

Revenue Cycle Software with Artificial Intelligence: RFP #9302026-1
Responses to Vendor Questions Received by Required Deadline
Responses issued within APHCA's Procurement Communication and Addendum Release, October 14, 2026

Date Received	Topic	Question	Question Answer	
10/2/2026	Scope	Health Note's AI handles patient access work at the front desk and call center (scheduling, rescheduling, refills, etc.). Is that kind of patient access automation in scope for the pilot, or is the pilot limited to coding and claims? If open, would APHCA consider a proposal that covers part of the scope?	No.	
10/2/2026	Timeline	The cover page lists a proposal due date of November 6, 2026, while the procurement schedule lists November 2, 2026 at 4:30 p.m. CT. Which date applies?	A technical correction was issued on 10/5/2026 and is included again in the Procurement Communication and Addendum Package issued on 10/14/2025. The proposal is due on November 6, 2026, at 4:30 p.m.	
10/2/2026	Attachment references	References mention Attachments 10, D, and H that were not included in the released package. Please confirm whether those references should be revised or whether additional attachments are required.	A technical correction was issued on 10/5/2026 related to these references and is included again in the Procurement Communication and Addendum Package issued on 10/14/2025.	
10/9/2026	Submission format	Are there page limits, file format requirements, or email size limits? Should the proposal be one PDF or several files?	There are no page limits; 35Mb limit; one PDF is requested.	
10/9/2026	Evaluators and tools	The Evaluation Criteria section states that evaluators will score independently before consensus. How many evaluators will serve, and what backgrounds will they bring (for example, clinical, coding and risk adjustment, technical, finance)? Will AI tools be used to review, evaluate, or score proposals? If so, please describe how.	AI tools may be used in scoring. There will be 5-8 evaluators with clinical, technical, financial, legal, and coding backgrounds.	
10/9/2026	Configured functionality	How will APHCA score functionality that is generally available but requires configuration for a specific EHR, relative to functionality already in production on that EHR?	APHCA will evaluate functionality as a component of System Solution, Connectivity, and AI Governance and review proposed functionality as part of the demonstrations for the top scoring proposals.	
10/9/2026	Coding gaps	Which programs does the coding-gap requirement in Section 1 cover: Medicare Advantage only, or also Medicaid, ACO/MSSP, or commercial value-based contracts? For Medicaid, does a risk adjustment model apply to the pilot site's payments, and if so, which one?	HCC risk coding gaps as well as CDPS coding gaps are of interest.	
10/9/2026	Coder workflow and claims functionality	(a) Does APHCA expect a coder-facing tool, such as worklists for reviewing, adding, and deleting diagnosis codes? (b) Should coder review occur before claim submission, retrospectively, or both? (c) Which claims functions are in scope for the pilot: pre-submission claim review, claim scrubbing, denial management, or another function?	A) APHCA prefers that both functionalities exist. While the software may be coder-facing, it needs to explain how provider input is integrated into the workflows. B) As mentioned throughout the RFP in descriptions of human engagement, expectations are that human review will occur. C) No claim function process is defined in the RFP, so all will be considered for best functionality and fit for achieving program objectives of improved accuracy and related provider reimbursement and value-based care performance.	
10/9/2026	Quality gaps	Do "quality gaps" refer to HEDIS measures, UDS clinical quality measures, payer-specific incentive measures, or another set? Please list the priority measures for the pilot. If HEDIS is in scope, is the expected support (a) delivering payer gap data to providers at the point of care, (b) abstracting evidence of closure from unstructured records and preparing supplemental data submissions (for example, confirming a dilated retinal exam from a scanned report), or (c) both?	Quality gaps refer to gaps in care that can be closed by a claim with CPT or CPTII codes for payer specific and/or HEDIS measures. The expectation is that the software would be able to proactively identify potential quality gap codes that should be submitted.	
10/9/2026	Retrospective review and write-back	In addition to the visit alerts described in Section 1, does APHCA expect retrospective chart review?	APHCA anticipates the software will read and evaluate current and previously documented clinical notes to surface related alerts across authorized calendar year(s).	

