Comagine HEALTH

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Washington Community Information Exchange Request for Proposal Questions and Answers

Oct. 16, 2026

Question ID	RFP Section Reference	Question	Response
1		Do you have a sense yet of the number of participating organizations and/or clients this CIE is intended to serve?	The initial MVP (Phase 1) launch of WA CIE will focus on onboarding all nine Washington State Community Care Hubs (CCHs) and their contracted social care network partners, representing approximately 150 health and social service organizations. Many of these organizations are on different instances of the same technology, so we do not anticipate that number of organizations equals the number of interoperability connections. While the initial launch is centered on CCHs, WA CIE is designed as scalable statewide infrastructure that can ultimately support and facilitate care coordination across Washington's broader health and social service ecosystem, which includes thousands of organizations.

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2		The ConOps requires granular, dynamic, and revocable consent. Will the state require the Hub vendor to enforce real-time API webhook consent verification across all external participant systems, or will nightly batch syncing be temporarily permitted despite the 42 CFR Part 2 compliance risks?	There is no planned exchange of sensitive data (including 42 CFR Part 2) during the MVP (Phase 1) initial launch of the system implementation. Also, as stated in the Functional Requirements, reconciliation of granular consent across systems, including conflict detection, conflict resolution, and provenance tracking functionality will not be required until Phase 2 for CST 15 (Consent Reconciliation Across Systems) and Phase 3 for CST 16 (Granular Consent).

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3		Will Comagine be publishing an interested bidders, prime contractors, or subcontractor/partnering list for this procurement?	Yes. Comagine Health will publish a WA CIE RFP Interested Parties List to support organizations seeking teaming partners for this procurement. Organizations that wish to be included should complete the Interested Parties Form at https://forms.cloud.microsoft/r/5Vn6nYSBJf by 4pm Pacific Time on October 9, 2026. Submissions will be posted to the WA CIE RFP webpage. Inclusion on the list is voluntary. It is not a notice of intent to propose, is not required to submit a proposal or participate on a proposal team and confers no advantage in the evaluation. Organizations that do not appear on the list remain fully eligible to propose as a prime or to join any proposal team. All information submitted through the form will be published on the WA CIE RFP webpage. Organizations should not submit confidential or proprietary information. Comagine Health does not verify, endorse, or recommend any organization appearing on the list and is not a party to any teaming arrangement. Proposals will be evaluated solely on the criteria established in Section 5.2 Evaluation Criteria.

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4	Section 1.1.2, page 7	Section 1.1.2 states a preference for a "proven, commercially available solution" over one "built from the ground up." Given the current state of AI-forward capabilities in the health/social care interoperability market, no single existing solution appears to fully satisfy every functional and non-functional requirement in this RFP without some degree of new development or configuration. Could Comagine Health clarify: (1) the rationale behind the "proven, commercially available" preference, and (2) whether a solution built substantially from new development but delivered by an organization with established, direct experience in multi-sector health/social care data exchange would be considered responsive, provided proposed costs remain within the stated budget?	Comagine Health is seeking proven solutions that have been successfully implemented. We understand that no single solution may meet all requirements without some customization and development. Section 5.10.1, System Demonstrations, describes the demonstration portion of the evaluation process and what the demonstrations will focus on. SUBMITTAL FORM C – Technical Understanding and Approach requests the following information. The Offeror must clearly identify: • Capabilities available as standard product functionality. • Capabilities requiring configuration. • Capabilities requiring customization or development. • Capabilities dependent on third-party products or service integrations. • Capabilities or services provided by Subcontractors or Third-Party Service Providers.
5	Section 4.1, page 58	Can vendors provide an executive summary as an introductory addendum/attachment to their proposal?	Comagine Health encourages Offerors to submit any relevant information within the guidelines in the correct form. We are not requesting an executive summary at this time outside of the identified submissions forms and their respective page limits. The page limits for each submission are detailed in SEC. 4.2 SPECIAL FORMATTING REQUIREMENTS.

