability connections, etc. Is it CalMHSA's intention to have complete, ongoing bidirectional capabilities in the test and Dev environments for the term of use?**
	The intent of this requirement is to support the development and testing of future interoperability efforts. As such it is anticipated that the Development and Test environments would support such activities under the licensing/support/maintenance agreement and would not require configuration/system administration by the vendor each time these efforts are undertaken.
64	**Does MHSA have a consulting firm helping with the RFP and evaluation, if so who?**
	CalMHSA is working with CTG (https://www.ctg.com/) and an independent Health IT Consultant in California, John Fitzgerald, throughout the RFP and evaluation efforts.

65	**Is there an incentive for counties to join this semi-wide EHR strategy? Are their penalties if counties commit to the project but don't actually move forward with joining the state-wide EHR? What is CalMHSA' strategy should fewer counties go-live than intended and how that plays out financially for the counties who do go live with the system?**
	There are no incentives for Counties to join and there are no penalties if Counties do not participate. The initial contract (i.e. user count) will be based upon the firm commitment of counties after a vendor has been selected. Successful implementation of the semi-statewide EHR will generate interest from the other California County BH organizations. Therefore additional purchasing/implementation phases are anticipated.
66	**Will the counties be required to devote personnel resources to the project? If so, what expectations has MHSA set for the counties to be able to provide these resources on a timely manner? Can vendors take these expectations into consideration when developing project plans?**
	CalMHSA will be evaluating the total staffing needs juxtaposed against the Professional Services proffered in the winning vendor's project plan. From there, CalMHSA will work across all stakeholders to assure appropriate staffing is provided in a timely manner per the agreed upon project timeline.
67	**Does CalMHSA anticipate a SI-led approach?**
	CalMHSA does not anticipate a Software Integrator-led approach. CalMHSA is looking to the vendors to propose a Project Approach and plan that they feel would be successful given the project variables (scope, timeline, etc.). If the respondent believes that a SI is crucial to the success of the implementation of their solution, then that should be the basis of their project approach. Whereas, if a vendor believes they can support the scope of this engagement without a SI, then their description of their project approach should identify why they believe they have the skills and staffing necessary to achieve a successful result.
68	**It is important for bidders to understand how success will be measured by both CalMHSA and the participating counties. Can CalMHSA share any KPIs or expectations that are desired or anticipated out of this project?**
	This is not available at this time, CalMHSA anticipates contracting with an evaluator who will support the overall management of this project including developing the KPIs. We know that driving down costs will be an essential KPI for counties.
69	**The requirements focus mainly on technical capabilities, with little focus on how the project will operate. Who will be responsible for Program Management on the clients'/counties side?**
	CalMHSA
70	**Will the value of the initial term contract be fixed and predictable, or will it be variable based on county participation?**
	The value of the initial term contract will be variable based upon county participation. The initial contract (i.e. user count) will be based upon the firm commitment of counties after a vendor has been selected. Successful implementation of the semi-statewide EHR will generate interest from the other California County Behavioral Health organizations. Therefore additional purchasing/implementation phases are anticipated.
71	**Can CalMHSA provide an organizational chart that outlines the current governance planned to support a successful project?**
	It is anticipated that the staffing plan and associated organizational chart will be a by-product of Project Planning activities between CalMHSA and the selected vendor.

72	**Under questionnaire set 2:2 can you clarify and/or define the term "regular" with regards to the frequency of penetration testing or is that left to the interpretation of each vendor?**
	An annual penetration test is normal. Some organizations do them twice a year.
73	**Will CalMHSA be responsible for end user training, or issuing a separate RFP for end user training services?**
	It is anticipated that CalMHSA coordinating with County Resources will perform End User Training. Should CalMHSA/County resources need to be augmented, this would be a separate, add-on procurement.
74	**Does CalMHSA expect bidders to provide a comprehensive governance and change management consultancy service as part of their proposal?**
	No. It is anticipated that CalMHSA will provide Project Management resources that will manage the project per Project Management Body of Knowledge (PMBOK) standards.
75	**Will CalMHSA be releasing a separate RFP for governance and change management services?**
	This is not anticipated at this time.
76	**How will governance be organized under the maintenance and operations phase, in regards to change requests and approvals?**
	CalMHSA will be the contract holder, will be the principal organization managing the project, will provide Tier-1 support, and will be the primary/exclusive point of contact for the vendor(s) under this agreement. As such, change requests and approvals during the implementation as well as during maintenance and operations periods will be managed through CalMHSA in coordination with the vendors(s).
77	**What funding has been secured or planned for related to the implementation/project costs?**
	There are multiple funding mechanisms being deployed depending on the participant county including federal, state and local monies.
78	**In the RFP, CalMHSA acknowledges current spend associated to EHR technologies across the counties (3% of $7B), and specifies roughly 1/3 (20 of 58) of the counties will be participating in this scope. That is an indication of $69m per year under current state. Is the funding/budget plan consistent with the estimation CalMHSA has suggested, or at least close? If not, will CalMHSA please provide guidance to funding expectations?**
	The estimated budget currently devoted to county health information technology was provided as a general indicator of the size of the project. The budget may change significantly with the number of participating counties. CalMHSA is unable to provide further guidance at this juncture.
79	**How will funding be handled for this contract? Will CalMHSA be provided the funds from individual counties who are participating, or will the funding come from another state-driven mechanism?**
	The contract will be funded by county participation fees. The counties receive their funding from state and federal sources.
80	**Will CalMHSA please specify its intended initial contract term, and anticipated option years?**
	Initial Term will be subject to negotiations with the selected vendor.
81	**Will counties be obligated/committed to the contract for the duration of the initial term, or will CalMHSA allow counties to leave the contract prior to the end of the initial term?**
	Initial Term will be subject to negotiations with the selected vendor.
82	**Will the contract be made between bidders and CalMHSA, or will there be agreements between bidders and the counties directly?**
	The contract will be made between bidders and CalMHSA.