		Is write-back into the EHR required?	Write back into EHR is not required. Surfacing alerts for providers and coders in a timely manner for undocumented or underdocumented conditions or RAF inaccuracy is preferred.	
10/9/2026	Dental	The interoperability section lists dental systems (AthenaOne Dental, Dentrix). Are dental encounters in scope for the pilot, and if so, what outcomes are expected?	The pilot may or may not include a dental encounter in year one, but the same functionality is expected.	
10/9/2026	Documentation accuracy.	Section 1 cites documentation accuracy as a goal. Should the solution identify unsupported diagnoses for removal as well as missed diagnoses for addition?	Yes.	
10/9/2026	Pilot size	How many providers (FTE), coders, and clinic locations will take part? Does the pilot site have coders reviewing provider notes for documentation integrity, before billing or retrospectively? If so, how many coders, what credentials do they hold, and do they add or delete diagnosis codes before claims are submitted?	APHCA is unable to provide proprietary data including FTEs. Participating providers will have coders ensuring documentation integrity.	
10/9/2026	Patient population	How many unique patients does the pilot site serve? Please break them out by line of business (for example, Medicare Advantage, traditional Medicare, Medicaid, ACO-attributed, commercial, uninsured), and indicate whether any are covered by shared-savings or downside-risk arrangements.	Based on publicly available data, the pilot location has approximately 20,000 patients. As a point of reference, Alabama's health center patient population includes 32% Medicaid, 14% Medicare, and 31% private insurance.	
10/9/2026	EHR environment	Which EHR and practice management system does the pilot site use, including version? Is it cloud-hosted or on-premises?	AthenaOne is the primary EHR for health centers in year one under this proposal.	
10/9/2026	Existing tools	Does the pilot site or APHCA currently use, or has it recently piloted, any tools for risk adjustment, documentation improvement, coding, population health, or quality reporting? Would the awarded solution replace, supplement, or integrate with them?	Yes. The pilot location currently uses AI-enabled tools embedded in and connected to its EHR, including ambient documentation, eligibility verification, and RAF gap identification. It is anticipated the awarded solution will supplement or replace existing tools with documented impact and effectiveness.	
10/9/2026	Data access method	Will the pilot site provide direct EHR or API access, or are scheduled extracts acceptable (for example, flat files over encrypted SFTP, or bulk FHIR)? If EHR access is unavailable, is a data warehouse available?	With any site, pilot, or otherwise, there is no prescribed access. There may be direct EHR access, API access given, or scheduled extracts.	
10/9/2026	Access to additional data sources	Does the pilot grant access to non-EMR data repositories, including claims records, CMS datasets, and external PDF files?	No.	
10/9/2026	Pilot support resources	What dedicated support resources will be provided throughout the pilot period? Specifically, will a PMO lead be assigned, along with specialized integration specialists to assist with non-FHIR API EMR connections and data warehouse retrieval?	APHCA has dedicated project management, technical, and pilot site resources with EHR integration and related expertise. APHCA requires the vendor to provide a dedicated implementation and integration specialist to support the process.	
10/9/2026	Baseline data	What baseline performance data is available for the pilot site over the past two years, and can it be shared with the selected vendor? Where available, please provide by line of business: (a) overall RAF score, year over year; (b) chronic condition recapture rate; (c) suspect acceptance rate; (d) quality measure performance.	Related information will not be provided as part of the RFP process. Pertinent information will be provided to the selected vendor upon contract execution and subject to confidentiality requirements.	
10/9/2026	Success metrics and measurement	Beyond the goals in Section 1, which metrics with numeric targets will APHCA use to judge the pilot? Who will calculate results: APHCA, the pilot site, or the vendor using platform data? Will results and the payer data needed to validate them (risk scores, gap lists) be shared with the vendor, and how often?	Please refer to Section 4.8 for metrics that will be used in the evaluation. APHCA will coordinate related data collection with the pilot provider and engage the vendor as needed to support data and documentation.	
10/9/2026	Leading indicators	Will APHCA consider leading indicators, such as suspect review rate, provider acceptance rate, and documentation completeness, as pilot measures alongside RAF and revenue?	APHCA will consider supplemental measures to evaluate performance and related impact. Measures included in the RFP represent required, minimum measures.	