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6	Attachment 1, Submittal Form A	Can the Form A minimum-qualification gates (two successful production implementations of the main proposed technology solution in the last five years; referenceable clients for creating APIs between disparate systems; referenceable clients for evaluating effectiveness of technology solutions) be satisfied in whole or in part by proposed subcontractors, consortium members, or joint-venture partners — or are they prime-only requirements?	The minimum requirements in form A, 12. REFERENCES SPECIFICATIONS, can be satisfied in whole or part by either the prime or subcontract Offeror. In all cases, if the Offeror proposes to perform the Contract through a joint venture, consortium, Subcontractors, Third-Party Service Providers, or other participating entities, the Offeror must provide the additional information regarding those entities, their roles, and the proposed delivery structure consistent with RFP SEC. 1.14 PERMISSIBLE CONTRACT ENTITIES.
7		Is the selected vendor partner expected or encouraged to subcontract with community-partner organizations for domain-specific capabilities such as resource-directory stewardship, referral management for specific provider segments (e.g., long-term care), or participant onboarding and training?	This RFP neither requires nor prohibits subcontracting with community-partner organizations for specific capabilities. Offerors may propose the delivery model best suited to meeting the Scope of Work, including a joint venture, consortium, Subcontractors, or Third-Party Service Providers as described in SEC. 1.14 PERMISSIBLE CONTRACT ENTITIES.

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8	Attachment 1, Submittal Form A	Can the minimum qualifications be met through subcontractors or consortium members, or does the prime have to meet them alone?	The minimum requirements in form A, 12. REFERENCES SPECIFICATIONS, can be satisfied in whole or part by either the prime or subcontract Offeror. In all cases, if the Offeror proposes to perform the Contract through a joint venture, consortium, Subcontractors, Third-Party Service Providers, or other participating entities, the Offeror must provide the additional information regarding those entities, their roles, and the proposed delivery structure consistent with RFP SEC. 1.14 PERMISSIBLE CONTRACT ENTITIES.

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9	Section 3.2, page 27	Once the Community Information Exchange is up and running, how does a community organization like ours join the network and get its services listed?	If a community organization is interested in joining the WA CIE as participating partner, there are a variety of ways they can get involved, share their interests, and learn more about the progress of the MVP / Phase 1 implementation. Soon we will be adding an Interest Form to the WA CIE monthly newsletter where organizations can express their interest. In the meantime, if you have questions, comments, or ideas for activities to engage with communities across Washington about WA CIE, please send us an email (WACIE@comagine.org) or send a message through the WA CIE Public Input Box (https://forms.office.com/r/knLLWibKRH). You can follow our progress by signing and spread the word about the WA CIE by sharing the sign-up link for our newsletter (https://forms.office.com/r/ME05fkDKBa). Finally, we developed the Frequently Asked Questions (FAQ) in response to questions and feedback from community members across the state (https://www.hca.wa.gov/assets/program/wa-cie-faq.pdf). We'll continue to update it to address common questions and provide consistent, current information.

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10	Attachment 4, Sample Contract Agreement, HCA Flow-Down Provisions, and Business Associate Agreement	Can you please provide a timeline for the release of Attachment 4: Sample Contract Agreement, HCA Flow-Down Provisions and Business Associate Agreement?	Attachment 4: Sample Contract Agreement, HCA Flow-Down Provisions and Business Associate Agreement is included with Amendment #1, which is planned to be issued the week of September 28th.
11	Section 3.4.2, page 40	Please confirm whether this CIE RFP, and the resulting contract, are subject to WaTech Section 701. If yes, are the milestone gates, budget approvals, and agile delivery requirements established in the RFP designed to comply with Section 701?	Yes, the WA CIE RFP and contract are subject to Section 701. The full text of this may be found in the 2026 supplemental operating budget (https://lawfilesext.leg.wa.gov/biennium/2025-26/Pdf/Bills/Session%20Laws/Senate/5998-S.SL.pdf) starting on page 526. Milestone gates and budget approvals are addressed by HCA, with inputs from LO and technology partner. The relevant Agile delivery requirements are: “[P]roject must use an agile development model holding live demonstrations of functioning software, developed using incremental user research, held at the end of every two-week sprint” “[P]roject must deploy usable functionality into production for users within 180 days from the date of an executed procurement contract in response to a competitive request for proposal”