83	**Given the list of questions was expanded significantly in the most recently released documents, will CalMHSA please provide a 2-week extension to the proposal submission deadline?**
	Given the overall project timelines, the proposal submission deadline will not be extended.
84	**Can bidders submit supplemental documentation (such as, Executive Summary) with their response to this proposal?**
	No.
85	**Is CALMHSA aware that there are discrepancies between the documents and document requirements posted to the CalMHSA website and Bonfire? Are vendors to assume that the document posted on Bonfire is the one we should proceed with in terms of instructions and requirements?**
	Thank you for alerting us. We are working to cross-reference all materials and anticipate having minor updates posted to Bonfire by the end of week, October 4th. Yes, Bonfire is the source vendors should use to proceed in terms of instructions and requirements.
86	**Are all documents that need to be reviewed and responded to on the Bonfire portal?**
	Yes. We are working to cross-reference all materials and will have minor updates posted to Bonfire by the end of week, October 4th.
87	**Does CalMHSA intend for vendors to propose a pharmacy management system as part of this solicitation?**
	Pharmacy management is not a requirement under the RFP.
88	**Will CalMHSA please provide a listing of the anticipated counties in scope of this solicitation?**
	Please see the response to question #1.
89	**Will CalMHSA consider a co-bid proposal whereas a collective group of partners would be selected and contracted with separately, or does MHSA require a singular vendor contract as a result of an award?**
	CalMHSA will consider a co-bid proposal.
90	**If CalMHSA does not intend for vendors to propose a pharmacy management system, how does CalMHSA expect vendors to propose meeting requirements for an integrated closed-loop medication process?**
	As previously identified, for pricing purposes, vendors should anticipate one closed-loop medication process. This would entail Computerized Provider Order Entry (CPOE) functions within the EHR, an HL-7 outbound feed to an existing pharmacy system, and an electronic medication administration record (eMAR) within the EHR to be fed by an inbound HL-7 feed from the existing pharmacy system.
91	**Out of 12K users, how many are expected to be providers (i.e., MD, NP, PA)?**
	Please refer to question #2.
92	**Do you have a preference if a) the vendor should train all the 12K users or b) will you prefer the vendor to do the initial rollout and train your trainers who will train all the remaining users? Additionally, elaborate any thoughts in this area.**
	It is anticipated that CalMHSA coordinating with County Resources will perform End User Training. Should CalMHSA/County resources need to be augmented, this would be a separate, add-on procurement.
	We would like to better understand the split between inpatient and outpatient. For example, can you provide a breakdown of how many inpatient locations, counties, patients, users etc.

93	Across the 20 counties the majority of operations/programs are outpatient. For purposes of responding to this RFP, vendors should assume only one inpatient site across the 20 for the initial term of the agreement. For user counts and staff break-downs, please refer to question #2.
94	**Our understanding is that as part of this RFP, 20 counties (with estimated 12K users) will buy the selected Enterprise at the same time. Is this correct?**
	Yes.
95	**Is there flexibility in the proposed rollout timelines?**
	The proposed timelines are fixed and reflect the business needs of the participating counties.
96	**We saw a reference to Salesforce. Do you have a preference for a CRM like Salesforce?**
	The RFP does not ask for a Customer Relationship Management (CRM) tool -- that example was used to demonstrate the concept of hierarchical relationships.
97	**Is it expected to interface with an existing CRM provider or to provide CRM functionality within the Enterprise Health Record?**
	See above.
98	**Currently, how do BHPs adjudicate/manage claims from their contract providers. Is there an electronic system in place? If yes, what commercial (if applicable) electronic system is in use?**
	Across the 58 counties in California, there are different mechanisms employed to manage/adjudicate claims from their contract providers. A majority of the BHPs adjudicate claims through their EHR systems for county provided services and contracted services. Others have Managed Care Services systems integrated with their EHR to adjudicate their claims.
99	**Currently, how is the outreach functionality provided? Is there an electronic system in place? If yes, what commercial (if applicable) electronic system is in use?**
	Mechanisms currently used by the 58 counties vary greatly. Vendors should perform their own research to determine Commercial Off the Shelf (COTS) solutions.
100	**Currently how is care coordination functionality provided. Is there an electronic system in place? If yes, what commercial (if applicable) electronic system is in use?**
	Mechanisms currently used by the 58 counties vary greatly. Vendors should perform their own research to determine Commercial Off the Shelf (COTS) solutions.
101	**Currently how are interactions with partners such as Child Welfare, Probation, Social Services and Homeless Services done? Is there an electronic system in place? If yes, what commercial (if applicable) electronic system is in use?**
	Mechanisms currently used by the 58 counties vary greatly. Vendors should perform their own research to determine Commercial Off the Shelf (COTS) solutions.
102	**Is it common or are there instances where during the referral process the referral made is to an entity outside of that county? If so, would it be expected that the referral information would transfer to that county's database?**
	Our overall aim is to move as closely as possible to a closed loop referral system, there are varying complexities given the diversity of network providers. Achieving the closed loop referrals may be a long term project.
	What other EHR systems have you already previewed (via demo) related to this RFP?

