Third-Party Medical Billing and Revenue Cycle Management Services RFP Question Responses – 08/31/2026

1. The RFP cover page lists the submission date as September 8, 2026. However, Section 4's procurement schedule lists the Proposal Submission Deadline as September 3, 2026, with the Proposal Evaluation Period beginning September 8, 2026. Could you please confirm the actual proposal submission date?

ANSWER: The RFP submission date is Tuesday, September 8th

2. What is the total outstanding A/R, including aging by bucket? What is the current A/R aging profile by bucket (0–30, 31–60, 61–90, 91–120, 121–180, 180+ days)? This is needed to set a realistic baseline for the Section 9 aging-percentage service-level commitments (A/R over 90/120/180 days). Please provide current inventory and aging by scope.

ANSWER:

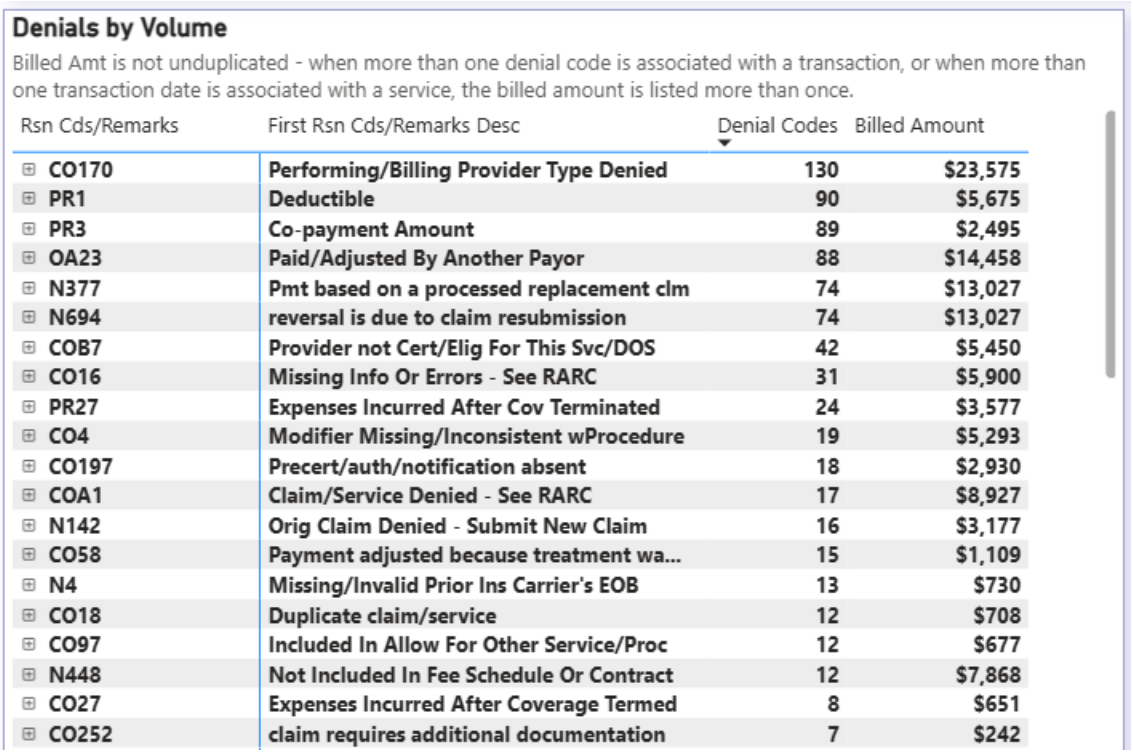
AR Aging as of 7/31/2026	0-30	31-60	61-90	91-120	121-150	151-180	181-up	Ln Itm Amt
Totals for 409 Blue Cross Blue Shield	$2,595	$9,905	$9,950	$4,238	$8	$362	$685	$27,742
Totals for 414 Aetna Better Health	$180	$0	$0	$0	$0	$0	$0	$180
Totals for 415 AmeriHealth Caritas	$4,236	$318	$0	$189	$784	$635	$521	$6,681
Totals for 416 UPMC for You	$11,457	$536	$484	$1,664	-$572	-$821	$572	$13,319
Totals for 417 United Medicaid MCO	$0	$77	$0	$0	$0	$0	-$78	-$1
Totals for 418 Highmark Wholecare	$153	$746	$608	$605	$48	$44	$1,240	$3,444
Totals for 419 United Commercial	$1,583	$0	$2,126	$1,870	$487	$0	$0	$6,065
Totals for 420 Cigna Commercial	$2,888	$138	$11	$80	$402	$0	$335	$3,853
Totals for 421 Medicare Fee For Service	$543	$174	$264	$0	$66	$0	$92	$1,138
Totals for 421 Medicare MCOs	$1,054	$175	$351	$121	$93	$47	$1,012	$2,853
Totals for 423 Self Pay	-$35	$803	$78	$401	$402	$251	$353	$2,252
Totals for 424 Healthy Beginnings	$0	$0	$0	$0	$0	$0	$0	$0
Totals for 424 Medicaid	$1,865	$630	$472	$165	$830	$87	$1,946	$5,994
Totals for 429 UPMC Commercial	$6,554	$3,807	$2,771	$4,863	-$63	-$1,999	-$1,066	$14,869
Totals for 430 Commercial Insurance	$5,498	$894	$1,654	$2,380	$310	$690	$1,447	$12,872
Totals for 431 Aetna Commercial	$2,131	$162	$145	$1,323	$33	$193	$150	$4,136
Totals for 442 Geisinger Medicaid	$1,027	$0	$0	$0	$0	$25	$47	$1,098
Totals for 442 Health Partners MA	$175	$0	$7	$0	$0	$0	$372	$553
Totals for 442 Other Medicaid MCOs	$617	$256	$194	$558	$986	$157	$598	$3,366
Totals for 447 Behavioral Health MCOs	$0	$0	$0	$0	$148	$186	$484	$818
Totals for Self Pay	$157,387	$11,329	$8,881	$11,494	$11,674	$11,990	$55,545	$268,653
TOTALS	$199,905	$29,947	$27,996	$29,952	$15,634	$11,847	$64,253	$379,887