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12	Attachment 2, Submittal Form E, Section 5.3	This section is marked “DO NO RESPOND, HCA TO COMPLETE”. Can Comagine confirm that we are not required to complete this section?	We have provided this information so that Offerors understand: • The content and level of detail in the (HCA) Security Assessment. • The related level of effort to achieve compliance. • The commitment they are providing in the 'Attestation' (last worksheet). Offerors are required to respond to the 'Requirements' - items/questions in columns: ▪ Column B: Yes, currently compliant OR ▪ Column C: Not currently compliant, but will be compliant before 06/30/2027 Offerors do NOT need to complete any Requirements sections labeled “DO NOT RESPOND, HCA TO COMPLETE.” The intent of this high-level assessment is for Comagine Health/HCA to understand the level of compliance the solution has "Out of the Box" and the general level of effort needed to achieve full compliance. Additionally, Offerors need to complete the Attestation (last worksheet).

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13	Attachment 2, Submittal Form E, Section 5.3	This section is marked “DO NO RESPOND, HCA TO COMPLETE.” Can Comagine confirm that we are not required to complete this section?	Please refer to the response for question no. 12.
14	Attachment 2, Submittal Form E, Section 5.7	This section is marked “DO NO RESPOND, HCA TO COMPLETE.” Can Comagine confirm that we are not required to complete this section?	Please refer to the response for question no. 12.

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15	Attachment 1, Submittal Form A, Section 7	The instructions on p. 10 state, "The offeror must confirm they meet each requirement and provide an explanation (up to 500 word maximum for each requirement) in the Explanation section at the end of this document to demonstrate their acknowledgement and how they meet or will comply with each related requirement." The footnote below the table on p. 11 states, "For any 'False' responses, provide clarification (up to 250 word maximum for each 'False' clarification) below." Please clarify these instructions. Many of these requirements are confirmations and certifications that would not seem to need explanation of a 'True' response (e.g., #2 confirms acceptance of the terms and conditions). Do you require Offerors to provide details for both 'True' and 'False' responses, or only for each 'False' response? Also, please confirm the maximum number of words allowed for each response.	Rephrased the instructions for clarity and consistency (see updated Form A).

Question ID	RFP Section Reference	Question	Response
16	Attachment 1, Submittal Form A, Section 7	The options given for responses to all questions are True or False, but Requirement #11 (Federal and State Debarment Certification) is phrased as a Yes or No question. Could you update the form to rephrase this item as a True/False statement?	Rephrased item #11 for clarity (see updated Form A).
17	Attachment 1, Submittal Form A, Section 7	The instructions for this section state, "A 'False' selection or failure to check 'True' and provide an explanation will cause the proposal to be deemed non-responsive." However, a 'True' answer to item #18 would indicate that the Offeror has been found to have willfully violated a provision of RCW chapter 49.46, 49.48, or 49.52. Please confirm that an answer of 'False' for item #18 will not cause the proposal to be deemed non-responsive.	Rephrased both the instructions and item #18 for clarity (see updated Form A).
18	Section 4.1, page 58	If letters of support are submitted in addition to the requested 3 references, will they be considered in the RFP response?	Updated Form A, Section 12: Reference Specifications to add ‘Endorsements’ and added Section 12.2 Letters of Support/Endorsement (see updated Form A).