103	We have not previewed EHR systems outside of this RFP.
104	**Do you dispense medications and track medications inventory?**
	There is a business need to track some medication inventory.
105	**Which Labs are a "must" requirement to interface with the EHR?**
	Please refer to question #22.
106	**Do you have any other systems which are a "must" to integrate with the new EHR?**
	The systems outlined in the RFP represent the essential integrations.
107	**Does Patagonia Health need to be licensed in your state prior to RFP submission?**
	No.
108	**Can you provide sample reports, forms, notes, etc.**
	The information contained in the RFP is all that will be provided at this time.
109	**What is the approximate make-up of level of care within the counties? Are there any hospital based inpatient or detox services?**
	We are not able to provide numbers at this time, a successful vendor should be able to provide services that cover all functions outlined in the RFP.
110	**Is it expected that the Enterprise Health Record performs the task of License Verifications or is it only expected that the record tracks such licensing / credentials as they become expired etc.?**
	That is not part of the scope outlined in the RFP.
111	**Is it expected that the Enterprise Health Record performs automated reporting to an external "Online Provider System (OPS)". If so will this be a batch upload separate for each county/provider or a real time upload for each database based on certain process oriented factors?**
	Based upon the question, it is difficult to understand the specific use case being represented. An ability to perform automated reporting to an external system is valuable, but not an element of the RFP for which vendors are scored.
112	**Will the "technical resource" outlined in 2.2.4 use case 1 be a common individual for all counties or will each county have their own "technical resource" type staff?**
	The aim of this project will be to develop a standardized implementation across counties. There will be system-wide technical staff at a project and county level.
113	**Financial Information: Proposer is required to submit copies of Proposer's most recent audited financial statements. Can we submit once we have been selected as a finalist?**
	Successful vendors need to submit all required documentation.
114	**Will the new EHR be purchased directly by CalMHSA or the individual Counties?**
	Directly by CalMHSA.
115	**Who is executing and paying for the contract? Is it CalMHSA or the individual Counties?**
	CalMHSA will execute the contract with the vendor and pay claims. The funding source for this project is individual counties.
116	**Will the new EHR be managed directly by CalMHSA or the individual Counties?**
	CalMHSA.

117	**The RFP indicates that the initial opportunity consists of approximately 20 Counties and an estimated 12,000 users. Who are the 20 Counties? Please provide a list of the 20 Counties who you anticipate comprise this opportunity.**
	Please refer to question #1.
118	**Who We Are/Our Mission Statement: What type of agreement is in place with CalMHSA and the participating Counties based on the selected Vendor of Choice for this RFP?**
	We have a participation agreement with counties.
119	**Implementation Requirements: Who are the 2 to 3 small Counties you anticipate will be implemented with a go-live date of July 1, 2022 (Phase 1)?**
	We are not yet able to share this information.
120	**Who are the Phase 2 Counties who will be implemented with a go-live date of July 1, 2023?**
	We are not yet able to share this information.
121	**Implementation Requirements: Please explain the Phase 1 go-live timing? If a new vendor is selected by January 15, 2022; and a contract is executed in February 2022; the Counties included in Phase 1 are expected go-live as of July 1, 2022, which only allows 4 months for implementation.**
	This project has a very aggressive timeline associated with CalAIM. For more information refer to question #24.
122	**What is the timeline you anticipate for contract execution?**
	Before the end of January 2022.
123	**Is it intended that the Counties in Phase 1 will go-live with the 'complete' system – all required/requested modules, functionality, and features?**
	Due to the scope of this RFP, CalMHSA realizes that all functionality may not be available for the Phase I date of 7/1/22. We anticipate that the vendor and CalMHSA will collaborate on what a minimally viable solution for the Phase I roll out will look like.
124	**Implementation Requirements: In Section 1.2 Market Size, you state that many of the County BHPs are dissatisfied with their current EHRs, which for some have been in use for 20 years. Yet, you are requiring they go live in 4 months from contract execution. Please explain what is driving the Phase 1 go-live date?**
	As addressed in question #24, the changes related to payment reform and clinical documentation as part of the new CalAIM regulations are extensive. As such, we are attempting to have the Go-Live of the semi-statewide EHR coincide with the implementation of these new regulations. Phase-1 go live date is intended to meet county partner requirements.
125	**Implementation Requirements: Will CalMHSA establish a project team who will work with the new EHR vendor on behalf of all of the Counties being implemented? Or will each County establish their own project team with whom the chosen vendor will have to collaborate?**
	The vendor should anticipate a bit of both. CalMHSA will take the lead on managing the overall implementation with each partner county. In addition, each county will be expected to have local SMEs trained and ready to directly participate in the deployment. As stated earlier, CalMHSA will act as Tier-1 support post implementation.
126	**Referral Process – Screening: The Second Use Case describes a clinician from Hope House logging into the Enterprise Health Record. Please clarify, will providers such as Hope House, have their own EHR system and also log into the new County EHR system?**
	In that use case, the provider is using the CalMHSA EHR under the instance of a county. Providers will not be required to log into both systems in order to document billable services.