3. Please share current baseline performance metrics: Days in A/R, clean claim rate, denial rate, and net collection rate.

ANSWER: Adagio Health currently monitors Days in A/R, claim correction activity and turnaround, and denial categories. A two-month snapshot of available claims-performance metrics is provided in response to Question 19. Adagio Health does not currently maintain validated baseline metrics for all requested measures. Respondents should propose appropriate KPIs, targets, and reporting methodologies as part of their response.

4. What are the current top denial and rejection categories?
What are the top 3–5 denial reason codes or categories, if known?

ANSWER:



Denials by Volume

Billed Amt is not unduplicated - when more than one denial code is associated with a transaction, or when more than one transaction date is associated with a service, the billed amount is listed more than once.

Rsn Cds/Remarks	First Rsn Cds/Remarks Desc	Denial Codes	Billed Amount
CO170	Performing/Billing Provider Type Denied	130	$23,575
PR1	Deductible	90	$5,675
PR3	Co-payment Amount	89	$2,495
OA23	Paid/Adjusted By Another Payor	88	$14,458
N377	Pmt based on a processed replacement clm	74	$13,027
N694	reversal is due to claim resubmission	74	$13,027
COB7	Provider not Cert/Elig For This Svc/DOS	42	$5,450
CO16	Missing Info Or Errors - See RARC	31	$5,900
PR27	Expenses Incurred After Cov Terminated	24	$3,577
CO4	Modifier Missing/Inconsistent wProcedure	19	$5,293
CO197	Precert/auth/notification absent	18	$2,930
COA1	Claim/Service Denied - See RARC	17	$8,927
N142	Orig Claim Denied - Submit New Claim	16	$3,177
CO58	Payment adjusted because treatment wa...	15	$1,109
N4	Missing/Invalid Prior Ins Carrier's EOB	13	$730
CO18	Duplicate claim/service	12	$708
CO97	Included In Allow For Other Service/Proc	12	$677
N448	Not Included In Fee Schedule Or Contract	12	$7,868
CO27	Expenses Incurred After Coverage Termed	8	$651
CO252	claim requires additional documentation	7	$242

