RIHCA Coding Consultant Services RFP - Response to Questions Tracker

Date: November 4, 2026 | Total Questions: 130

Category	Q #	Full Question Text	Response
Category 1: Scope of Services & Program Expectations			
Scope of Services & Program Expectations	1	Section 2 (Scope of Services) - Quality Reporting and Population Health Documentation – Can you give us some more specifics regarding what you are looking for in this section as it pertains to coding and documentation?	Quality reporting and population health documentation support may include identifying documentation gaps that affect quality measure performance, risk-adjustment accuracy, and population health indicators. CHCs will define specific quality-related priorities during engagement-level scoping, and vendors should be prepared to align coding and documentation reviews with each CHC's quality and population health goals.
Scope of Services & Program Expectations	2	Demand priorities: Of the service areas listed in Section 2, are there specific needs or priorities identified across the CHCs for the initial program period?	RIHCA is not establishing system-wide priorities for the initial program period. Each CHC will determine its own needs based on operational readiness and value-based care goals.
Scope of Services & Program Expectations	3	Will existing measures—such as coding accuracy, denial rates, risk-adjustment documentation gaps, or quality performance—be provided during project scoping? Are any shared outcome targets or required measures of success anticipated?	CHCs may provide baseline measures during scoping, but RIHCA is not requiring standardized measures or shared outcome targets across all CHCs. Each CHC will determine the metrics most relevant to its operational priorities and may request vendor support in improving those measures. Success criteria will be defined individually by each CHC. RIHCA is looking for vendors to provide recommendations based on best practices and industry standards.
Scope of Services & Program Expectations	4	Can RIHCA provide additional details on the anticipated coding audit scope? Will the focus primarily be on professional fee coding, primary care and E&M encounters, or a broader range of services?	RIHCA is not prescribing a uniform audit scope. RIHCA is looking for vendors to provide recommendations for audit scope based on items listed in the Request for Proposal - Section 2. Audit scope will vary by CHC based on service lines, compliance priorities, and value-based care readiness. Each CHC will define the specific encounter types and service areas to be included during engagement-level scoping. Many CHCs have speciality services that may also be included in their scopes of work and respective audits. These may include but are not limited to behavorial health, dental, ob/gyn, opthamology, podiatry.
Scope of Services & Program Expectations	5	Does RIHCA anticipate retrospective coding audits, prospective/pre-bill reviews, or a combination of both?	RIHCA is not prescribing a uniform audit scope. Audit scope will focus on retrospective coding audits and NOT prospective/pre-bill reviews.
Scope of Services & Program Expectations	6	Can RIHCA clarify the anticipated scope of behavioral health/SUD coding and risk adjustment services? Are these expected to be significant components of the engagements?	RIHCA is not projecting the size or significance of behavioral health/SUD work at the program level; each CHC will define its own priorities during scoping.
Scope of Services & Program Expectations	7	Are vendors expected to provide ongoing coding and billing support, or will engagements primarily focus on assessments, audits, training, and recommendations for improvement?	Engagements will primarily focus on assessments, audits, documentation improvement, provider training, and recommendations for improvement. Some CHCs may request limited ongoing support, but RIHCA is not establishing expectations for continuous coding or billing services. Each CHC will determine whether ongoing support is needed when developing its scope of work.
Scope of Services & Program Expectations	8	Audit methodology. Does RIHCA have standard audit expectations (for example, charts per provider, random vs. targeted sampling, accuracy-scoring method), or should vendors propose a methodology for each CHC? Will a common baseline approach be expected across CHCs so results can be compared at the program level?	RIHCA is not prescribing a standard audit methodology. Vendors may propose methodologies tailored to each CHC during scoping. A common baseline approach is not required across CHCs; results are not being standardized or compared at the program level.
Scope of Services & Program Expectations	9	Value-based care focus. For items (g) and (h), which payer programs and measure sets matter most (for example, RI Medicaid Accountable Entity quality measures, UDS, HEDIS, Medicare Advantage or Medicaid managed care risk adjustment)? For item (l), does RIHCA expect vendors to provide software or tools, or to assess and advise on the CHCs' existing infrastructure?	RIHCA is not prescribing specific payer programs or measure sets for this procurement. Vendors should be prepared to align coding, documentation, and quality support with the measure sets identified by each CHC during scoping. For item (l), RIHCA does not expect vendors to provide proprietary software or tools.
Scope of Services & Program Expectations	10	Work product. May RIHCA or other CHCs reuse training materials and tip sheets developed for one CHC, and should vendors plan for a shared program-level education curriculum?	Yes. Training materials, tip sheets, and educational content developed for one CHC may be reused by RIHCA or other participating CHCs. CHCs may request customized content, but a shared program-level curriculum is acceptable and encouraged where appropriate.
Scope of Services & Program Expectations	11	Please clarify whether the services contemplated under this RFP are expected to be performed on-site at participating Community Health Centers, remotely/off-site, or through a hybrid delivery model.	RIHCA anticipates that most services will be delivered remotely by U.S.–based personnel. Some CHCs may request limited on-site support for provider training or workflow observation, but on-site presence is not a universal requirement.
Scope of Services & Program Expectations	12	If on-site support is anticipated, please provide the expected locations and approximate frequency of on-site presence.	Any on-site expectations, including locations and frequency, will be defined individually by CHCs during engagement-level scoping.
Scope of Services & Program Expectations	13	Engagement timing: When are individual CHCs expected to begin issuing scopes to prequalified firms, and are there expected milestone or completion requirements beyond the stated June 30, 2027 funding authorization?	CHCs may begin issuing scopes shortly after the pre-qualified pool is established. Engagement timing will vary by CHC based on internal readiness and priorities.
Category 2: Vendor Qualifications & Eligibility			
Vendor Qualifications & Eligibility	14	Relevant CHC Experience: Can a consulting firm satisfy the community health center experience requirement through its principal's prior professional experience working in Federally Qualified Health Centers (FQHCs), even if that experience was gained before establishing the consulting firm?	Yes. CHC experience may be demonstrated through the prior professional experience of the firm's principal or proposed personnel, including experience gained before the consulting firm was established. The intent is to ensure that the vendor team collectively has practical familiarity with CHC or FQHC environments. Experience may be held by the organization, its leadership, or its proposed staff.
Vendor Qualifications & Eligibility	15	Certified Coding Professionals: Does RIHCA permit consulting firms to engage appropriately credentialed coding professionals as subcontractors to satisfy the certification and technical expertise requirements, provided their qualifications and responsibilities are clearly documented in the proposal?	Yes. Vendors may use certified coding professionals as subcontractors, provided their credentials, roles, and responsibilities are clearly documented in the proposal. Subcontracted personnel must meet the same certification, experience, and U.S.–based staffing requirements as prime vendor staff.
Vendor Qualifications & Eligibility	16	Organizational Capacity: Are smaller, independently owned consulting firms eligible for consideration if they demonstrate the ability to meet project requirements through a combination of principal oversight and qualified subcontracted professionals?	Yes. Smaller or independently owned consulting firms are eligible for consideration.
Vendor Qualifications & Eligibility	17	CHC experience requirement: Section 4 states that "experience working with CHCs will be a required qualification for all firms." However, the Relevant Experience criterion in Section 6 evaluates experience "providing coding, documentation, and chart audit services in CHCs or comparable primary care settings," and its scoring guidance awards a 3 for "some CHC or primary care exposure." The two sections appear to set different standards. Please clarify whether experience in comparable primary care settings satisfies the Section 4 requirement, or whether direct CHC experience is a pass/fail threshold, with comparable settings considered only in scoring.	Direct experience working with FQHCs/CHCs is a required minimum qualification under Section 4. Experience in comparable primary care settings, while relevant, does NOT satisfy this minimum requirement and will not be considered a substitute for direct CHC experience. The references to "comparable primary care settings" in Section 6 are intended to inform the evaluation of the depth and breadth of a firm's experience among vendors that meet the minimum qualification. However, proposers must first demonstrate direct CHC experience to be considered responsive to the RFP.

Vendor Qualifications & Eligibility	**18**	Related to this, would either of the following satisfy the requirement: (a) the documented CHC/FQHC experience of the individual consultants proposed, or (b) the firm's outpatient coding and audit work for a county-operated safety-net ambulatory care network serving a predominantly Medicaid and uninsured population?	Direct experience working with FQHCs/CHCs is a required minimum qualification under Section 4. Experience in comparable primary care settings, while relevant, does NOT satisfy this minimum requirement and will not be considered a substitute for direct CHC experience.