19	Section 1.2, page 8; Section 3.6.2, pages 46-47	The RFP states that the WA CIE solution will include four primary pricing components—implementation, licensing/subscription, ongoing maintenance and operations, and T&M labor rates—and that Offerors must propose costs that do not exceed the applicable annual funding ceiling of $3.4 million in CY 2027 and CY 2028 and $3.5 million annually from CY 2029–2031. Could Comagine Health please clarify whether these annual funding ceilings are intended to cover all costs associated with the WA CIE solution, including implementation, licensing/subscription, ongoing maintenance and operations, and T&M services, or whether the stated annual funding amounts are intended to cover the core implementation and operation of the WA CIE, with licensing/subscription and/or participation costs (e.g., portal use or integration) to be funded separately outside of these annual ceilings? Additionally, if licensing/subscription or other participation costs for organizations choosing to use the WA CIE Portal or integrate their existing systems are expected to be included within the annual funding ceilings, please clarify the anticipated number of portal users and	The annual funding ceilings listed in the RFP Section 1.2 are intended to cover all costs including implementation, Annual licensing / subscription, and Ongoing M&O, support & T&M NTE services (excl. licensing). Licensing for existing systems should not be included in the costs provided in the cost proposal. The initial MVP (Phase 1) launch of WA CIE will focus on onboarding all nine Washington State Community Care Hubs (CCHs) and their contracted social care network partners, representing approximately 150 health and social service organizations. Many of these organizations are on different instances of the same technology, so we do not anticipate that number of organizations equals the number of interoperability connections. While the initial launch is centered on CCHs, WA CIE is designed as scalable statewide infrastructure that can ultimately support and facilitate care coordination across Washington's broader health and social service ecosystem, which includes thousands of organizations.

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		participating organizations/integrations that Offerors should assume when developing their annual pricing.	
20	Sections 1.13, page 11; Sections 1.14.3–1.14.4, page 12; Section 3.6.5, page 49	May a vendor whose commercial technology addresses a discrete, specialized portion of the WA CIE requirements submit a proposal limited to that capability, or must the vendor participate as a Third-Party Service Provider or Subcontractor under a Prime Contractor proposing the complete WA CIE solution?	No. Each proposal must address the full scope of the WA CIE solution, and the Prime Contractor is responsible for all contract obligations. A vendor whose technology covers only part of the WA CIE requirements may participate as a Subcontractor or Third-Party Service Provider under a Prime Contractor, or as a member of a joint venture or consortium. These arrangements are described in Section 1.14 Permissible Contract Entities and Section 3.6.5 Contract Entities & Related Requirements. Organizations seeking partners may request to be added to the WA CIE RFP Interested Parties List by completing the Interested Parties Form at https://forms.cloud.microsoft/r/5Vn6nYSBJf by 4:00 p.m. Pacific Time on October 9, 2026. Inclusion on the list is voluntary and confers no advantage in the evaluation.

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21	Sections 1.14.2–1.14.4, page 12; Section 3.6.5, page 49	Does Comagine Health maintain, or plan to provide, an opt-in teaming list or another mechanism through which prospective Prime Contractors can connect with vendors offering specialized technology components?	Organizations seeking partners may request to be added to the WA CIE RFP Interested Parties List by completing the Interested Parties Form at https://forms.cloud.microsoft/r/5Vn6nYSBJf by 4:00 p.m. Pacific Time on October 9, 2026. Inclusion on the list is voluntary and confers no advantage in the evaluation.

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22	Section 3.1.1, page 25	Please identify the number of data feeds required for each project phase, including the originating system, data type, frequency, and whether each feed is unidirectional or bidirectional.	During the implementation of MVP (Phase 1), WA CIE will focus on the initial use case of interoperably connecting all of the CCHs (approximately six-to-eight connection feeds) – and their respective social care network contracted partners – to the WA CIE ecosystem. There will also be an initial set of state agencies (approximately five connection feeds) which will be hoping to integrate during this phase, as well as statewide partner organizations (approximately three connection feeds) who currently support the state, bringing the estimated number of feeds to approximately 14-16. The six-to-eight integrations is an assumption for MVP (based on the CCHs and the technologies they share), we believe those will be a mix of different types of technology. These will represent all current CCHs and contracted partners who use their source systems, as well as the required integrations described in ConOps and Requirements. All integrations should have the ability to be bidirectional. Our intent is to grow in both the number of use cases and participant in future phases, as will be defined in the WA CIE product roadmap that will be developed by the Technology Utilization Committee, once it is empaneled.