10/9/2026	Gap identification and closure	How will APHCA evaluate gap identification relative to gap closure? Will the pilot site designate provider champions or protected time for acting on surfaced gaps?	The proposed technology should identify coding gaps and facilitate related closures using fixed data points and CPT II codes. The software should identify care gaps to address code denials and workflow challenges. The solution should not add burden or impede clinical workflow. Participating providers will maintain oversight and review of surface gaps.	
10/9/2026	Expansion beyond the pilot	How will expansion pricing and budget be handled after the pilot? If the pilot meets its agreed success metrics, will the awarded vendor move directly to network expansion at the proposed pricing, or will expansion require a new procurement or competitive process?	Subject to CMS and ADECA approval and related funding for subsequent project expansion, APHCA does not anticipate a secondary procurement process unless the funder or business necessity requires it. Respondents should propose its best pricing for nonprofits and federally funded programs.	
10/9/2026	AI accuracy	How does APHCA define "average accuracy of the AI data model"? For example, is it the share of surfaced suspects validated by a certified coder, the provider acceptance rate, agreement with independent coder review, or another method?	Average accuracy should reflect the result after coder review and provider acceptance.	
10/9/2026	Code capture	How does APHCA define "code capture" in Section 4.8.3.2: HCC capture rate, recapture of previously documented conditions, or another measure?	Code capture includes all of the referenced indicators.	
10/9/2026	Revenue increase	For Section 4.8.3.3, which revenue streams should "average revenue increase" reflect: PPS/FFS visit revenue, risk-adjusted capitation, shared savings, or quality incentive payments?	Revenue increases will be evaluated by the overall revenue impact created by the use of the technology.	
10/9/2026	Production period	Does the six-month production period run from go-live (roughly February to July 2027)?	Yes.	
10/9/2026	Schedule	If contract execution or ADECA approval slips past December 28, will the February 1, 2027 implementation deadline move accordingly?	APHCA anticipates implementation to occur and be completed within January, and not later than February 15, with at least six months of software use in a go-live status with active related claims processing use.	
10/9/2026	Budget	Is there a not-to-exceed amount or budget range for the Year 1 pilot? What simplified acquisition threshold applies under APHCA's procurement policy?	APHCA will not provide a not-to exceed or budget range. Vendor should propose its best pricing for nonprofits and federally funded programs.	
10/9/2026	Pricing basis	May pricing be submitted per member per year (or per patient) under line 4.9, or must it map to the listed units (user, provider, claim/encounter)?	Either method is acceptable, but it must be clearly explained and allow calculation of the overall cost from the rate basis provided in the response. Any pricing proposal established on a per-year basis will be prorated to the actual project performance period.	
10/9/2026	Indirect costs	Attachment 5 states that prices must include overhead and profit, and also that pricing must not include administrative or indirect costs. Please confirm that standard commercial subscription pricing is acceptable.	Standard commercial subscription pricing is acceptable, provided the pricing represents a direct programmatic expense or is properly incorporated within the allowable provisions of the Rural Health Transformation Program, as required by federal procurement and cost principles, and state procurement rules. Vendors should propose its best pricing for nonprofits and federally funded programs.	
10/9/2026	Registration	Do the RHTP award terms require active SAM.gov registration before contract execution?	No.	
10/12/2026	Tech stack/AI workflows	To ensure our upcoming formal submission aligns perfectly with your existing tech stack, could you kindly clarify if your infrastructure primarily relies on standard REST APIs, or if our custom AI workflows will need to interface with a legacy EHR/EMR framework via custom webhooks?	The initial pilot provider relies on standard REST APIs; expansion frameworks, depending on EHR may required legacy connections and will be determined subject to federal and state program and funding continuation.	
10/12/2026	Remote or international vendors may participate	Could you please confirm whether remote or international vendors may participate if we can meet all technical, security, support, insurance, documentation, and contracting requirements?	APHCA has clarified as part of its Procurement Documentation and Addendum Packet released 10/14/2026 the requirement for contracting with a domestic corporation.	
10/9/2026	Interface fees	If the EHR vendor charges interface or API fees, will the health center or the respondent pay them?	This is not an expectation of the vendor.	

10/9/2026	Proprietary information	The Proposal Confidentiality term permits sharing proposals with members and payers. May respondents mark pricing, client outcome data, and security documentation as proprietary and exclude them from sharing with payers?	Confidential/proprietary designation includes trade secrets, commercial or financial information, or proprietary technical know-how. However, simply labeling a page "confidential" does not automatically or permanently shield it from public disclosure under state or federal laws. Federal regulations require applicants to conspicuously mark the cover page and every individual page containing proprietary data with a specific restrictive legend (e.g., "Confidential and Proprietary Information")	
10/9/2026	Clarification before scoring	If evaluators find a response incomplete or internally inconsistent, will APHCA issue written clarification requests before scoring, or will responses be scored as submitted?	APHCA reserves the right to request clarification from a vendor during the RFP scoring process through a uniform, documented process. Clarification efforts will not allow a vendor to materially alter or upgrade submitted proposals. Absent technical issues, APHCA does not anticipate use of the clarification process on minimum responsiveness requirements; see Section 7.1 of RFP.	
10/9/2026	Termination	Please clarify expectations for termination for convenience within the pilot contract.	The resulting software agreement is expected to include a termination-for-convenience provision that allows APHCA to discontinue the pilot, in whole or in part, if programmatic, operational, funding, regulatory, or organizational considerations warrant ending the engagement. In the event of such termination, the selected vendor would be compensated for authorized and satisfactorily performed services, approved deliverables, and allowable expenses incurred through the effective date of termination, consistent with the terms of the final agreement.	
10/9/2026	Insurance	What minimum limits are required for general liability, professional/E&O, cyber liability, and workers' compensation?	Vendors shall maintain commercially reasonable coverage limits. APHCA anticipates vendors have a minimum of \$1,000,000 aggregate for individual corporate policies (general liability and professional/E&O; Workers' Compensation as required by statutory limits). Cybersecurity coverage should reflect a minimum of \$3,000,000 per occurrence.	