127	**Medi-Cal Rx: How many named prescribers need to be included in the project pricing? We do not require special licenses for support staff that may assist in the prescribing process, just the actual prescribers.**
	As addressed in question #31, this information is not available at this time. For pricing information, assume 600 Prescribers and 9,600 Non-Prescribers.
128	**ePrescribing, Closed-Loop Medication Administration and eLabs: Please describe the current Pharmacy environment and what should be included within the project scope.**
	Please refer to questions #20 and #21. Within the County SUD Provider networks, there are MAT programs but these organizations have and will keep their specialized dispensing systems. Therefore, requirements in this RFP do not include/concern MAT dispensing.
129	**Is this the same for each County?**
	Linked to question #128 - N/A
130	**Do all of the Counties use a delivery service, have an onsite pharmacy, or have dispensing machines? We will need to understand quantities to include in the project pricing.**
	Please refer to questions #20 and #21.
131	**ePrescribing, Closed-Loop Medication Administration and eLabs: Do all of the Counties use Pyxis or other automated medication dispensing cabinets?**
	Please refer to questions #20, #21 and #43.
132	**Can you detail how many are needed per County so that we can accurately provide pricing?**
	Please refer to questions #20, #21 and #43.
133	**ePrescribing, Closed-Loop Medication Administration and eLabs: Do all of the Counties use the same lab provider?**
	As answered in question #22, we do not have a specific number at this time. Throughout each of the Counties, Quest and Labcorp are the predominant laboratory services providers. Additionally, counties may have other commercial providers or send labs to local hospitals. For pricing, please provide an estimate based upon a "per connection"/"Per interface" basis.
134	**Do some Counties have multiple lab providers?**
	Yes.
135	**How many lab interfaces should be included within the project scope if priced per vendor interface?**
	As answered in question #22, we do not have a specific number at this time. Throughout each of the Counties, Quest and Labcorp are the predominant laboratory services providers. Additionally, counties may have other commercial providers or send labs to local hospitals. For pricing, please provide an estimate based upon a "per connection"/"Per interface" basis.
136	**ePrescribing, Closed-Loop Medication Administration and eLabs: Do any of the Counties offer direct Medication Assisted Treatment (MAT) including the use of Methadone?**
	Methadone dispensing is not part of this RFP.
137	**Should this functionality be included in the project scope? Alternatively, price can be detailed below the line.**

	No.
138	**Integration Tools – Standard Healthcare APIs and System Open Architecture: Should HIE integration be included in the project scope?**
	Please refer to question #39.
139	**If yes, which one(s)?**
	Part of preceding question: N/A
140	**Please describe the functionality utilized, or use case, (i.e. CCD sharing, ADT data, lab delivery, secure messaging, etc.)**
	Part of preceding question: This RFP defines the need for interoperability as more of an architectural requirement rather than specific "current" requirements. CalMHSA anticipates that over time that the need for integration with other entities will increase. This will include county contract providers, hospitals, jails among others. As such, many different integration protocols need to be supported.
141	**Specific Required State Reporting Requirements: Should any of the following reporting requirements be included in the project scope: MIPS, HEDIS, NOMS, and CCBHC?**
	No.
142	**Project Scope of Work: Is Primary Care functionality required for any of the participating Counties? We could leave this out of the immediate project scope, and instead provide pricing below the line.**
	Primary Care functionality is not in the scope of this RFP.
143	**Project Scope of Work: Should disconnected functionality be included in the project scope?**
	Please refer to question #33: No. The need to deliver a disconnected solution is not a requirement of this RFP.
144	**How many named users will need access to the new EHR system in a disconnected state? For example, staff who provide services in the community and who often do not have access to reliable Wi-Fi.**
	No. The need to deliver a disconnected solution is not a requirement of this RFP.
145	**# of Acute Care Staffed Beds (Total number of acute care beds that are actively staffed.)**
	A majority of the operations across the 20 Behavioral Health organizations are outpatient in nature. The specific needs related to Inpatient Acute Psychiatric Care are a very small component of the anticipated requirements. Specific metrics related to Inpatient Acute Psychiatric Care will be provided to the vendors selected for final review.
146	**# of Acute Care Licensed Beds (Total number of acute care beds licensed for use.)**
	A majority of the operations across the 20 Behavioral Health organizations are outpatient in nature. The specific needs related to Inpatient Acute Psychiatric Care are a very small component of the anticipated requirements. Specific metrics related to Inpatient Acute Psychiatric Care will be provided to the vendors selected for final review.
147	**# of Acute Care Annual Admissions (Total number of acute care annual admissions.)**
	A majority of the operations across the 20 Behavioral Health organizations are outpatient in nature. The specific needs related to Inpatient Acute Psychiatric Care are a very small component of the anticipated requirements. Specific metrics related to Inpatient Acute Psychiatric Care will be provided to the vendors selected for final review.

148	**Acute Care Average Length of Stay (Average length of stay across all acute care facilities.)**
	A majority of the operations across the 20 Behavioral Health organizations are outpatient in nature. The specific needs related to Inpatient Acute Psychiatric Care are a very small component of the anticipated requirements. Specific metrics related to Inpatient Acute Psychiatric Care will be provided to the vendors selected for final review.
149	**# of Acute Care Hospitals (Total number of acute care hospitals.)**
	A majority of the operations across the 20 Behavioral Health organizations are outpatient in nature. The specific needs related to Inpatient Acute Psychiatric Care are a very small component of the anticipated requirements. Specific metrics related to Inpatient Acute Psychiatric Care will be provided to the vendors selected for final review.
150	**# of Residential Care Staffed Beds (Total number of residential are beds that are actively staffed.)**
	A majority of the operations across the 20 Behavioral Health organizations are outpatient in nature. The specific needs related to Residential Care are a very small component of the anticipated requirements. Specific metrics related to Residential Care will be provided to the vendors selected for final review.
151	**# of Residential Care Licensed Beds (Total number of residential care beds licensed for use.)**
	A majority of the operations across the 20 Behavioral Health organizations are outpatient in nature. The specific needs related to Residential Care are a very small component of the anticipated requirements. Specific metrics related to Residential Care will be provided to the vendors selected for final review.
152	**# of Residential Care Annual Admissions (Total number of residential care annual admissions.)**
	A majority of the operations across the 20 Behavioral Health organizations are outpatient in nature. The specific needs related to Residential Care are a very small component of the anticipated requirements. Specific metrics related to Residential Care will be provided to the vendors selected for final review.
153	**Residential Care Average Length of Stay (Average length of stay across all residential care facilities.)**
	A majority of the operations across the 20 Behavioral Health organizations are outpatient in nature. The specific needs related to Residential Care are a very small component of the anticipated requirements. Specific metrics related to Residential Care will be provided to the vendors selected for final review.
154	**# of Residential Care Hospitals (Total number of residential care hospitals.)**
	A majority of the operations across the 20 Behavioral Health organizations are outpatient in nature. The specific needs related to Residential Care are a very small component of the anticipated requirements. Specific metrics related to Residential Care will be provided to the vendors selected for final review.
155	**Total Named Users (Total number of unique human beings expected to have access to your EHR system at full rollout.)**
	Please refer to question #2.
156	**Peak Concurrent Users (Number of staff expected, at full rollout, to be logged into the EHR system during peak times, typically late morning and early afternoon. Note that these users may be using different systems today (EHR, billing, scheduling systems, etc.). Please make sure all users are accounted for.**
	Please refer to question #3.
	Annual Inpatient Days (Each day a patient is admitted to a short-term acute care inpatient facility at midnight according to your daily census. Includes medically supervised detox.)