5. Are there any current billing backlogs, enrollment issues, or unposted payments that must be addressed during transition?

ANSWER: There are no billing backlogs, enrollment issues, or unposted payments. Billing and payments are currently managed within 7 business days. Enrollment occurs immediately upon hire.

6. Will the selected vendor manage existing A/R along with new claims? Please provide the inventory expected to transition to the selected vendor at go-live.

ANSWER: Yes, this is full scope transition of all outstanding A/R claims and future claims responsibility will transition to the vendor effective on the go-live date.

7. Which activities will remain with Adagio Health – particularly coding, charge entry, eligibility, authorization, credentialing, and refunds?

ANSWER: Adagio Health will retain coding, charge entry, eligibility, and authorization; vendor to provide assistance, review, tasking, and training. Credentialing is currently with another vendor, and refunds will be a tandem project between the billing vendor and Adagio Health staff.

8. Is the vendor expected to handle PQRS billing as well?

ANSWER: Currently we do not participate in this.

9. Please provide the current payer mix, including Medicare, Medicaid, commercial insurance, managed care, self-pay, and grant-funded services. What are the top payers by claim volume, and what is the overall payer mix (Medicaid, Medicaid MCO, commercial, marketplace, grant-funded/sliding scale, self-pay)?

ANSWER:

Payer Name	**Claim Total Count**	**Claims %**
UPMC Health Plan	8,613	44%
BCBS Pennsylvania - Highmark	4,052	21%
Highmark Wholecare Medicaid	2,235	11%
AmeriHealth Caritas Pennsylvania	748	4%
United Healthcare	618	3%
Aetna Affordable Health Choices SRC	422	2%
Aetna	410	2%
Medicaid Pennsylvania	380	2%
Health Partners PA	348	2%
Cigna Health Plans	333	2%
Geisinger Health Plan	297	2%
Medicare B Pennsylvania	250	1%
Gateway Health Plan Medicare Assured	199	1%
Meritain Health Minneapolis	118	1%

Payer Mix

for time period 7/1/2025 through 6/30/2026

Payer Name Financial Class	Visits %
416 UPMC for You	26%
409 Blue Cross Blue Shield	17%
427 Title Grant Funding	9%
418 Gateway Health Plan	9%
429 UPMC Commercial	9%
STD Project	4%
423 Self Pay	3%
BCCEDP	3%
421 Medicare	3%
415 AmeriHealth Caritas	3%
431 Aetna Commercial	3%
430 Commercial Insurance	2%
419 United Commercial	2%
420 Cigna Commercial	1%
442 Health Partners MA	1%
424 Medicaid	1%
442 Geisinger Medicaid	1%
421 Medicare Fee For Service	1%
442 Other Medicaid MCO	1%
447 Behavioral Health MCOs	0%
417 United Medicaid MCO	0%
414 Aetna Better Health	0%
435 FPS Waiver Pending	0%
Total	**100%**

10. What is the approximate % split between grant-funded and insurance patients?

ANSWER: Grant Funded patients are 18%, self-pay patients are 3%, and insurance patients are 79%

11. Are there any capitation insurances in the payer mix?

ANSWER: No.

12. Will Adagio Health provide direct access and licenses for NextGen Enterprise and Waystar?

ANSWER: We will provide direct access and licenses for Next Gen; our current vendor uses their own Waystar access with us as a client.