Vendor Qualifications & Eligibility	**19**	Is direct experience with Federally Qualified Health Centers (FQHCs) a mandatory qualification, or would comparable experience supporting primary care practices, physician groups, and health systems be considered?	Direct experience working with FQHCs/CHCs is a required minimum qualification under Section 4. Experience in comparable primary care settings, while relevant, does NOT satisfy this minimum requirement and will not be considered a substitute for direct CHC experience.
Vendor Qualifications & Eligibility	**20**	Are vendors expected to demonstrate capabilities across all listed service areas, or can they qualify for specific services where they have established expertise?	Vendors may qualify for specific service areas where they have established expertise.
Vendor Qualifications & Eligibility	**21**	Are there specific certification, experience, or credentialing requirements for proposed coding consultants beyond those outlined in the RFP?	No additional certification requirements are being imposed beyond those outlined in the RFP.
Vendor Qualifications & Eligibility	**22**	Comparable experience. Section 4 makes CHC experience a required qualification, while Section 6 scores experience in "CHCs or comparable primary care settings." Will RIHCA count Rural Health Clinics, hospital-affiliated rural primary care and behavioral health clinics, and FQHC look-alikes toward the CHC requirement? Is the requirement pass/fail or scored?	Direct experience working with FQHCs/CHCs is a required minimum qualification under Section 4. Experience in comparable primary care settings, while relevant, does NOT satisfy this minimum requirement and will not be considered a substitute for direct CHC experience. The references to "comparable primary care settings" in Section 6 are intended to inform the evaluation of the depth and breadth of a firm's experience among vendors that meet the minimum qualification. However, proposers must first demonstrate direct CHC experience to be considered responsive to the RFP.
Vendor Qualifications & Eligibility	**23**	EHR experience (Section 4): The minimum requirements list eClinicalWorks, Epic, and NextGen. Is experience with one of these platforms enough, or should vendors show experience with all three?	Experience with one or more of the listed platforms is sufficient.
Vendor Qualifications & Eligibility	**24**	Pricing in the response (Sections 4 and 5): Section 4 calls for itemized pricing, but Section 5 doesn't list pricing as a proposal component. Does RIHCA prefer a format, such as hourly rates by role, fixed fees for service packages, or a per-chart audit rate?	Pricing is not required at the prequalification/pool stage.
Vendor Qualifications & Eligibility	**25**	Does RIHCA permit a prime consulting firm to submit a proposal using qualified subcontracted coding professionals, provided their credentials, relevant experience, organizational capacity, and data security safeguards are documented?	Yes. Prime vendors may propose qualified subcontracted coding professionals, provided their credentials, experience, roles, and data-security safeguards are clearly documented.
Vendor Qualifications & Eligibility	**26**	Additionally, may relevant experience and references from a proposed subcontracting partner be considered as part of the team's qualifications?	Yes. Relevant experience and references from proposed subcontracting partners may be included as part of the team's qualifications.
Vendor Qualifications & Eligibility	**27**	To help us assess staffing and capacity requirements, can RIHCA provide information regarding the approximate size of each participating CHC (e.g., provider counts) and any expectations regarding the volume of the audits that may be requested?	RIHCA is not publishing provider counts, encounter volumes, or anticipated audit volumes for participating CHCs at this stage. Each CHC will provide its own size, volume, and audit expectations during engagement-level scoping.
Vendor Qualifications & Eligibility	**28**	For a typical coding audit, what approximate sample size should vendors anticipate—for example, charts per provider, charts per service line, or total charts per CHC?	RIHCA is not prescribing audit sample sizes for this procurement. Chart volumes and sampling methodologies will be determined individually by each CHC based on their compliance needs, service mix, and operational priorities.
Vendor Qualifications & Eligibility	**29**	Approximately how many providers may require individual or group training, and does RIHCA anticipate one-time education or recurring remediation/follow-up sessions?	Training needs will vary by CHC and will be defined during individual scoping. Some CHCs may request one-time education sessions, while others may prefer recurring remediation or follow-up training based on audit findings.
Vendor Qualifications & Eligibility	**30**	How many CHCs may a qualified vendor be expected to support concurrently?	Concurrent engagement levels will depend on CHC demand and vendor capacity. Multiple CHCs may choose to initiate work during the program period, but participation and timing will vary by center. Vendors should be prepared to support more than one CHC if selected, with specific workloads determined through CHC-level scopes of work.
Vendor Qualifications & Eligibility	**31**	Approximately how many CHC locations or clinical sites may be included within a typical engagement?	RIHCA is not prescribing the number of locations or clinical sites for any engagement. Each CHC will define the specific sites included in its scope of work during engagement-level scoping.
Vendor Qualifications & Eligibility	**32**	What is the approximate distribution of audit activity anticipated across primary care, behavioral health/SUD, dental, women's health, specialty care, and other service lines?	RIHCA is not projecting a distribution of audit activity across service lines. Audit needs will vary by CHC based on service mix, compliance priorities, and operational readiness.
Vendor Qualifications & Eligibility	**33**	What proportion of anticipated work is expected to focus on coding/compliance auditing versus risk adjustment/VBC optimization, revenue recovery/denial management, training, and technology/analytics support?	RIHCA is not establishing expected proportions across service categories. The mix of work will depend on each CHC's needs and priorities.
Vendor Qualifications & Eligibility	**34**	Does the requirement to support eClinicalWorks, Epic and NextGen mean that each pre-qualified vendor must demonstrate experience with all three platforms, or may vendors qualify based on support for a subset aligned to particular CHCs?	Vendors are not required to demonstrate experience with all three platforms. Experience with one or more of the listed systems is sufficient to meet the qualification requirement.
Vendor Qualifications & Eligibility	**35**	Credential Requirements: Must every consultant proposed under this engagement possess one of the listed coding credentials (CPC, CRC, CCS, RHIA, RHIT, etc.), or is it acceptable for the overall project team to collectively possess the required certifications based on individual roles?	Credentials may be met collectively across the project team.
Vendor Qualifications & Eligibility	**36**	Behavioral Health / SUD Experience: Must the prime vendor itself demonstrate organizational experience with behavioral health and SUD programs, or may this requirement be met through qualified proposed personnel or subcontractors with relevant experience?	Behavioral health and SUD experience may be demonstrated through the prime vendor, proposed personnel, or qualified subcontractors.
Vendor Qualifications & Eligibility	**37**	Will each CHC independently select its vendor, or will RIHCA participate in/approve downstream vendor selection?	Each CHC will independently select its vendor from the pre-qualified pool. CHCs will issue their own scopes of work, request pricing, and determine which vendor best meets their needs. RIHCA will not approve or participate in downstream vendor selection once the pool is established.
Vendor Qualifications & Eligibility	**38**	Section 2(f), dental and women's/specialty coding, is marked as not required. Does a firm need to demonstrate capability in all other areas (a–e and g–l) to join the pool, or can a firm qualify for a subset of services?	Vendors may qualify for specific service areas where they have established expertise.
Category 3: Subcontractors, Teaming & Personnel Use			
Subcontractors, Teaming & Personnel Use	**39**	May a qualified coding firm submit as the lead vendor and name a technology subcontractor in its proposal? The subcontractor would supply audit, analytics and documentation tools under the RFP's "value-added services, innovations, or tools" provision. It would not supply coding staff.	Yes. A qualified coding firm may submit as the lead vendor and include a technology subcontractor that provides audit, analytics, or documentation tools.
Subcontractors, Teaming & Personnel Use	**40**	Subcontractors and affiliates (Sections 4 and 5A): May proposers use qualified subcontractors or staff from affiliated entities for part of the work? If so, should we name those resources in the proposal, and are there documentation or approval requirements?	Yes. Vendors may use qualified subcontractors or staff from affiliated entities to perform portions of the work. Subcontractors should be identified in the proposal when known, including a description of their role and qualifications. CHCs may request résumés, credentials, or other documentation for any personnel assigned to their engagement.