157	A majority of the operations across the 20 Behavioral Health organizations are outpatient in nature. The specific needs related to Inpatient Acute Psychiatric Care are a very small component of the anticipated requirements. Specific metrics related to Inpatient Acute Psychiatric Care will be provided to the vendors selected for final review.
158	**Annual Same Day Stays (Each same day stay treated as an admission to your inpatient facility and the patient is assigned to a bed, but not counted in your Inpatient Days listed above. Includes same day stays and observations and ECT/TMS.)**
	A majority of the operations across the 20 Behavioral Health organizations are outpatient in nature. The specific needs related to Inpatient Acute Psychiatric Care are a very small component of the anticipated requirements. Specific metrics related to Inpatient Acute Psychiatric Care will be provided to the vendors selected for final review.
159	**Annual Long Term Acute Care Days (Each day that a patient is an inpatient at one of your long term acute care facilities at midnight according to your daily census. These are licensed as inpatient facilities and beds. Includes rehab facilities.)**
	Long Term Care Facilities are not part of the RFP.
160	**Annual Long Term Non-Acute Care Days (Each day that a patient is staying at one of your long term non-acute care facilities at midnight according to your daily census. These are not licensed as inpatient facilities. Includes residential care facilities and long term addiction treatment facilities.)**
	Long Term Care Facilities are not part of the RFP.
161	**Annual Ambulatory Clinic Visits (Any completed ambulatory patient appointment with a decision-making medical provider. Decision-making providers are providers whose role typically requires a minimum of a 4-yr degree. Excluded are medical students, RNs and LPNs. Doctors, PAs, nurses with advanced training (NPs, CRNA, etc.) are included. Other examples include social workers, case managers, dieticians & nutritionists, psychologists, physical therapists, occupational therapists, and counselors. Includes office visits with decision-making providers, urgent care visits to facilities that primarily treat patients with lower acuity problems, and telemedicine/video visits. Excludes telephone encounters, diagnostic-only visits (lab, rad, etc.) where the patient doesn't see a decision-making provider, nurse (RN) injection visits, or methadone-only visits.)**
	The RFP is related to California County Behavioral Health Programs. This question does not appear to pertain to our stated requirements.
162	**Annual Partial Hospitalization Program / Intensive Outpatient Programs (Ambulatory Visits, as defined above, which take place in your hospital for non-admitted patients. Includes partial hospitalization, recurring day treatment visits, and telemedicine/video visits. Excludes diagnostic-only visits (lab, rad, etc.) where the patient doesn't see a decision-making provider or visits for patients who are admitted to a bed in an inpatient unit.)**
	Specific metrics related to Partial Hospitalization/Intensive Outpatient Programs will be provided to the vendors selected for final review.
163	**Do you have methadone clinics?**
	Methadone dispensing is not part of this RFP.
164	**Annual Home Care Visits (Any completed home care patient visit/assessment. Includes home health, hospice, and bereavement. Excludes staff communication & coordination and telehealth/telassess.)**
	The RFP is related to California County Behavioral Health Programs. This question does not appear to pertain to our stated requirements.