13. Which NextGen modules, and which current versions, are in use? Will the vendor use Adagio Health's NextGen Practice Management Platform or need to provide a hosted solution?

ANSWER: We will provide access to our Next Gen system, and we are currently using Next Gen version 8, with the Next Gen Superbill module for billing.

NextGen specific products:

- EHR - NGE EHR (version 8.3.1.569)
- PM - NGE PM (version 8.3.1.569)
- Mobile Solutions - Mobile Basic (Free/Collaboration)
- Patient Payments - Pay Powered by Instamed
- Patient Virtual Visits - Virtual Visits
- Ancillary Solutions - LMS License
- Annual Libraries - Other Annual Libraries
- Data & Interop - NG Share
- Data & Interop - Interfaces

We also use a third-party patient engagement portal (Intelichart) that integrates with NextGen. It allows for scheduling, check-in, and payments via a patient portal.

- Patient Notify
- Patient Schedule
- Patient Intake
- Patient ehealth

14. Are any additional platforms used for patient payments, lockbox services, etc.?

ANSWER: We have Dollar Bank and their lockbox services, we use Instamed and Intelichart for patient payments, currently we are also using Simple Practice for Nutrition billing and payments.

15. What is the approximate monthly volume of patient statements and billing calls? What is current patient statement volume and frequency, and what delivery channels are expected — paper, email, portal, or text? Will the vendor use Adagio Health's NextGen Practice Management Platform to send patient statements, or do they need to provide a hosted solution? Who is responsible for printing, postage, SMS, email, and digital statements?

ANSWER: The vendor will need to send out approximately 923 statements a month, with additional parameters set in place by Adagio Health staff, after monthly review. The statements will need to be processed outside of Next Gen as they are not tailored to our specific requirements. The vendor would be responsible for paper statements, while all email, portal, and text statements are currently automated.

16. What is current monthly claim volume by claim type — professional (837P) vs. institutional/facility (837I)?

ANSWER: Approximately 1,378 claims per month; all are professional claims (837P/CMS-1500).

17. How many distinct billing/rendering provider NPIs are in scope, and across how many specialties/taxonomies (e.g., OB/GYN, behavioral health, nutrition, primary care)? How many providers are providing services?

ANSWER: We currently can bill under 12 taxonomies, we bill for clinic services, OB/GYN services, family planning services, nutrition services, and behavioral health services. We have 20 NPIs in the mix between providers and company, with approximately 19 being providers.

18. Please clarify whether code assignment itself is in scope for the Vendor, or whether the Vendor's role is limited to claim editing/QA on codes Adagio Health has already assigned

ANSWER: Adagio Health will continue to code with assistance, review, tasking, and training from vendor.

19. What is the current clean claim rate, first-pass acceptance rate, and claim rejection rate? What is the current denial rate?

ANSWER: This is a 2-month snapshot (May and June).

Key Claims Metrics

Clearinghouse Rejections	Payer Rejections	Perfect Pass Claims	Clean After Waystar
0.4%	1.5%	98.1%	98.5%

4 Accounts

Account	Total Claims	Normal Processing	Clearinghouse Rejections	Payer Rejections	At Payer	Claim Complete	Clean after Waystar
TOTAL	**2,756**	**0**	**0**	**2**	**704**	**2,050**	**99.9%**
ADAGIO HEALTH INC (154767)	2,756	0	0	2	704	2,050	99.9%

20. Are there confidential-services billing requirements — for example, family planning/Title X claims where the Explanation of Benefits must not be routed to a policyholder other than the patient — that affect claim submission routing or require payer-specific handling?

ANSWER: Yes, there are specific parameters set in place by Adagio Health staff on confidential services, grant billable services, and statement creation.

21. Is Adagio Health a 340B covered entity for pharmacy or LARC device billing, and if so, does that create claim-handling requirements the Vendor needs to plan for?