Subcontractors, Teaming & Personnel Use	**41**	Credentials (Section 4): Must every proposed consultant hold a certified coding credential? Or may the team also include experts in value-based payment, PPS/APM, revenue cycle, or training who work alongside credentialed coders?	Not every consultant must hold a certified coding credential. Teams may include subject-matter experts in value-based payment, PPS/APM, revenue cycle, analytics, or provider training, provided credentialed coders perform all coding-specific work. CHCs may request verification of credentials for coding personnel.
Subcontractors, Teaming & Personnel Use	**42**	Subcontracting: Are prime vendors permitted to utilize subcontractors, independent consultants, staffing partners, or other third-party resources to perform any portion of the services under this RFP?	Yes. Prime vendors may utilize subcontractors, independent consultants, staffing partners, or other qualified third-party resources. The prime vendor remains responsible for oversight, quality, compliance, and performance of all subcontracted work.
Subcontractors, Teaming & Personnel Use	**43**	Disclosure of Subcontractors: If subcontracting is permitted, must proposed subcontractors be identified at the time of proposal submission, or may subcontractors be added after award subject to RIHCA approval?	Subcontractors should be identified at the time of proposal submission when known. Additional subcontractors may be added after award, subject to CHC approval to ensure qualifications, compliance, and alignment with the scope of work. CHCs may request résumés or documentation for any subcontracted personnel.
Subcontractors, Teaming & Personnel Use	**44**	Minimum Qualifications Through Subcontractors: The RFP specifies several minimum vendor qualifications. Please clarify whether each minimum qualification must be independently satisfied by the prime/vendor organization itself, or whether the qualifications and experience of an identified subcontractor or proposed consultant may be used to satisfy one or more minimum requirements.	Minimum qualifications may be met by the prime vendor or by identified subcontractors or proposed personnel. The prime vendor must demonstrate that its team—collectively—meets all required qualifications through a combination of organizational experience, subcontractor capabilities, and individual consultant expertise. The prime vendor retains responsibility for oversight, quality, and compliance, regardless of how qualifications are distributed across team members.
Subcontractors, Teaming & Personnel Use	**45**	CHC Experience Requirement: The RFP states that experience working with Community Health Centers is a required qualification. Please clarify whether this requirement must be demonstrated specifically by the prime contractor, or whether relevant CHC experience held by proposed personnel or subcontractors will qualify	CHC experience may be demonstrated by the prime vendor, proposed personnel, or subcontractors. Experience working with Community Health Centers can be satisfied through the qualifications of individual team members, provided those individuals will be involved in delivering the services. The intent is to ensure the vendor team has practical familiarity with CHC environments, regardless of whether that experience resides with the prime or its subcontractors.
Subcontractors, Teaming & Personnel Use	**46**	References – Prime Contractor vs. Subcontractor: The RFP requires at least two references for similar coding, auditing, or documentation improvement services. Please confirm whether references must be from contracts performed directly by the prime/vendor organization, or whether references associated with proposed subcontractors, teaming partners, or key personnel may also be submitted.	References may come from the prime vendor or from subcontractors, teaming partners, or key personnel, as long as the referenced work is relevant to coding, auditing, documentation improvement, or related services. Vendors should clearly indicate which entity performed the referenced work and ensure that the personnel or subcontractors associated with those references will be part of the proposed team.
Subcontractors, Teaming & Personnel Use	**47**	Small Business / Subcontractor References: If a vendor proposes an experienced small-business subcontractor or specialized consulting partner, may the vendor use that subcontractor's relevant client references and past performance to demonstrate the team's overall qualifications?	Yes. Vendors may use relevant client references and past performance from proposed subcontractors or specialized consulting partners to demonstrate the qualifications of the overall team. References should clearly identify the subcontractor's role and confirm that the referenced personnel or capabilities will be part of the proposed engagement. The intent is to allow vendors to present the full strength of their combined team.
Subcontractors, Teaming & Personnel Use	**48**	Past Performance of Key Personnel: Where relevant experience was gained by proposed consultants while employed by another organization, may the vendor cite the individual's prior project experience as evidence of qualifications, provided the individual's role and prior employer are clearly disclosed?	Yes. Vendors may cite the prior project experience of proposed personnel, even if that experience was gained under a different employer. The proposal should clearly disclose the individual's role, the prior employer, and how that experience is relevant to the services being proposed. CHCs may request additional detail to confirm alignment with the scope of work.
Subcontractors, Teaming & Personnel Use	**49**	Joint Ventures / Teaming Arrangements: Are joint ventures, teaming arrangements, or prime/subcontractor proposal structures permitted under this procurement? If so, are there any specific documentation or qualification requirements for such arrangements?	Joint ventures, teaming arrangements, and prime/subcontractor structures are permitted. Vendors should clearly describe the structure of the team, the roles of each participating entity, and how responsibilities will be managed. All entities contributing to the work must collectively meet the minimum qualifications outlined in the RFP. CHCs may request documentation such as résumés, credentials, or organizational descriptions to confirm qualifications and ensure compliance with program requirements.
Subcontractors, Teaming & Personnel Use	**50**	Proposed staff: Section 5B asks for résumés or bios for all proposed consultants. May firms propose credentialed subcontractor or contract coders, provided their credentials are documented?	Yes. Prime vendors may utilize subcontractors, independent consultants, staffing partners, or other qualified third-party resources. The prime vendor remains responsible for oversight, quality, compliance, and performance of all subcontracted work.
Category 4: Pricing, Rate Structure & Funding			
Pricing, Rate Structure & Funding	**51**	At the pool stage, does RIHCA expect proposals to include indicative rates? Or will itemized pricing be set only in each CHC's scope of work?	RIHCA does not require pricing or indicative rates at the pool stage. Itemized pricing will be requested later by individual CHCs when developing engagement-specific scopes of work. Vendors may describe general pricing approaches if they choose, but rate schedules, per-chart fees, or cost proposals are not required for this submission.
Pricing, Rate Structure & Funding	**52**	If a CHC chooses optional technology services, would those be paid from the same RHTP allocation as coding services, or contracted separately?	Any optional technology services selected by a CHC would be funded at the CHC's discretion. CHCs may choose to use their RHTP allocation or contract separately depending on their internal budgeting and procurement processes. RIHCA is not prescribing a single funding pathway for optional technology components.
Pricing, Rate Structure & Funding	**53**	Pricing: Section 4 calls for transparent pricing with itemized costs and deliverables, but Section 5 does not include a pricing component and price is not among the evaluation criteria. Should proposers include a rate schedule (e.g., hourly rates by role, per-chart audit rates, training fees), or will pricing be set within each CHC's individual scope of work?	Proposers are not required to submit rate schedules or itemized pricing at this stage. Although Section 4 references transparent pricing, actual rates and cost structures will be established later during CHC-specific scoping. Pricing is not part of the evaluation criteria for pool selection, and CHCs will request detailed pricing only when initiating individual engagements.
Pricing, Rate Structure & Funding	**54**	Pricing options: May vendors submit multiple pricing methodologies (such as hourly rates, per-chart fees, fixed-fee assessments, and recurring support) with clear assumptions and volume-based tiers? Is a standard pricing template required?	Vendors may describe typical pricing methodologies if they wish, but detailed rate structures, tiers, or templates are not required for the pool stage. No standard pricing template is being issued. CHCs will request specific pricing formats — hourly, per-chart, fixed-fee, or blended models — when developing individual scopes of work after the pool is established.
Pricing, Rate Structure & Funding	**55**	Funding parameters: Are any service-specific or per-CHC budgets, spending caps, or expected project-value ranges available to guide appropriate pricing?	The total funding available for this program is $82,000 through June 30, 2027. RIHCA is not issuing service-specific or per-CHC spending caps at this stage. Each CHC will determine how much of the overall allocation to use and will set engagement-level budgets during individual scoping. Vendors are not required to submit pricing during the pool phase; CHCs will request detailed pricing only when initiating their own scopes of work.

Pricing, Rate Structure & Funding	**56**	Rate commitments: Will proposed rates serve as a nonbinding schedule for prequalification, or must they remain fixed for subsequent CHC engagements? May individual statements of work establish negotiated pricing based on complexity, scope, and volume?	Because pricing is not required at the pool stage, no rate commitments are being established as part of prequalification. All pricing will be negotiated separately with each CHC during the development of individual statements of work. CHCs may request hourly rates, per-chart pricing, fixed-fee packages, or other structures depending on the complexity, scope, and volume of the engagement.