165	**Annual Professional Billing Charges (The total annual count of professional billing charges billed out of your current system, including charges for visits and services occurring at other facilities. This should be the count of charges, not the dollar value of charges. Includes professional charges for services performed by owned providers or from affiliates/third parties and interfaced or imported charges from other systems. Excludes voided or zero dollar charges and institutional charges billed out of your hospital billing system.)**
	The number of claims anticipated to be created across the 20 counties will be greater than 20 million per year. It is anticipated that with additional adoption by other counties, this number will continue to grow substantially.
166	**Annual Inpatient Hospital Billing Accounts (Hospital accounts used to facilitate billing for patients with an Inpatient patient class. Generally, a separate account is created for each admission. Do not count voided accounts or accounts without any charges. Accounts for recurring services are counted once per month.)**
	Specific metrics related to inpatient claims will be provided to the vendors selected for final review.
167	**Annual Other Hospital Billing Accounts (Hospital accounts used to facilitate billing for patients with a patient class other than Inpatient (e.g., Outpatient, ED, Observation). Do not count voided accounts or accounts without any charges. Accounts for recurring services are counted once per month.)**
	Specific metrics related to inpatient claims will be provided to the vendors selected for final review.
168	**Annual Completed Appointments (Any appointment that is scheduled and completed. Multiple appointments for the same patient/member in the same day are counted once. Includes outpatient doctor and nurse visits, walk-ins, diagnostic and scheduled inpatient appointments, scheduled outreach phone calls or video visits, and scheduled in-home visits. Excludes no shows, multiple appointments in the same day, interfaced appointments that are not checked in or out, cancelled appointments, and crisis line telephone encounters.)**
	A majority of the operations across the 20 Behavioral Health organizations are outpatient in nature. As such, appointment scheduling will be a highly utilized function within the system. We anticipate millions of Annual Completed Appointments.
169	**Comprehensive Care Program Recipients (An individual that you have enrolled in a care management case, social care program, specialty pharmacy therapy management, or medication therapy management. This volume is evaluated quarterly, rather than on an annual basis, and is based on the maximum number of individuals that are concurrently enrolled in a program at any point in time. Includes coordinating or delivering community services through programs such as Complex Care Management, CPC+, Accountable Communities for Health, Mom & Baby Programs, PACE, Specialty Pharmacy Therapy, and Medication Therapy Management. If the same person is enrolled in multiple programs, they should only be counted once.)**
	These are primarily medical managed care requirements and as such do not pertain to the California County Behavioral Health Programs. This is not part of the RFP.
170	**Financial Information: Proposer is required to submit copies of Proposer's most recent audited financial statements. Can we submit once we have been selected as a finalist?**
	Financial information must be submitted with the proposal.
171	**Has CalMHSA identified an implementation schedule or prioritization among Cohort 1 counties?**
	Please refer to question #24
172	**The RFP indicates the go-live dates are firm. Given that the scope of some of the implementations is unknown (for example, conversion), would CalMHSA be open to flexibility with the implementation date for the first 2-3 counties?**
	Compelling events outside of our control dictate the July 2022 go-live date for the initial 2-3 counties. We do not currently have flexibility.
	If vendors respond as a team, are qualifications to be met as a team?

173	CalMHSA will accept proposals where multiple vendors are integrating their separate solutions as a means to address all requirements. In such an approach, CalMHSA would desire one agreement with one party who would be responsible for delivery and performance during the implementation and throughout the engagement with CalMHSA.
174	**Will CalMHSA consider extending the deadline until December 20th? The solution requires multi-vendor solutioning which takes time.**
	Due to several restraints, the timelines as identified are firm.
175	**Will CalMHSA allow vendors to submit a 2nd round of questions after the bidder's conference?**
	No
176	**Can CalMHSA share the total budget for this opportunity?**
	The value of the initial term contract will be variable based upon county participation. The initial contract (i.e. user count) will be based upon the firm commitment of counties after a vendor has been selected. Successful implementation of the semi-statewide EHR will generate interest from the other California County Behavioral Health organizations. Therefore, additional purchasing/implementation phases are anticipated
177	**Can CalMHSA clarify if the audited financials are to be submitted by the prime vendor, or all vendors included in a team?**
	All vendors
178	**Would CalMHSA consider extending the deadline for RFP questions?**
	No.
179	**2.2.5 Related to the requirement 'the Enterprise Health Record should support the ingestion of data from outside sources for any data input form', does CalMHSA anticipate providing a specification which vendors could follow?**
	Since the enterprise health record would be the entity consuming the data payload, it would be the "service provider" which provides the resources that the submitting system would use. As such, the enterprise health record would be producing the specifications/resources, not the other way around as suggested.
180	**For the two Excel workbooks released, labeled as CalMHSA Semi-Statewide EHR RFP Questionnaire (Q-18KM) and CalMHSA-EHR-RFP-Vendor-Response-Sheets-20210920-0430PM, please confirm bidders should only reference and respond to the Excel labeled CalMHSA Semi-Statewide EHR RFP Questionnaire (Q-18KM) that appears to be an exact extract of the requirements as published on Bonfire.**
	All vendor responses should be entered/provided through Bonfire. (The Excel spreadsheets were provided as a resource/tool for vendors in their preparation of responses)
181	**Please confirm for each requirement, only an applicable drop down selection is required and comments should only be made as needed to provide clarification.**
	This is correct.
182	**Please confirm bidders are allowed to provide a separate narrative in a PDF attachment to serve as an Executive Summary.**
	No additional documentation (including Executive Summaries) will be accepted.

183	**Please confirm bidders are allowed to provide supplemental attachments with exhibits to support individual responses.**
	No additional documentation (including Executive Summaries) will be accepted.
184	**Section 1: For Excel workbook questions 1.4.1 through 1.4.3, please confirm a total number of contracts only is acceptable in lieu of providing confidential client information.**
	Vendors may determine how to respond to the questions.
185	**Section 2.2: With the proposed architecture, will CalMHSA be entering into an agreement for ongoing maintenance?**
	Yes.
186	**Section 2.2.9: Who is responsible for building the external scripts?**
	Technical/Programming resources within CalMHSA and/or contracted entities.
187	**Section 2.2.11: Will contracting be executed by CalMHSA or with each County individually?**
	CalMHSA
188	**Section 2.2.2: Is FedRamp certification required as the security standard for the data center?**
	While current FedRAMP certification is not required for consideration, it is expected that the selected vendor will achieve FedRAMP certification prior to go-live.
189	**Section 2.2.15: Has CalMHSA considered using the CIN number for the MPI?**
	County Behavioral Health Plans serve clients who may not have Medi-Cal, so utilizing CINs would not capture the full client population.
190	**Section 2.2.6: Is CalMHSA considering contracting with the Contract Providers directly for the Enterprise Health Record?**
	Please refer to question #11.
191	**Can CalMHSA provide details related to participating county agencies that are part of this procurement?**
	Please refer to question #1.
192	**RFP provides sufficient detail on the expected technical capabilities in the envisioned Enterprise Health Record project, but is light on the details around the plan for executing the project. Can CalMHSA provide additional information regarding the EHR modernization goals and objectives with any specific details available related to the expectations for project implementation and rollout?**
	CalMHSA understands that the scope of the requirements may necessitate a solution comprised of different solutions tightly integrated and/or a level of development prior to implementation. As such, we believe that the vendors are in the best position to provide initial input on Project Planning. Responding vendors should evaluate the solution they are proposing, evaluate the level of effort associated with development/integration, evaluate the professional services they believe their organization and partners can and should provide. This will be the basis for project planning (Staffing Plan, WBS, etc.) between CalMHSA and the selected vendor.

