SEARHC-RFP-26-7

Addendum 1

Questions and Answers

#	Question	Answer
1	**Section 3 – Project Overview / Section 4 – Scope of Services** Are these professional fee coding operations currently managed by an internal centralized team, decentralized by facility, or outsourced to a third-party vendor?	These operations are outsourced to 3rd party.
2	**Section 4 – Scope of Services** Please confirm whether the requested autonomous coding solution is intended for professional fee coding, facility coding, or both. If both are in scope, please identify the applicable patient types, service lines, and estimated annual chart volumes for each.	The initial focus will be professional fee coding, but SEARHC does not want to limit functionality to pro fee coding; respondents should consider scoping both.
3	**Section 4 – Scope of Services** Can SEARHC provide the anticipated implementation timeline, target go-live date, and any planned phased deployment approach? If a phased rollout is anticipated, please identify the expected phases, service lines, and implementation priorities.	The intent is to have vendor selection and contract completed by end of August with implementation by end of calendar year 2026. We do not intend to do a phased implementation; however, if selected vendor strongly encourages us to phase implementation, SEARHC will consider their best practice suggestions.
4	**Section 4.1 – Required Solution Capabilities** What percentage of the total professional fee volume is currently processed via automated or electronic charging versus manual coding?	All accounts are currently reviewed by a coder, but we expect providers to initiate all charges. Based on review of charge activity from 7/1/25-6/30/26 35% of pro fees were either initiated or modified by a coder. Attaching summary of encounter volume by specialty for period of (7/1/25-6/30/26) to address request for specialty mix.
5	**Section 4.1 – Required Solution Capabilities** While the RFP references support for professional fee coding operations and the "full scope of medical professional fees," it does not identify which encounter types are in scope or provide associated coding volumes needed for implementation planning, staffing assumptions, and pricing. Can SEARHC confirm the scope of coding services by encounter type? Are vendors expected to support all Professional Fee categories listed in Attachment D (IP, ED, SDS, IR, Cardiac Cath, OBS, Clinic, Series, and Ancillary), or is the initial implementation limited to specific areas? Please also provide current monthly and annual volumes for each category.	The majority of our volume is in primary care so if respondents can't support IR SEARHC won't remove vendor from consideration. Attachment D - See below for period 7/1/25-6/30/26: • IP/Swing Admissions - 890 • ED Visits - 5,838 • Same Day Surgery - 1,210 • IR - Minimal volume (<200) • Cardiac Cath - Minimal volume (<200) • Observation Patients - 429 • Clinic (includes behavioral health) - 220,461 • Ancillary - 36,689
6	**Section 4.2.1** Is the Meditech Expanse environment hosted locally by SEARHC, or is it a Meditech-hosted (Cloud/MaaS) environment?	Hosted locally. Potential of shifting to MaaS later.

7	**Section 4.2.1** Please provide the current MEDITECH Expanse version, applicable Revenue Cycle/HIM modules, hosting model, and interface technologies currently in use (HL7, FHIR, APIs, etc.).	SEARHC is on Expanse 2.2.68 and are on prem. MaaS could be a later consideration. SEARHC uses Rhapsody for its interface engine.
8	**Section 4.2.2 / Section 4.2.5** Does SEARHC utilize a centralized corporate interface engine (e.g., Cloverleaf, Corepoint) to manage HL7 traffic?	Yes, SEARHC use Rhapsody
9	**Section 4.3.1** Is the current average discharge-to-bill turnaround time for professional fee coding?	DNFB for pro fee coding service runs a little over 8 days. SEARHC has a standard hold of 3 days for providers to complete charts.
10	**Section 4.5.3** SEARHC have a preference or restriction regarding the geographic location of the human-in-the-loop (HITL) coding and audit resources, specifically regarding domestic (US-based) versus global (offshore) delivery models?	Yes, while SEARHC will approve special project work for global resources we generally are not in support of global coding. SEARHC had a couple of coders working on our accounts and they were pulled due to some poor experience. SEARHC be willing to entertain global resources again but would need a detailed outline of how the resources would be managed and would want performance reporting on them discreetly with quick action if/when quality issues occur.
11	**Section 5.7 – Attachment D** Can SEARHC clarify the scope of the CDI component? Is the expectation to identify and surface **all records** for CDI review, or is the effort intended to focus on specific service lines, diagnoses, encounter types, patient populations, or other targeted areas? Additionally, are there defined criteria or prioritization rules for selecting records for CDI review?	CDI would have some value to SEARHC but realistically it would be an ancillary component of the service. SEARHC has an internal resource that does our provider training. Since we're largely a primary care/outpatient driven organization, the highest and best use of CDI would be in support of our primary care providers. If respondents don't feel comfortable with our general scope, it is acceptable for respondents to elect not to provide fees for that part of the fee schedule and to defer to further review/consultation with SEARHC on optimized process (between internal resources and vendor) and cost of that service.
12	**Section 5.7 & Section 6.1** Please provide historical and projected annual volumes for each pricing category listed in Attachment D. Additionally, does SEARHC prefer a subscription-based, transaction-based (per-record), or hybrid pricing model? If subscription pricing will be considered, are there minimum volume commitments or growth projections vendors should incorporate into their pricing assumptions?	SEARHC believes volume above aligns with pricing categories. Respondents should also share the encounters by specialty in the event it helps. SEARHC is open to both hybrid and subscription models. There is not a lot of service growth in SE Alaska. Short of a substantial acquisition, growth will likely be minimal and correlate to expanded specialty access which would generally be fractional provider FTEs and unlikely to significantly move needle for minimum volume associated with any subscription-based service.
13	**Attachment D – Price Schedule** Can SEARHC provide the historical or projected annual encounter volumes for each of the fee types listed in Attachment D (Inpatient, ED, SDS, IR, Cardiac Cath, Observation, Clinic, and Ancillary)?	For period 7/1/25-6/30/26: • IP/Swing Admissions - 890 • ED Visits - 5,838 • Same Day Surgery - 1,210 • IR - Minimal volume (<200) • Cardiac Cath - Minimal volume (<200) • Observation Patients - 429 • Clinic (includes behavioral health) - 220,461 • Ancillary - 36,689