Pricing, Rate Structure & Funding	**57**	Pricing in selection: Section 6 identifies experience, organizational capacity, and personnel qualifications as the weighted evaluation criteria. Will pricing be considered at the prequalification stage, at individual CHC selection, or both?	Pricing will not be considered at the prequalification stage. Pool selection is based solely on experience, organizational capacity, and personnel qualifications. Pricing will be evaluated only at the CHC level when individual scopes of work are developed and vendors are selected for specific engagements.
Pricing, Rate Structure & Funding	**58**	Has RIHCA established an overall budget or anticipated funding allocation for coding consultant services under this program?	Yes. The total funding available under this program is $82,000 through June 30, 2027. Individual CHCs will determine how to allocate this funding based on their operational needs and readiness to initiate work.
Pricing, Rate Structure & Funding	**59**	Is there a preferred pricing structure, such as hourly consulting rates, per-chart audit fees, fixed project pricing, or dedicated FTE-based pricing?	RIHCA is not prescribing a preferred pricing structure at the pool stage. Pricing will be established later by individual CHCs when developing engagement-specific scopes of work.
Pricing, Rate Structure & Funding	**60**	Pricing in the proposal. Section 4 requires transparent, itemized pricing, but Section 5 does not include a pricing section. Should pricing come with the November 3 proposal? If so, does RIHCA prefer hourly rates, per-chart or per-provider audit pricing, or fixed fees per deliverable? Will each CHC negotiate pricing in its own scope of work, and will proposed rates be shared with the CHCs?	Pricing is not required with the November 3 proposal. Although Section 4 references transparent pricing, actual rates and itemized costs will be negotiated later by each CHC during the development of individual scopes of work. CHCs will request pricing directly from vendors at that time, and rates will be shared only with the CHCs initiating engagements. No pricing format is required or evaluated during the pool selection process.
Pricing, Rate Structure & Funding	**61**	Funding and period of performance. Is there an RHTP funding allocation or not-to-exceed amount per CHC or per vendor? Must services be delivered and invoiced by June 30, 2027? If the one-year renewal is exercised, may rates be adjusted?	The total funding available for this program is $82,000 through June 30, 2027. All services supported by this allocation must be delivered and invoiced by June 30, 2027. If the optional one-year renewal is exercised, CHCs may negotiate updated rates as part of their individual scopes of work.
Pricing, Rate Structure & Funding	**62**	Pricing assumptions: Since each health center will set its own scope, should we price sample service packages with stated assumptions? Can RIHCA share any assumptions to use, such as chart volumes, number of providers, or engagement length?	Vendors are not required to submit sample pricing packages or assumptions at the pool stage. RIHCA is not providing chart volumes, provider counts, or engagement-length assumptions for pricing purposes. These details vary significantly across CHCs and will be defined directly by each center during engagement-level scoping. Pricing will be requested only when CHCs initiate individual statements of work.
Pricing, Rate Structure & Funding	**63**	Pricing. Section 4 requires transparent pricing with itemized costs and deliverables, but Section 5 doesn't list pricing as a proposal element and cost isn't among the evaluation criteria. Should we include a rate schedule with the proposal, or is pricing established with each health center when its individual scope of service is developed? If you would like rates up front, please confirm the format you prefer — hourly by role, per chart, per engagement, or some combination.	Pricing is not required at the pool stage. Although Section 4 references transparent pricing, actual rates, itemized costs, and pricing structures will be established later by individual CHCs when developing engagement-specific scopes of work. CHCs will request pricing directly from vendors at that time and may specify the preferred format (hourly, per-chart, fixed-fee, or blended). No rate schedule or pricing template is required for the November 3 submission, and pricing is not part of the evaluation criteria for pre-qualification.
Pricing, Rate Structure & Funding	**64**	Will individual CHCs issue separate SOWs/work orders to vendors selected from the pool, including specific scope, volume, timeline, deliverables and pricing?	Yes. Each CHC will issue its own statement of work or work order when initiating an engagement. These SOWs will define the specific scope, chart volumes, timelines, deliverables, and pricing for that engagement. All pricing will be negotiated directly between the CHC and the selected vendor at the time of scoping.
Pricing, Rate Structure & Funding	**65**	Does selection to the pre-qualified pool guarantee any minimum volume, or will all work be assigned at the discretion of individual CHCs?	Selection into the pre-qualified pool does not guarantee any minimum level of work, revenue, or number of engagements. All work will be initiated at the discretion of individual CHCs based on their operational needs, available funding, and readiness. CHCs will independently determine whether, when, and how to engage vendors from the pool.
Pricing, Rate Structure & Funding	**66**	Guaranteed Work / Pre-Qualified Pool: Does selection into the pre-qualified vendor pool guarantee any minimum level of work, revenue, number of engagements, or hours, or will individual CHCs independently determine whether and when to engage a pre-qualified vendor?	Selection into the pre-qualified pool does not guarantee any minimum level of work, revenue, or number of engagements. All work will be initiated at the discretion of individual CHCs based on their operational needs, available funding, and readiness. CHCs will independently determine whether, when, and how to engage vendors from the pool.
Pricing, Rate Structure & Funding	**67**	Pricing Format: Please clarify the preferred pricing structure for proposals. Should vendors provide hourly rates by labor category, fixed-price service packages, per-chart/per-audit pricing, training rates, or another pricing methodology?	RIHCA does not require pricing with the proposal and is not prescribing a preferred pricing structure at this stage. Vendors may describe general pricing approaches if they choose, but detailed rate schedules, per-chart fees, fixed-fee packages, or training rates are not required for pre-qualification. CHCs will request specific pricing formats when developing individual scopes of work after the pool is established.
Pricing, Rate Structure & Funding	**68**	Pricing: Section 4 calls for "transparent pricing and clearly defined scope of work documentation, including itemized costs and deliverables," but Section 5 doesn't list a pricing section. Should proposals include a rate schedule now (for example hourly rates, per-chart audit pricing, or fixed fees for standard services), or will pricing be set with each health center as it scopes work?	Pricing is not required with the November 3 proposal. Although Section 4 references transparent pricing, actual rates and itemized costs will be negotiated later by each CHC during the development of individual scopes of work.
Category 5: Contracting Structure, Agreements & Compliance			
Contracting Structure, Agreements & Compliance	**69**	Contracting: Is a template professional services agreement or BAA available for review? What insurance types and limits will be required, and will RHTP federal flow-down terms (e.g., 2 CFR 200) apply?	RIHCA does not have a template agreement available for review. Vendors should expect standard insurance requirements for healthcare coding and PHI-related services, including professional liability (E&O), general liability, and cyber/privacy liability. Specific limits may vary by CHC. Federal flow-down requirements associated with RHTP funding (including applicable 2 CFR 200 provisions) may apply and may be incorporated into agreements as required. Contracting may occur either directly with RIHCA or with individual CHCs, depending on the nature of the engagement and the CHC's preference.

Contracting Structure, Agreements & Compliance	**70**	Will selected vendors contract directly with RIHCA under a master agreement, or will individual health centers negotiate separate agreements and statements of work?	RIHCA anticipates that most engagements will be contracted directly between individual CHCs and the selected vendor, as this structure allows each CHC to tailor scope, timelines, and deliverables to its operational needs. However, RIHCA may execute agreements for centrally coordinated activities when appropriate. In all cases, the contracting approach will be determined based on the nature of the engagement and the preferences of the participating CHC(s).
Contracting Structure, Agreements & Compliance	**71**	Contracting party and terms. Section 3 says vendors may contract with either RIHCA or individual CHCs. How will RIHCA decide which applies to each engagement? Can RIHCA share its template professional services agreement and business associate agreement, payment terms, and any federal RHTP flow-down clauses (for example, 2 CFR 200 provisions, debarment certification, SAM.gov/UEI registration)?	The contracting structure will depend on the specific engagement. Some projects may be administered centrally through RIHCA, while others will be contracted directly between the CHC and the selected vendor. RIHCA will provide template agreements—including professional services terms, business associate agreements, and any required federal flow-down clauses—to vendors once the pool is established. CHCs may also use their own contracting templates, and vendors should be prepared to work with either structure.