193	**What is the intended initial contract term, and anticipated option years for this procurement?**
	Initial Term will be subject to negotiations with the selected vendor.
194	**As this Enterprise Health Record project is more of a coordinated effort across multiple participating county agencies, it is critical to establish a robust centralized governance model and have a System Integrator to govern and manage critical activities such as the program management office (PMO), business & clinical transformation, analysis & design, testing, change management and operational readiness activities, clinical & business adoption, and activation preparation. How is CalMHSA planning to incorporate the System Implementor / Integrator (SI) to provide the critical SI services for this project?**
	It is anticipated that CalMHSA will provide Project Management resources that will manage the project per Project Management Body of Knowledge (PMBOK) standards.
195	**How is CalMHSA planning to provide the required resources from the participating counties to assist with this project? What are the resource commitments that vendors can take into consideration for preparing the implementation rollout plans?**
	Please refer to question #192.
196	**Change management and training activities play an important role in increasing the success rate of EHR system implementation projects by enabling effective user adoption. We see references to training in a very few instances of the use cases outlined in this RFP. Can CalMHSA elaborate on plans for allocating appropriate resources/funds to perform the necessary and critical change management and training activities required for this Enterprise Health Record project? Will CalMHSA be responsible for end user training / change management activities, or will it be issuing a separate RFP for these services?**
	It is anticipated that CalMHSA coordinating with County Resources will perform End User Training. Should CalMHSA/County resources need to be augmented, this would be a separate, add-on procurement.
197	**What are the incentives for county agencies to join this statewide EHR system? Is there an alternative plan in place if there are only fewer county agencies that plan to utilize this centralized EHR system?**
	There are no incentives for Counties to join. There are no penalties if Counties do not participate. The initial contract (i.e. user count) will be based upon the firm commitment of counties after a vendor has been selected. Successful implementation of the semi-statewide EHR will generate interest from the other California County BH organizations. Therefore additional purchasing/implementation phases are anticipated.
198	**Do you have an estimate of how many users will be charting providers?**
	Please refer to question #2.
199	**With what systems will the new EHR System be expected to interface/integrate: Laboratories (i.e. LabCorp, Quest, etc.), including Radiology? If yes, please provide the names of the labs?**
	Please refer to question #22. There will be no need for an integration to Radiology.
200	**With what systems will the new EHR System be expected to interface/integrate: HIEs**
	Please refer to question #38.
201	**Are the demonstrations going to be live or Zoom?**
	Demonstrations will be performed via Zoom.
	Will we be able to share screenshots, supporting documentation, and video links in our response?

202	No additional documentation (including Executive Summaries) will be accepted.
203	**Provider breakdown- In the RFP it uses the word clinician are you also including nurses, case workers in this definition? (This definition will also assist in configuring the most accurate pricing.)**
	Please refer to question # 2.
204	**Will the "technical resource" outlined in 2.2.4 use case 1 be a common individual for all counties or will each county have their own "technical resource" type staff?**
	CalMHSA will be the primary vendor contact for contracting, implementation, Tier-1 support, and on-site technical/configuration activities.
205	**How many Prescriber licenses are required?**
	For pricing information, assume 600 Prescribers and 9,600 Non-Prescribers.
206	**1.2 Market Size: The RFP indicates that the initial opportunity consists of approximately 20 Counties and an estimated 12,000 users. Who are the 20 Counties? Please provide a list of the 20 Counties who you anticipate comprise this opportunity.**
	Please refer to question #1.
207	**Does CalMHSA have a proposed implementation team in place? How many members does the team have, and what are their roles? Can CalMHSA provide anticipated involvement by these resources on a weekly or monthly basis?**
	Please refer to question #192.
208	**What level FedRAMP certification does CalMHSA require: Low, Moderate, or High?**
	Moderate
209	**What is CalMHSA's budget for this project? Can CalMHSA provide a budget estimate for annual recurring fees?**
	The budget has not yet been established for this project. We are interested in front loading costs to drive down ongoing costs.
210	**Has CalMHSA identified the 2-3 counties to be implemented for the pilot go-live in July 2022?**
	Yes.
211	**Under how many NPIs does CalMHSA anticipate the counties and related network providers to bill monthly?**
	The billing for services provided across the 20 facilities will incorporate hundreds of Provider Agencies (NPI-1) and thousands of Clinicians (NPI-2).
212	**Can CalMHSA describe its internal team responsible for ongoing maintenance of this solution following go-live?**
	CalMHSA will be staffing a Tier-1 Support Organization comprised of technical, billing, and clinical resources.
213	**Does CalMHSA anticipate a Train-the-Trainer model for training, or is end user training in scope for this project?**
	It is anticipated that a Train-the-Trainer approach will be provided for this project. Once trained by the vendor, it is anticipated that CalMHSA coordinating with County Resources will perform End User Training. Should CalMHSA/County resources need to be augmented, this would be a separate, add-on procurement.
	Can CalMHSA estimate its anticipated number of client portal users?