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23	Section 3.1.1, page 25	The RFP references approximately six to eight integrations. Please confirm whether these represent the complete set of required integrations. If not, please identify all external systems that must integrate with WA CIE and indicate the applicable implementation phase.	Please refer to the response for question #22.
24	Section 2.2.2, page 22; Attachment 5, Functional Requirements tab, RD01–RD16	Section 2.2.2 references a statewide directory partner, while Attachment 5 identifies RD01–RD16 as Phase 1 MVP capabilities. Please clarify whether the Resource Directory is within the Contractor's scope or will be provided by a third-party partner with which the Contractor must integrate. If a third party is involved, please define the respective responsibilities for directory curation, data stewardship, closed-loop referral availability status (RD05), and synchronization (RD08).	WA CIE will be pursuing a federated approach to integrate to and utilize existing resource directory services in Washington State. It is not expected that the Resource Directory would need to be with the Contractor's scope. However, it would be expected that the Contractor would support connecting to and managing that federated process into the referral management workflow.

Question ID	RFP Section Reference	Question	Response
25	Attachment 5, Non-Functional Requirements tab, NFR10(g)	NFR10(g) requires interoperability with a state-designated HIE, state MPI, and ConsentLink. Please clarify whether the Contractor is expected to provide the authoritative statewide MPI/EMPI capabilities identified in CIM01–CIM10 and the consent service identified under CST, or integrate with state-operated services. Where CIM/CST and ConsentLink capabilities overlap, which system will serve as the system of record? Please also confirm whether these state resources will be available and production-ready by MVP.	HCA has selected Comagine Health as Lead Organization (LO) to develop and operate the WA CIE, it is expected that the LO will maintain (through its selected Contractor technology) an authoritative Person Index of individuals recorded only within the CIE's operational ecosystem (not for any other state agencies). It is also expected that the WA CIE Person Index will be interoperable with the Washington State MPI (which is now operational), or any other state identity matching system. A similar expectation of interoperability with the State's ConsentLink utility will exist once the interoperability capabilities are fully in production. However, as the WA CIE Consent Management services will only expect simple consent functionality (CST01-13) during MVP/Phase 1, and interoperability with the state system is not anticipated until Phase 2-3. Advanced consent utility features (CST14-16) are not currently planned for the initial MVP release but should be described as a part of the Offeror's existing solution.

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26	Section 2.1.3, page 17	Please clarify whether legacy client, referral, and resource data from the existing CCH systems identified in Table 3 must be migrated into WA CIE at MVP, or whether MVP will support only net-new data going forward. If migration is required, please identify the source systems, data domains, historical period, expected data volumes, data quality expectations, and migration responsibilities.	The policy as to if and how much historical data will be part of MVP/Phase 1 is a governance decision which is currently under discussion with participating partner organizations. However, batch and bulk load is a required function, and in the event that the decision is made to provision WA CIE with an amount of historical client information for MVP/Phase 1 on or prior to day 1, the Contractor should be ready to do so.
27	Section 3.3.2, page 34	Deliverable D5 requires the Contractor to convert the existing draft WA CIE design into implementation-ready architecture. Please confirm whether the draft design and Attachments 4, 6, and 7 will be provided to Offerors. Please also clarify which elements of the existing design are mandatory and the extent to which Offerors may recommend alternative architectures, technologies, or implementation approaches.	Attachment 4 – Sample Contract Agreement, HCA Flow-Down Provisions, and Business Associate Agreement will be released by amendment. Attachments 6 - Concept of Operations and 7 - Program Governance Structure are available now through the links on the Washington Community Information Exchange RFP site https://comagine.org/program/washington-community-information-exchange. The draft WA CIE design will not be released to Offerors before the proposal deadline but will be provided to the Contractor. We welcome alternative architectures, technologies, or implementation approaches that meet the scope of work and requirements included in the RFP.