ANSWER: Yes, we are a 340B covered entity, however it does not currently require a separate claims-processing workflow for the services included in this RFP.

22. What percentage of remittances currently arrive as electronic ERA (835) versus paper EOB requiring manual posting? What percentage of your payments currently are set up for EFTs? What percentage of your payments currently are set up for ERAs?

ANSWER: We currently receive approximately 98% of all remittances electronically.

23. What patient payment channels exist today (in-office card/cash, online portal, mail, phone/IVR), and is the Vendor expected to operate and support these channels, or only post payments received through them?

ANSWER: We accept payments in office via cash, check, or credit card; online portal via Instamed and Intelichart, by mail, and phone. The vendor would be responsible for posting all payments to the correct visits/charges, however in-office receipts would be batched and processed by staff.

24. Does Adagio Health have an existing lockbox arrangement, and with which bank? Is the Vendor expected to manage that banking relationship, or only reconcile against lockbox activity Adagio Health already receives?

ANSWER: We have a lockbox through Dollar Bank. Adagio Health manages the banking relationship; the vendor would be responsible for reconciling the receipts.

25. What cadence and format of reconciliation and audit documentation does Adagio Health's finance team require — daily cash reconciliation, month-end close packages, bank statement tie-outs, or a specific existing template? Describe task of "maintain payment tracking documentation required by Adagio Health."

ANSWER: We provide a monthly template for documenting daily cash reconciliations, for matching the daily NextGen posted payments to the bank. It must be tied to the NextGen monthly payments report. Finance department staff will send you daily cash receipt reports to reconcile along with these.

26. Which appeal levels is the Vendor expected to handle — first level, second-level, and/or external/independent review — and is there a dollar threshold above which Adagio Health wants direct involvement or sign-off before an appeal is filed?

ANSWER: the vendor would be responsible for handling all appeals, however significant appeals would need to involve Adagio Health, with us taking the lead on certain issues. Significance would be determined as high dollar amounts, high volume occurrence, and prolonged period of discrepancy.

27. Is the Vendor expected to staff a dedicated patient billing inquiry line? If so, what call volume, hours of coverage, service levels, and language requirements (e.g., Spanish-language support) should be planned for? For patient-facing services, please provide monthly inbound/outbound call volumes, AHT, service levels, abandonment rates, language requirements, and contact-channel requirements.

ANSWER: The vendor would not be expected to staff a dedicated patient billing inquiry line, however there are a few phone calls per month the vendor would need to respond to.

28. What is the current volume of patient refund requests that needs to be processed?

ANSWER: We process 5-10 refunds a month.

29. Please identify all systems and applications required to perform the services and indicate which licenses, connectivity, telephony, and technology costs will be provided by Adagio Health versus the vendor.

ANSWER: We will provide direct access and licenses for Next Gen, Instamed, Intelichart, Simple Practice, and our banking lockbox. The vendor will be responsible for answering phone calls and utilizing Waystar as the clearinghouse; our current vendor uses their own Waystar access with us as a client.

30. Will the vendor use Adagio Health's claims clearinghouse or need to provide a hosted solution?

ANSWER: Our current vendor uses their own Waystar access with us as a client; we would like to continue with this method.

31. Are sections 6 and 12 to be included with a narrative in the Proposal? Only sections 7, 8, 9, 10, 13, 14, (with section 11 mentioned within section 5 as required) are included in Evaluation Criteria.

ANSWER: Section 6 and 12 are to be included in the Technical Response.

32. Please provide historical productivity metrics, staffing levels, average touches, turnaround times, and other operational benchmarks for each workstream. Please provide all applicable KPIs/SLAs, performance guarantees, penalties, and service-credit requirements by scope.

ANSWER: Adagio Health has not established uniform KPIs or performance guarantees for all services included in this RFP. Respondents should propose measurable KPIs/SLAs, target performance levels, reporting frequency, and remediation processes based on their recommended operating model. Adagio Health does not currently use a penalty-based payment structure; any proposed service credits or performance guarantees should be clearly identified in the proposal.