214	This information is not available at this time. If pricing is driven by the number of users of the portal, please provide pricing for 50,000 and information as to how pricing is impacted with each additional block of 5,000.
215	**Can CalMHSA estimate its anticipated number of clinicians that would leverage a Mobile App on a tablet or smartphone?**
	This information is not available at this time.
216	**Can CalMHSA estimate its anticipated number of ePrescribe/EPCS users?**
	For pricing information, assume 600 Prescribers and 9,600 Non-Prescribers.
217	**Can CalMHSA estimate its anticipated number of eLab users?**
	For pricing information, assume 600.
218	**Will CalMHSA evaluate vendors who comply with FedRAMP and NIST guidelines if the vendor does not hold a FedRAMP or NIST certification?**
	While current FedRAMP certification is not required for consideration, it is expected that the selected vendor will achieve FedRAMP certification prior to go-live.
219	**Will CalMHSA evaluate vendors who are in the process of getting FedRAMP certification or does the vendor need to be fully certified before go-live?**
	While current FedRAMP certification is not required for consideration, it is expected that the selected vendor will achieve FedRAMP certification prior to go-live.
220	**Can CalMHSA provide any further information regarding the 5% of disparate functional needs that would not apply across all underlying agencies?**
	Question is too broad to address clearly.
221	**Will CalMHSA have dedicated resources for extracting data to be migrated from existing EHR systems used by providers? If so, what level of involvement is expected from these resources?**
	Yes. The level of involvement will initially be determined by the scope of the conversion supported by the selected vendor. CalMHSA anticipates that it will be the responsibility of CalMHSA working with its county partners to extract and format data to be converted per the requirements of the selected vendor's system.
222	**Would CalMHSA consider a solution that includes an electronic health record system and claims processing system from another solution?**
	Yes. CalMHSA is willing to consider any approach that vendors believe meets all of the requirements defined in the RFP. If vendors are proposing a solution that combines multiple systems, they will need to be extremely tightly integrated to assure that the stated Highly Accessible Data Architecture and Reporting Tools are addressed.
223	**How many lives total will be managed in the platform?**
	The specific number of "lives" managed is available. Nonetheless, vendors should anticipate this value to be in the millions. Roughly 34% of California's ~40million citizens are enrolled in Medicaid and such enrollees comprise more than 25% of the population within 49 of the 58 Counties. Since population across counties varies greatly, a specific number of "managed lives" for the initial 20 County Cohort is not immediately available.
224	**Are these 20 counties in Southern or Northern California ?**
	The 20 counties are spread out across the entire state (North and South).
225	**Can you please confirm that CalMHSA is looking for one instance used by all participating counties, or is that one instance per county?**
	One instance to be used by all participating counties.
	Given the complexity of this project, past experience with multiple EHR; what is driving the timeline?

226	The proposed timelines are fixed and reflect the business needs of the participating counties. Our current understanding is that 2-3 of the 20 participating counties will need to go-live on the semi-statewide EHR on July 1, 2022. These Counties will be used as a beta for the overall implementation. The remaining counties will then go-live July 1, 2023 to coincide with the go-live of new CalAIM requirements.
227	**Is CalMHSA, going forward, planning to provide to the 20 counties similar services as past analogous multi-county installations?**
	Yes. CalMHSA will be the primary vendor contact for contracting, implementation, Tier-1 support, and on-site technical/configuration activities.
228	**Data Conversion - We understand CalMHSA wishes for vendors to provide capabilities regarding data to be migrated to support a smooth transition in order to continue providing services to active clients. Does current clinical documentation (Treatment Plans, recent notes, assessments) fit into CalMHSA's desired conversion that is within scope for this initial implementation project? Will flattened PDF files for prior documentation from existing EHR systems meet this need?**
	In their response Vendors should outline the scope of their "Core" conversion capabilities. In addition to the record types supported in the vendor's core conversion, if additional record types are available to be converted for additional fee, please identify along with the corresponding optional fees.
229	**You stated the initial go-live date of July 1, 2022 is to accommodate a couple of participating counties, but that counties have not been solidified. For clarity, should bidders propose an alternative timeline if that is what is recommended or has CalMHSA committed to the July 1, 2022 go-live date?**
	No. Identified timelines are firm.
230	**Is CalMHSA going to provide population management type reporting and associated technology?**
	Such functions are not part of the scope of this RFP.
231	**It will be helpful to outline what CalMHSA will do for 20 counties.**
	Please refer to question #227.
232	**Would your timelines shift/move out if new CA payment model rollout changes?**
	Yes.
233	**How much time is allotted for the demonstrations?**
	TBD
234	**If a vendor can provide an inpatient pharmacy solution as part of the closed loop med admin, can this be explained in the narrative and priced as an optional solution?**
	No. It is suggested that vendors do not include additional functions/capabilities that extend beyond the scope of the RFP.
235	**Methadone clinics are out of scope. Are there other providers/programs covered by 42 CFR Part 2 that are in scope?**
	Yes. The single installation of this semi-statewide EHR will be used across multiple counties, many of whom operate both Mental Health and SUD programs. As such, CFR42 rules will apply to data across counties and across MH/SUD programs within each county.
236	**Do vendors need to achieve FedRAMP Certification (Moderate) prior to the initial 7/1/2022 go-live date?**
	Yes.
237	**Can vendors only be FedRAMP Certified (Moderate) for their data center, or do then need full certification?**
	Full certification.