Contracting Structure, Agreements & Compliance	**72**	Contracting structure. Section 3 refers to agreements with "either RIHCA or individual CHCs." Which do you anticipate as the default? Specifically: a master agreement with RIHCA with scopes issued beneath it, or separate agreements with each center? And will business associate agreements be executed centrally by RIHCA or by each center — if there is a template you would like us to work from, we are happy to review it in advance.	RIHCA anticipates that most engagements will be contracted directly between CHCs and the selected vendor, as this allows each CHC to tailor scope, timelines, and deliverables to its operational needs. RIHCA may execute agreements for centrally coordinated activities when appropriate. Business associate agreements will typically be executed by each CHC, though RIHCA may provide a standard template to streamline the process. Template agreements will be shared with vendors once the pool is established.
Contracting Structure, Agreements & Compliance	**73**	Federal flow-down terms. As RHTP funding is federal, we would like to understand what passes through to vendors: whether these engagements are treated as federal subawards subject to 2 CFR Part 200, whether single-audit, FFATA or other reporting obligations fall on us, whether SAM.gov registration is required, and whether there are certifications — debarment, anti-lobbying or similar — you would like included with the proposal. We would rather build these in now than amend later.	Engagements supported through RHTP funding may include certain federal flow-down requirements, but this would be a contract and not a federal subaward. RIHCA will incorporate applicable 2 CFR 200 provisions, standard federal certifications, and any required representations into the contracting documents. RIHCA's goal is to provide all required federal terms upfront so vendors can incorporate them without later amendment.
Contracting Structure, Agreements & Compliance	**74**	Will RIHCA or the individual CHCs require execution of a Business Associate Agreement before consultants access PHI?	Yes. A Business Associate Agreement will be required before any vendor accesses PHI. BAAs will typically be executed directly with the individual CHCs, though RIHCA may provide a standard template to streamline the process. CHCs may also use their own BAA templates depending on their internal compliance requirements.
Contracting Structure, Agreements & Compliance	**75**	Are there required security standards, approved secure-transfer platforms, or data-retention/destruction requirements beyond HIPAA that vendors should incorporate into their proposal?	Vendors must comply with HIPAA and industry-standard security practices for handling PHI, including secure transmission, storage, and access controls. CHCs may specify additional requirements such as use of approved secure-transfer platforms, multi-factor authentication, or specific data-retention and destruction protocols. These requirements will be communicated during onboarding or contracting to ensure alignment with each CHC's security policies.
Contracting Structure, Agreements & Compliance	**76**	Will RIHCA establish a common audit methodology, accuracy threshold, reporting template, and sampling methodology, or will each selected consultant propose these within individual CHC SOWs?	RIHCA may provide general expectations for audit quality, documentation standards, and reporting consistency; however, individual vendors may propose their own audit methodologies, sampling approaches, and reporting formats as part of CHC-specific scopes of work. CHCs may request adjustments to ensure alignment with their internal workflows, EHR environments, and compliance priorities. The goal is to maintain a consistent baseline across engagements while allowing vendors to apply their established best practices.
Contracting Structure, Agreements & Compliance	**77**	RHTP requirements (Section 7): Are there RHTP requirements the proposal should address, such as federal flow-down terms, reporting, insurance, or certifications?	Vendors should be prepared to comply with applicable RHTP requirements, including federal flow-down terms, standard certifications (such as debarment and anti-lobbying), and insurance requirements appropriate for coding and PHI-related services. Any additional federal or program-specific obligations will be incorporated into contracting documents once the pool is established.
Contracting Structure, Agreements & Compliance	**78**	Contracting party: Section 3 says vendors will be engaged by RIHCA or by individual health centers. Will pool vendors sign a master agreement with RIHCA? Are there insurance, federal RHTP flow-down, or registration requirements (such as SAM.gov/UEI) we should address in the proposal?	RIHCA anticipates that most engagements will be contracted directly between CHCs and the selected vendor, as this allows each CHC to tailor scope, timelines, and deliverables to its operational needs. RIHCA may execute agreements for centrally coordinated activities when appropriate. Engagements supported through RHTP funding may include certain federal flow-down requirements, but this would be a contract and not a federal subaward. RIHCA will incorporate applicable 2 CFR 200 provisions, standard federal certifications, and any required representations into the contracting documents.
Category 6: EHR Platforms, Data Access & Security			
EHR Platforms, Data Access & Security	**79**	Section 4 (Vendor Qualifications) - Support of EHR platforms – Can you elaborate more on what you are looking with this criteria?	This criterion is intended to confirm that vendors can operate effectively within the EHR environments commonly used by Rhode Island CHCs. Vendors should demonstrate familiarity with EHR platforms—such as eClinicalWorks, Epic, and NextGen—and describe their experience conducting audits, documentation reviews, and coding support within those systems. CHCs will define specific access methods, workflows, and security requirements during individual scoping.
EHR Platforms, Data Access & Security	**80**	EHR access: The RFP references eClinicalWorks, Epic, and NextGen. Will system mix, data access methods, and security/access arrangements be defined separately by each CHC when developing its scope?	Yes. Each CHC will define its own system configuration, access method, and security requirements during engagement-level scoping. Some CHCs may provide read-only EHR access, while others may prefer secure data extracts or chart exports. Access provisioning, onboarding steps, and security controls will vary by CHC and will be communicated directly during scope development.
EHR Platforms, Data Access & Security	**81**	EHR and system access. Which EHR and practice management systems does each CHC use (eClinicalWorks, Epic, NextGen, other)? Will consultants receive remote, read-only EHR access for audits, or should vendors plan to work from secure data extracts? Do any CHCs use a shared or Health Center Controlled Network (HCCN) platform or data warehouse?	Participating CHCs use a mix of eClinicalWorks, Epic, NextGen, and other practice management systems. Each CHC will determine whether consultants receive remote, read-only access or whether work will be performed from secure U.S.–based data extracts. Access models differ by CHC based on workflow, security posture, and technical configuration. Some CHCs participate in shared data environments or HCCN-supported infrastructure, but access to those systems will be defined individually during scoping. Vendors should be prepared to support either access model.

EHR Platforms, Data Access & Security	**82**	Will consultants receive direct role-based access to CHC EHRs, or will participating CHCs provide secure chart extracts/data sets for review?	EHR access models will be determined individually by each CHC during engagement-level scoping. Some CHCs may provide remote, read-only, role-based access to their EHRs, while others may prefer to supply secure chart extracts or data sets for audit and documentation review. Access decisions depend on each CHC's security posture, workflow preferences, and technical configuration. Vendors should be prepared to support either model.
EHR Platforms, Data Access & Security	**83**	EHR Platform Requirements: The minimum requirements reference support for eClinicalWorks, Epic, and NextGen. Is the vendor required to demonstrate experience with all three platforms, or will experience with one or more of these platforms satisfy the requirement?	Experience with one or more of the listed EHR platforms—eClinicalWorks, Epic, or NextGen—is acceptable. Vendors are not required to demonstrate experience with all three systems. The intent of this criterion is to ensure that vendors have relevant ambulatory EHR experience and can operate effectively within the systems commonly used by Rhode Island CHCs. CHCs will define platform-specific workflows and access requirements during individual scoping.
EHR Platforms, Data Access & Security	**84**	Is experience with all three EHR platforms (Epic, eClinicalWorks, and NextGen) required, or would experience with one or more be acceptable?	Experience with one or more of the listed EHR platforms—eClinicalWorks, Epic, or NextGen—is acceptable. Vendors are not required to demonstrate experience with all three systems. The intent of this criterion is to ensure that vendors have relevant ambulatory EHR experience and can operate effectively within the systems commonly used by Rhode Island CHCs. CHCs will define platform-specific workflows and access requirements during individual scoping.
EHR Platforms, Data Access & Security	**85**	For audits, will CHCs provide remote EHR access, or should proposers plan for exported records?	CHCs may provide either remote, read-only EHR access or secure exported records, depending on their internal policies and technical setup. Some CHCs prefer direct system access for audit efficiency, while others rely on secure extracts to manage PHI access. Vendors should be prepared to support both approaches, with the specific model defined during CHC-level scoping.
Category 7: Onsite vs Remote Delivery & Travel			
Onsite vs Remote Delivery & Travel	**86**	Delivery model and data access: May chart audits, CDI reviews and provider training be delivered remotely by U.S.-based staff? If onsite visits are expected, how often, and is travel billable?	Yes, remote work is allowed as long as it is based in the U.S. Onsite visits (if required) will be determined by each CHC.