33. Is this RFP for only professional claims billing on a HCFA 1500 form?

ANSWER: Yes.

34. Please identify required operating hours, staffing-location requirements, credential requirements, and restrictions regarding offshore/nearshore resources, automation, or shared staffing.

ANSWER: There is not a set schedule for hours in the day, this is a performance-based plan, other than scheduled monthly/weekly meetings. Location, shared staffing, and credentialing requirements should be clearly identified in the proposal. Offshore/nearshore resources and automation is not acceptable at this time.

35. Please provide historical collection/recovery/liquidation results for the RFP scope of work.

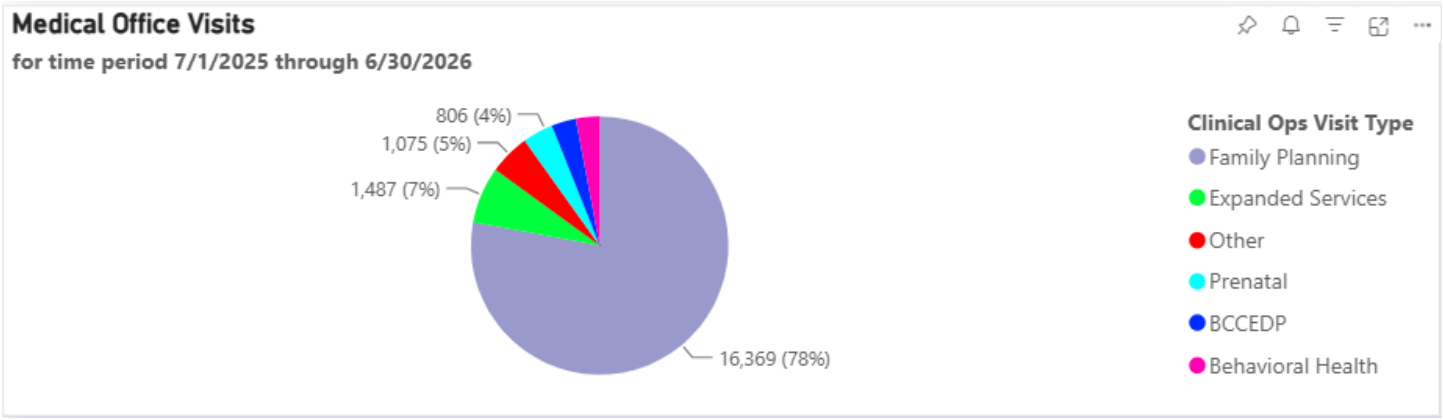
ANSWER: Adagio Health does not currently use collections/early-out or debt liquidation.

36. Does Adagio Health's version of NextGen flag underpayments through reporting?

ANSWER: No. We have contractual allowances baked into NextGen; however, these are not always accurate based on all the contracts in the system and will sometimes require review and editing. There are reports that can be run to find these.

37. Please provide monthly encounter volumes by specialty.
    - Family planning services.
    - Women's health services.
    - Behavioral health services.
    - Prenatal care.
    - Preventive nutrition counseling.
    - Diabetes prevention and management programs.
    - Community Health Worker services.
    - Community-based service delivery models.
    - Grant-funded healthcare services.

ANSWER: Nutrition counseling, diabetes prevention, and CHW billing are all new services and are not readily separated from this volume.



38. Does the $2.75 million annual insurance revenue include regrant revenue?

ANSWER: No.

39. What is your annual self-pay revenue?

ANSWER: Approximately $90,000.

40. Is the vendor expected to work accounts through final resolution or return accounts after a specified number of attempts?

ANSWER: Yes, we expect accounts to be fully resolved. Whether it is through payment, payer resolution, approved adjustment/write-off, or other final disposition under Adagio Health policy.