14	**Attachment D – Price Schedule** For the CDI audit services identified in Attachment D, can SEARHC provide the anticipated number of records to be reviewed or audited annually, along with any expected sampling methodology or audit criteria?	SEARHC does not have a specific expectation but would like recommendations from respondents based on what they see as best practice. See #16 response as SEARHC has an internal resource that we would like to be involved in CDI process and any communication feedback to providers.
15	**Attachment D – Price Schedule** What is the expected frequency of CDI audits (e.g., monthly, quarterly, semi-annually, or annually), and are audits expected to be performed on a recurring schedule or on an as-needed basis?	SEARHC does not have a specific expectation but would like recommendations from respondents based on what they see as best practice. See #16 response as we have an internal resource that we would like to be involved in CDI process and any communication feedback to providers.
16	**Attachment D – Price Schedule** Can SEARHC clarify whether CDI services are expected for inpatient encounters only, outpatient encounters only, or both? If outpatient CDI is included, please identify the applicable specialties and anticipated volumes.	SEARHC has an internal resource that does provider education. Our IP volume is pretty low and we're CAH so payment model isn't dependent on DRGS. Value would generally be in outpatient CDI. Would mostly look for model that informs our internal resource but isn't providing CDI directly back to providers. Would be interested in discussing what that structure looks like and cost, but non-response to these fees will not remove vendor from consideration.
17	**Attachment D – Price Schedule** Can SEARHC clarify the expected frequency, format, and audience for CDI education services? For example, are educational sessions anticipated monthly, quarterly, or annually, and are they intended for providers, coders, CDI staff, or a combination of these groups?	Education would be rendered to providers. We utilize a 3rd party for coding and expect them to cover their educational needs. We have an internal resource that will be involved in CDI process and run point on any communication to providers. Ideally this becomes a routine part of our service delivery, so no less than quarterly cadence would be desired.
18	**Attachment D** Beyond the chart types listed in the price schedule, can SEARHC provide a breakdown of specific clinical specialties represented within the Clinic and SDS volumes (e.g., Orthopedics, Cardiology, Pediatrics, Behavioral Health)?	
19	**Attachment D** Please provide historical and projected annual volumes for each pricing category listed in Attachment D. Additionally, does SEARHC prefer a subscription-based, transaction-based (per-record),	See response in #13. Open to all pricing models

PRO FEES BY PROVIDER SPECIALTY

ProviderSpecialty MisSpecID	Specialty	Count	ProviderSpecialty MisSpecID	Specialty	Count
ADDM	Addiction Medicine	811	OM	Obesity Medicine	1,215
ANE	Anesthesia	1,325	OPTH	Ophthalmology	155
AUD	Audiology	1,067	OPTO	Optometry	7,295
BEH	Behavioral Health	65,022	ORT	Orthopedics	3,194
CARD	Cardiology	4,582	PD.DIETARY	Pediatric Nutrition	70
CC	Critical Care	23	PD.FOOTCAR	Pediatric Footcare	445
CHAP	Community Health Aid Practitioner	541	PED	Pediatrics	3,293
DENT	Dental	129	PEDCARD	Pediatric Cardiology	14
DERM	Dermatology	879	PEDNEU	Pediatric Neurology	85
EM	Emergency Medicine	1,038	PM	Pain Management	3,121
ENT	Ear, Nose and Throat	1,341	POD	Podiatry	2,583
FP	Family Practice	96,754	PRIMECARE	Primary Care	1,207
HEMA	Hematology	1	PSYCHI	Psychiatry	4,199
HEMAONC	HemOnc	7	PUL	Pulmonolgy	2
HEP	Hepatology	125	RAD	Radiology	24,917
HOSP	Hospitalist	3,940	RHE	Rheumatology	829
INTMED	Internal Med	6,343	SLEEP	Sleep Medicine	1,657
NEU	Neurology	276	SOCW	Social Work	1,075
NURS	Nurse	85	SUR	General Surgery	2,703
NUTR	Nutrition	38	URO	Urology	487
OBG	OBGYN	5,333			

	or hybrid pricing model? If subscription pricing will be considered, are there minimum volume commitments or growth projections vendors should incorporate into their pricing assumptions?	