Onsite vs Remote Delivery & Travel	**87**	On-site vs. remote delivery. Are any on-site visits expected, such as provider training or audit readouts? If so, is travel reimbursable, and under what policy?	Onsite visits (if required) will be determined by each CHC. Travel may be reimbursable if negotiated in the respective CHC contracts.
Onsite vs Remote Delivery & Travel	**88**	Does RIHCA anticipate services being performed remotely, onsite at individual CHCs, or through a hybrid model? If onsite work is requested, should travel be separately priced?	Onsite visits (if required) will be determined by each CHC. Travel may be reimbursable if negotiated in the respective CHC contracts. Pricing is not required at this time. That will be negotiated with each CHC.
Onsite vs Remote Delivery & Travel	**89**	Onsite or remote: Do you expect onsite work in Rhode Island, or can audits, CDI, and training be delivered remotely? If travel is needed, is it reimbursable?	Onsite visits (if required) will be determined by each CHC. Travel may be reimbursable if negotiated in the respective CHC contracts. Pricing is not required at this time. That will be negotiated with each CHC.
Category 8: Pool Mechanics, Vendor Selection & Engagement Process			
Pool Mechanics, Vendor Selection & Engagement Process	**90**	How many firms does RIHCA anticipate pre-qualifying, and is there an estimated budget or volume of work across the eight CHCs through June 30, 2027?	RIHCA does not have a predetermined number of firms it expects to pre-qualify. All vendors that meet the evaluation criteria and achieve the minimum scoring threshold will be admitted to the pool. The goal is to ensure CHCs have access to a diverse set of qualified vendors who can meet varying operational and coding needs. At this time, RIHCA is not projecting a specific budget or volume of work across the eight CHCs. Demand will vary by center based on their internal staffing, coding volume, documentation improvement priorities, and readiness to initiate engagements. Funding is available to CHCs through June 30, 2027, and each CHC will determine how and when to allocate those resources based on its individual needs.
Pool Mechanics, Vendor Selection & Engagement Process	**91**	While RIHCA serves eight CHCs, how many are currently expected to use this vendor pool, and are engagements anticipated to be primarily one-time projects, recurring support, or both?	RIHCA anticipates that all eight CHCs may utilize the vendor pool; however, participation will vary based on each CHC's operational needs, staffing model, and coding volume. Engagements may include both one-time projects (such as targeted audits or training) and recurring support for ongoing coding needs. The pool is designed to provide flexibility so CHCs can select the level and duration of support that best aligns with their internal workflows.
Pool Mechanics, Vendor Selection & Engagement Process	**92**	How many vendors does RIHCA anticipate including in the prequalified pool, and will there be any guaranteed work or minimum engagement commitments once vendors are selected?	RIHCA does not have a predetermined number of vendors for the pool. The final pool size will depend on the number of qualified submissions that meet the evaluation criteria. Inclusion in the pool does not guarantee work or a minimum level of engagement. CHCs will select vendors based on their specific needs, and work will be assigned at the discretion of each CHC.
Pool Mechanics, Vendor Selection & Engagement Process	**93**	Pool size and selection threshold. Does RIHCA expect to qualify a set number of firms, or will every firm that meets a minimum score be added to the pool? If there is a minimum, what is it (for example, a weighted average of 3.0 on the 1–5 scale in Section 6)?	RIHCA will qualify all firms that meet the minimum scoring threshold outlined in the evaluation criteria. There is no set limit on the number of vendors that may be included. Vendors must achieve a minimum weighted score to be added to the pool; the threshold will be based on the scoring rubric in Section 6 to ensure consistency and fairness across all submissions. RIHCA's goal is to establish a pool of vendors who demonstrate the technical capability, compliance posture, and experience necessary to support CHCs effectively.
Pool Mechanics, Vendor Selection & Engagement Process	**94**	Partial-scope qualification. Section 2 says item (f), dental and women's/specialty coding, is not required to be selected. Must a qualified firm offer every other service, (a)–(e) and (g)–(l), or may a firm qualify for a subset and say which services it offers?	RIHCA does not require firms to offer every service listed in Section 2. Vendors may qualify for a subset of services, provided they clearly identify which components they can deliver and demonstrate sufficient expertise in those areas. The pool is intended to offer CHCs a range of options, and firms with partial-scope capabilities may still be selected if their services align with a CHC's needs.
Pool Mechanics, Vendor Selection & Engagement Process	**95**	Expected demand (Section 3): How many health centers does RIHCA expect to engage a vendor, and roughly when? Will funding be allocated to each health center through June 30, 2027?	RIHCA anticipates that multiple CHCs will engage vendors from the pool, though timing will vary based on each center's operational readiness and internal priorities. Some CHCs may initiate engagements shortly after the pool is established, while others may do so later in the program period. Funding is available to CHCs through June 30, 2027, and each CHC will determine how and when to allocate those resources based on their specific coding and documentation needs.

Pool Mechanics, Vendor Selection & Engagement Process	**96**	Pool mechanics. How many firms does RIHCA anticipate admitting to the pool? How long does pre-qualified status run, and will the pool reopen or require re-qualification during the program period? Will RIHCA facilitate introductions between centers and pool firms, or is selection entirely center-initiated?	RIHCA does not have a predetermined number of firms for the pool; all vendors meeting the minimum scoring threshold will be admitted. Pre-qualified status will remain in effect for the duration of the program period unless performance concerns require reevaluation. RIHCA may reopen the pool or conduct additional qualification rounds if needed to ensure adequate vendor coverage. RIHCA will facilitate initial introductions and make pool information available to CHCs, but final vendor selection and engagement decisions will be made directly by each CHC based on their needs.
Pool Mechanics, Vendor Selection & Engagement Process	**97**	Insurance. Are there required coverage types and limits for vendors — professional liability, cyber, general liability? We would like to confirm our certificates match your requirements in a single step.	RIHCA requires vendors to maintain standard insurance coverage appropriate for coding, auditing, and PHI-related services. At minimum, vendors must carry professional liability (E&O), general liability, and cyber/privacy liability coverage. Specific limits may vary by CHC, but vendors should ensure coverage levels are consistent with industry norms for healthcare coding and compliance work. CHCs may request certificates of insurance during onboarding to confirm coverage.
Pool Mechanics, Vendor Selection & Engagement Process	**98**	Number of Vendors to be Selected: Does RIHCA anticipate selecting a specific number of vendors for the pre-qualified pool, or will all vendors meeting the qualification and evaluation requirements be admitted?	RIHCA does not have a predetermined number of vendors for the pool. All firms that meet the qualification criteria and achieve the minimum scoring threshold will be admitted. The goal is to ensure CHCs have access to a diverse set of qualified vendors who can meet varying operational needs.
Pool Mechanics, Vendor Selection & Engagement Process	**99**	Allocation of Work Among Qualified Vendors: Once the pre-qualified pool has been established, how will individual assignments be awarded? Will CHCs independently select a vendor, request quotations from multiple pre-qualified vendors, conduct mini-competitions, or will RIHCA allocate assignments?	Once the pool is established, CHCs will independently select vendors based on their specific needs, timelines, and preferred service models. CHCs may choose to engage a vendor directly, request quotes from multiple pool vendors, or conduct a mini-competition if desired. RIHCA will not allocate assignments; its role is to establish and maintain the pool, provide guidance as needed, and facilitate introductions between CHCs and qualified vendors.
Pool Mechanics, Vendor Selection & Engagement Process	**100**	Résumés / Bios Required at Proposal Stage: Section 5.B requests résumés or bios for all proposed consultants. Please confirm whether vendors are required to identify and submit résumés for all personnel at the time of proposal submission, or whether representative/key personnel résumés may be submitted with additional resources identified following individual CHC task awards.	Vendors are not required to submit résumés for every potential staff member at the proposal stage. Representative or key personnel résumés may be submitted initially, with additional staff identified and approved at the time individual CHC engagements are awarded. CHCs may request résumés for any personnel assigned to their project to confirm qualifications and alignment with the scope of work.
Pool Mechanics, Vendor Selection & Engagement Process	**101**	Resource Substitution: If named personnel become unavailable after proposal submission or during the contract period, will the selected vendor be permitted to substitute personnel with individuals possessing equal or greater qualifications, subject to RIHCA/CHC approval?	Yes. Vendors may substitute personnel if individuals named in the proposal become unavailable, provided the replacement staff have equal or greater qualifications. All substitutions must be reviewed and approved by the CHC to ensure continuity, quality, and alignment with project requirements.