41. Are rebilling, appeals, payer calls, portal work, corrected claims, and medical-record submission included?

ANSWER: Yes.

42. Are there account-balance thresholds below which Adagio Health permits administrative adjustment or write-off?

ANSWER: Adagio Health does not send statements for account balances under $5. All patient accounts older than 365 days are automatically written off.

43. How many accounts and dollars are placed into early-out monthly?

ANSWER: We do not do this currently but would like to look at it in the future.

44. At what exact point is an account considered placed with the vendor?

ANSWER: The vendor takes control when Adagio Health staff closes the superbill and then vendor processes the claim.

45. How many statements are expected per account?

ANSWER: Currently we implement a 3-statement max.

46. Are vendors permitted to use SMS, email, automated dialing, IVR, and digital payment links?

ANSWER: We currently use SMS and a patient portal. Digital payment links as well as QR codes may be used subject to Adagio Health approval; outbound collection calls are not permitted at this time.

47. Are coding changes permitted directly by vendor staff?

ANSWER: No. We ask that necessary edits be tasked back to the medical offices for correction and training purposes.

48. What certifications are required, for example CPC, CCS, RHIA, RHIT, or specialty coding credentials?

ANSWER: We require access to appropriately credentialed coding expertise; however, all members of the billing staff do not require to maintain all credentials.

49. What is the expected turnaround time for edits?

ANSWER: Adagio Health has not established a fixed turnaround requirement; respondents should propose a standard turnaround time as part of their SLA response.

50. How many work queues are in scope?

ANSWER: No fixed number of work queues is prescribed; vendor should recommend an appropriate structure.

51. What is the current backlog and aging of each queue?

ANSWER: We do not currently have a backlog.

52. What dollar thresholds will be outsourced? Please provide monthly account counts and dollars falling within those thresholds. Please provide the inventory by balance band, such as:

- <$25
- $25–$50
- $51–$100
- $101–$250
- $251–$500
- $500

What are the top payers and denial categories represented in this population? What are the historical gross and net liquidation rates for this inventory? What is the average and median account balance?

ANSWER: All insurance A/R within the scope of this RFP will transition to the selected billing vendor; Adagio Health does not establish dollar thresholds for that work. Adagio Health does not currently place patient balances with a separate early-out or third-party collections vendor. Patient billing follows Adagio Health's established statement and write-off policies described elsewhere in these responses.

53. What outbound contact cadence is required?

ANSWER: We do not have an outbound contact requirement set, but we expect the accounts to be managed effectively. Patients are not to be called directly, but insurance providers can be contacted and claims be worked until fully resolved.

54. Please provide monthly volumes of coding edits and billing/claim edits separately.
    - Please provide edit volumes by source:
        - NextGen
        - Clearinghouse
        - Other systems

ANSWER: This information is not readily available.

55. Please identify the top edit categories and historical volumes for each.

ANSWER: This information is not readily available.

56. Which edits require coding credentials versus billing expertise?

ANSWER: This information is not readily available.

57. What percentage requires provider queries or clinical documentation review?

ANSWER: This information is not readily available.

58. Please provide 12 months of monthly account, claim, transaction, call, and dollar volumes for each scope, segmented by professional/technical, payer, service area/entity, and applicable work type.

ANSWER: Adagio Health will not be providing this level of historical transactional detail as part of the RFP process. Respondents should base their proposals on the volumes, payer mix, A/R information, and other baseline data provided in the RFP and these responses and should clearly identify any assumptions used in developing their staffing and pricing models.

59. Please provide detailed historical volumes by work type for denials, billing/coding/registration edits, appeals, eligibility applications, Medicare DDE rejects.

ANSWER: Adagio Health will not be providing this level of historical transactional detail as part of the RFP process. Respondents should base their proposals on the volumes, payer mix, A/R information, and other baseline data provided in the RFP and these responses and should clearly identify any assumptions used in developing their staffing and pricing models.