Category 9: Workload, Volume, Demand & CHC Profiles			
Workload, Volume, Demand & CHC Profiles	**102**	Workload assumptions: Can RIHCA provide approximate provider counts, annual encounter volumes, anticipated chart-review volumes, or expected audit sample sizes for participating CHCs? If not, will this information be shared at individual CHC scoping?	RIHCA is not providing provider counts, encounter volumes, chart-review volumes, or estimated project sizes at this stage. These metrics vary significantly across CHCs based on staffing models, service lines, and operational priorities. Detailed workload information will be shared directly by each CHC during the development of individual scopes of work. Vendors should expect engagement-specific scoping discussions once the pool is established.
Workload, Volume, Demand & CHC Profiles	**103**	Are there estimated chart volumes, consulting hours, or anticipated project sizes available for the eight participating community health centers?	RIHCA is not providing provider counts, encounter volumes, chart-review volumes, or estimated project sizes at this stage. These metrics vary significantly across CHCs based on staffing models, service lines, and operational priorities. Detailed workload information will be shared directly by each CHC during the development of individual scopes of work. Vendors should expect engagement-specific scoping discussions once the pool is established.
Workload, Volume, Demand & CHC Profiles	**104**	Participating CHCs and demand. How many of Rhode Island's eight CHCs plan to use the pool? Has RIHCA collected their priority needs, approximate provider counts, sites, or annual encounter volumes, and can it share them? When does RIHCA expect the first CHC engagements to start after the November 10 notification?	RIHCA anticipates that multiple CHCs may use the vendor pool, but participation will vary based on each center's internal needs and readiness. CHCs have identified general priority areas — such as coding support, auditing, documentation improvement, and provider training — but RIHCA is not publishing provider counts, site lists, or encounter volumes as part of this procurement. Each CHC will share its specific needs and operational details during engagement-level scoping. CHCs may begin initiating engagements shortly after the December 11 (previously November 10) notification, depending on their internal timelines and readiness. Some centers may move quickly to scope work, while others may begin later in the program period. Engagement start dates will be determined individually by each CHC.
Workload, Volume, Demand & CHC Profiles	**105**	Indicative volumes. Organizational capacity carries 30% of the evaluation, and we would rather answer it against real numbers than generalities. Can you share approximate aggregate provider counts across the eight centers, and any expectation of typical engagement size or cadence — charts per audit, audits per year?	RIHCA is not publishing aggregate provider counts, encounter volumes, or indicative chart-review volumes for the eight CHCs as part of this procurement. These figures vary significantly across centers based on size, service mix, and operational priorities. Typical engagement size, cadence, chart volumes, and audit sample sizes will be defined directly by each CHC during individual scoping discussions. Vendors should describe their organizational capacity in general terms at this stage, with engagement-specific workload details provided later by CHCs.
Workload, Volume, Demand & CHC Profiles	**106**	Of RIHCA's eight CHCs, how many does RIHCA currently anticipate will engage one or more vendors from the qualified pool during the initial period through June 30, 2027?	RIHCA anticipates that multiple CHCs may utilize the qualified vendor pool, but participation will depend on each center's internal needs, staffing capacity, and readiness to initiate work. RIHCA is not projecting a specific number of CHCs that will engage vendors during the initial period. Each CHC will determine its own timeline and level of participation once the pool is established.
Workload, Volume, Demand & CHC Profiles	**107**	For planning purposes, can RIHCA provide an approximate range of providers, annual encounters, or charts that may be subject to coding/documentation review across participating CHCs?	RIHCA is not providing provider counts, encounter volumes, or estimated chart ranges at this stage. These metrics differ substantially across CHCs and will be shared directly by each center during engagement-level scoping. Vendors should expect that workload details — including provider rosters, encounter volumes, chart-review ranges, and audit sample sizes — will be defined individually by CHCs once scopes of work are developed.

Workload, Volume, Demand & CHC Profiles	**108**	Does RIHCA have any preliminary estimates of the expected coding audit volume, approximate number of consulting hours, or number of health centers likely to engage outside coding consultants during the initial program period?	RIHCA is not publishing preliminary estimates of coding audit volumes, consulting hours, or anticipated project sizes for this procurement. These needs vary significantly across CHCs based on staffing levels, service lines, and operational priorities. Multiple CHCs may choose to engage vendors from the qualified pool, but participation and workload will be determined individually by each center. Detailed volume information — including chart counts, audit sample sizes, and expected consulting hours — will be provided directly by CHCs during engagement-level scoping once the pool is established.
Workload, Volume, Demand & CHC Profiles	**109**	Rural designation. Given RHTP's rural focus and Rhode Island's geography, are there site-level or population-level eligibility constraints on where consulting work can be applied? If so, will we need to track and report time and deliverables by site to evidence it?	RHTP funding may include rural-focused requirements, but RIHCA is not imposing site-level or population-level eligibility constraints for this procurement. CHCs will determine how RHTP-supported work aligns with their service areas and operational needs. If any site-specific tracking or reporting is required, CHCs will communicate those expectations during individual scoping. Vendors should be prepared to track work at the level of detail requested by each CHC, but no standardized site-level reporting requirements are being issued at this stage.
EHR Platforms, Data Access & Security	**110**	Expected demand and EHR systems: Can RIHCA share which EHR each of the eight health centers uses, and a rough estimate of demand (how many centers expect to start work this period, likely chart volumes, or funding available per center)?	RIHCA is not providing provider counts, encounter volumes, or estimated chart ranges at this stage. These metrics differ substantially across CHCs and will be shared directly by each center during engagement-level scoping. Vendors should expect that workload details — including provider rosters, encounter volumes, chart-review ranges, and audit sample sizes — will be defined individually by CHCs once scopes of work are developed.
Category 10: Audit Methodology, CDI, Training & VBC/Risk Adjustment			
Audit Methodology, CDI, Training & VBC/Risk Adjustment	**111**	Audit and training requirements: Will RIHCA prescribe minimum chart sample sizes, audit/reporting standards, and provider training or post-remediation validation requirements, or may vendors tailor these elements by CHC?	RIHCA is not prescribing minimum chart sample sizes, audit standards, reporting formats, or training requirements for this procurement. These elements will be defined individually by each CHC based on its operational priorities, coding volume, and compliance needs. Vendors may tailor audit methodologies, sample sizes, reporting formats, and training approaches in collaboration with each CHC during engagement-level scoping. CHCs may request post-remediation validation or follow-up audits depending on their internal goals.
Audit Methodology, CDI, Training & VBC/Risk Adjustment	**112**	For clinical documentation improvement and provider education, will vendors be expected to interact directly with physicians and clinical staff, or can these services be delivered remotely through certified coding and CDI professionals?	Vendors may deliver CDI and provider education remotely through U.S.–based certified coding and CDI professionals. Direct interaction with physicians and clinical staff may be requested by some CHCs, but remote delivery is acceptable and expected to be the primary model.
Audit Methodology, CDI, Training & VBC/Risk Adjustment	**113**	Does RIHCA expect retrospective audits, prospective/pre-bill audits, concurrent coding reviews, or some combination depending on CHC needs?	Audit scope will focus on retrospective coding audits and NOT prospective/pre-bill reviews.
Audit Methodology, CDI, Training & VBC/Risk Adjustment	**114**	Will engagements require formal re-audits to measure improvement following remediation and training?	Some CHCs may request follow-up audits or post-training validation to measure improvement, but this is not a universal requirement. Re-audit expectations will be determined individually by each CHC during scoping. Vendors should be prepared to support re-audits if requested.
Category 11: Offshore/Onshore Staffing & PHI Restrictions			
Offshore/Onshore Staffing & PHI Restrictions	**115**	Does the RFP permit (an offshore) staffing arrangement under the supervision of US based offices, or are there any specific restrictions regarding offshore personnel accessing patient information?	Offshore staffing arrangements are not permitted under this procurement. All personnel accessing PHI, EHR systems, audit materials, or CHC data must be U.S.–based. Vendors must ensure that all coding, auditing, CDI, risk-adjustment, training, and related consulting services are performed by staff located within the United States.
Offshore/Onshore Staffing & PHI Restrictions	**116**	Delivery and staffing location: Are remote audits, virtual training, and remote consulting permitted? Are there any requirements for onsite delivery, U.S.-based personnel, or restrictions concerning subcontracted/offshore resources?	Remote audits, virtual training, and remote consulting are permitted. Onsite delivery is not required unless specifically requested by a CHC. However, all personnel performing work under this program must be U.S.–based. Subcontracted resources are allowed only if they meet the same U.S.–based staffing requirement.
Offshore/Onshore Staffing & PHI Restrictions	**117**	Does RIHCA permit vendors to utilize offshore resources for coding audits, CDI, risk adjustment, and related consulting services, provided all HIPAA and security requirements are met? Are there any onsite or US-based staffing requirements?	RIHCA does not permit the use of offshore personnel for coding audits, CDI, risk adjustment, or related consulting services. All staff performing work or accessing PHI must be located in the United States. Vendors should disclose staffing locations in their proposals and ensure all proposed personnel, prime or subcontracted, meet this requirement.
Offshore/Onshore Staffing & PHI Restrictions	**118**	a. Is there a constraint on where PHI may reside during an engagement — must records remain within the health center's environment, or may a vendor work from extracts within its own HIPAA-compliant environment? b. For the EHR platforms listed, do centers typically provide vendor staff read-only access, or export charts for review? Where access is provided, who bears licensing and training costs, and what lead time should we assume?	a. PHI must remain within secure, U.S.–based environments at all times. Vendors may work from extracts or chart exports within their own HIPAA-compliant U.S. environments if permitted by the CHC, or CHCs may provide read-only EHR access depending on their internal policies. CHCs determine whether access or extracts are appropriate based on workflow, security posture, and system configuration. b. Where EHR access is provided, CHCs typically cover licensing or access-related costs. Vendors should anticipate a short onboarding period for access provisioning and training, though timelines may vary by CHC and platform. All PHI access, storage, and transmission must comply with HIPAA and CHC-specific security requirements.
Offshore/Onshore Staffing & PHI Restrictions	**119**	Onshore / Offshore Resources: Are vendors permitted to utilize offshore resources for any portion of the services, including coding audits, chart reviews, analytics, reporting, or other back-office activities? If offshore resources are permitted, are there any specific restrictions associated with PHI access, HIPAA compliance, data residency, or system access?	Offshore resources are not permitted for any portion of the services under this procurement. All personnel performing work must be located within the United States. Offshore personnel may not access PHI, EHR systems, CHC data, or project materials. Vendors must ensure all subcontractors and independent consultants also meet this U.S.–based staffing requirement.
Offshore/Onshore Staffing & PHI Restrictions	**120**	Could you please confirm whether HIPAA-compliant remote delivery, including offshore resources, is permissible, and whether any onsite presence is required?	HIPAA-compliant remote delivery is permitted and expected to be the primary model for most engagements. Onsite presence is not required unless specifically requested by a CHC. However, all remote work must be performed by U.S.–based personnel only. Offshore resources are not allowed for any component of the engagement.
Category 12: Administrative Requirements			
Administrative Requirements (Format, Submission, Deadlines)	**121**	Format and attachments. Is there a page limit, required file format (such as a single PDF), or email attachment size limit? Do résumés, references, and supporting documents count toward any page limit? Should a W-9, certificate of insurance, or HIPAA policy documents come with the proposal or after selection, and are minimum insurance coverages required?	RIHCA does not impose a page limit for this qualification response. A single consolidated PDF is preferred, and resumes, references, and supporting documents may be included as attachments within that file. There is no specific attachment size limit beyond standard email transmission constraints. A W-9, certificate of insurance, and HIPAA policy documents are not required at the proposal stage and may be submitted after selection. Vendors should ensure they can meet standard insurance requirements for coding and PHI-related services.

Administrative Requirements (Format, Submission, Deadlines)	**122**	Deadline time and confirmation. What is the time of day and time zone for the November 3 deadline? Will RIHCA confirm receipt by email? Where will the October 27 Q&A responses be posted?	The proposal deadline is November 13 at 5:00 p.m. ET. RIHCA will confirm receipt of proposals via email. Q&A responses from the November 6 (previously Oct 27) deadline will be posted on the RIHCA website in the same location where the RFP materials were made available.
Administrative Requirements (Format, Submission, Deadlines)	**123**	Proposal mechanics. Is there a page limit, and do résumés and references count toward it? Is a single consolidated PDF acceptable? For Section B, would you like bios for our full audit roster, for a representative proposed team given that individual scopes are defined later, or for only our managerial staff? And should subcontracted consultants be disclosed and credentialed in the proposal?	There is no page limit, and a single consolidated PDF is preferred. Vendors may submit résumés or bios for a representative proposed team, recognizing that individual scopes will be defined later by each CHC. Key personnel bios are sufficient at the proposal stage, though CHCs may request additional personnel documentation during engagement onboarding. Subcontracted consultants should be disclosed when known, and resumes or credentials should be included for any subcontractors expected to support CHC engagements.
Administrative Requirements (Format, Submission, Deadlines)	**124**	Should proposers submit pricing or a rate card with this qualification response? If yes, what pricing structure does RIHCA prefer—hourly, per chart, fixed-fee service package, or another method?	Pricing is not required at this qualification stage.
Administrative Requirements (Format, Submission, Deadlines)	**125**	Pricing Format: Please clarify the preferred pricing structure for proposals. Should vendors provide hourly rates by labor category, fixed-price service packages, per-chart/per-audit pricing, training rates, or another pricing methodology?	Pricing is not required at this qualification stage.
Administrative Requirements (Format, Submission, Deadlines)	**126**	Submission details: Is there a required time of day for the November 3 deadline, a page limit, a preferred file format (for example a single PDF), or an attachment size limit? Where will the October 27 responses be posted?	The proposal deadline is November 13 at 5:00 p.m. ET. RIHCA will confirm receipt of proposals via email. Q&A responses from the November 6 (previously Oct 27) deadline will be posted on the RIHCA website in the same location where the RFP materials were made available. There is no page or size limit, and a single consolidated PDF is preferred.
Category 13: Historical Spend, Budget & Funding Parameters			
Historical Spend, Budget & Funding Parameters	**127**	Historical Spend: Please provide, if available, the historical annual spend for similar coding consultant, audit, clinical documentation improvement, or related services across RIHCA and the participating CHCs.	RIHCA does not centrally track historical spend for coding, auditing, or documentation improvement services, as these engagements are contracted independently by individual CHCs based on their operational needs. Spend levels vary significantly across centers depending on coding volume, staffing models, and compliance priorities. As a result, RIHCA is not able to provide a consolidated historical annual spend estimate for these services.
Historical Spend, Budget & Funding Parameters	**128**	Available Budget / Funding: Is there an established budget, funding ceiling, or estimated aggregate spend associated with this procurement through June 30, 2027? If individual CHCs will control their respective budgets, can RIHCA provide an estimated range of potential engagement values?	The total funding available for this procurement is $82,000 through June 30, 2027. Engagement values will vary based on each CHC's needs, volume, and readiness. RIHCA is not projecting specific engagement sizes or ranges at this stage; detailed scoping and budget allocation will occur directly with each CHC once the vendor pool is established.
Historical Spend, Budget & Funding Parameters	**129**	Anticipated Volume of Work: Can RIHCA provide an estimate of the anticipated volume of work under this program, including the expected number of CHCs requiring services, approximate number of engagements, chart/audit volumes, training requirements, or expected consultant hours?	RIHCA is not projecting a specific volume of work for this program. Multiple CHCs may choose to engage vendors from the pool, but the number and size of engagements will depend on each center's operational priorities, coding volume, and internal staffing capacity. Chart volumes, audit needs, training requirements, and consultant hours will vary by CHC and will be defined at the time individual scopes of work are developed. The pool is designed to provide flexibility so CHCs can request support at the level and timing that best meets their needs.
Category 14: Incumbent Vendors			
Incumbent Vendors	**130**	Incumbent Vendor(s): Are there currently incumbent vendors providing coding, auditing, documentation improvement, provider education, or related services to RIHCA or the participating CHCs? If so, please identify whether incumbent vendors are eligible to compete under this RFP.	Some CHCs may currently engage coding or documentation consultants independently, but these engagements are not administered through RIHCA. Any existing vendors are eligible to compete under this RFP, provided their current scopes of work remain separate from this effort and they meet all minimum qualifications and evaluation criteria. All proposers - incumbent or new - will be evaluated consistently under the requirements of this procurement.