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28	Attachment 9, Section 4.7	Section 4.7 is conditional. Is WA CIE currently expected to be subject to CMS Streamlined Modular Certification or Conditions for Enhanced Funding? If so, what is the scope and timeline, and will Comagine confirm the $250,000/month FFP-reduction remedy applies only to failures within the Contractor's sole control?	Section 4.7 applies only if WA CIE becomes subject to CMS review or certification and that obligation flows down to the Contractor. The $250,000 monthly remedy applies only when Federal Financial Participation is reduced because the Contractor failed to maintain the system. Under Section 7.4, the Contractor is responsible only for the amount attributable to its own failure. Comagine Health will not recover twice for the same event.
29	Attachment 5, Non-Functional Requirements tab, NFR40	NFR40 and CR14/RM01 require field-, record-, and value-level segmentation for 42 CFR Part 2, Tribal data sovereignty, and domestic violence data across all MVP capabilities. Please identify the authoritative policies, standards, and implementation guidance governing these requirements. Please also clarify whether the policies are finalized or may evolve through the Data Governance Committee during implementation.	42 CFR Part 2 data is not planned for inclusion in the initial MVP scope, however the technical ability to support data segmentation to handle sensitive data types is a requirement of the technical solution. The policies governing the usage of data types are currently under draft by the policy workgroup and will continue to develop to address multiple data types.

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30	Attachment 5, Non-Functional Requirements tab, NFR7	For the read-style API requirement, please confirm whether the phrase “shall be at least half-second” is intended to require a response time of no more than 0.5 seconds. Please clarify which API operations are included, including individual client or resource retrieval, single-resource lookups, searches, and query operations. Please also define how the 95% performance threshold will be measured, including the measurement point, test conditions, transaction volumes, exclusions, and whether performance will be assessed server-side, end-to-end, or by organization.	The intent of the API Response Time NFR (7) is to ensure that straightforward transaction types are responsive within reasonable industry benchmarks. The required response time of no more than 0.5 seconds is required for a single resource lookup or query. For completed bi-directional/referral create/update it is understood that some response times may be one second per operation or more depending on the number of concurrent operations being performed (e.g., parsing data, performing matches, creating/updating clients, privacy, client data sources), and where operations are being executed (e.g., on the cloud, internet connections speeds, network latency, db/crm response time). Regarding the measurement of the “95% performance threshold”, we would expect to work with Contractor to develop a shared measurement framework (including measurement points, test conditions, transaction volumes, and exclusions at server-side) appropriate to the ecosystem (once developed), with defined baseline metrics and key indicators (e.g., response time percentiles, error rates) to measure performance at, or approaching, expected peak volume of operational capacity (approximately 95%).

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31	Attachment 5, Non-Functional Requirements tab, NFR7(b) and NFR27	NFR7(b) requires person-matching APIs to complete in under one second, while NFR27 establishes an SLA of under two seconds for person-matching operations. Please clarify whether these requirements apply to the same operation or to different person-matching workflows. If they apply to different workflows, please define the scope and performance measurement method for each.	Please refer to the response for question #30.
32	Attachment 5, Non-Functional Requirements tab, NFR54	Could you clarify the 2-second eventual consistency requirement and the use case around this?	This NFR is intended to set expectations for the time between a database update and the availability of that information within the application and user interface. It is not intended to prescribe a specific technical implementation approach. Rather, it provides a performance target for typical user interactions where recently updated information should be reflected in the system within a reasonable timeframe. The expectation is that users will be able to view updated information shortly after a transaction is completed, supporting a responsive and reliable user experience. This requirement should be interpreted as an NFR establishing expected system behavior and responsiveness, rather than as a design specification for how eventual consistency must be achieved.

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33	Attachment 5, Non-Functional Requirements tab, NFR6	Please confirm whether the State has a preferred cloud service provider.	Comagine Health and HCA do not have a preferred cloud service provider for WA CIE. Offerors may propose the cloud hosting approach and provider that best fits their solution, provided it meets the requirements in Attachment 5 - WA CIE System Requirements and Section 3.5.2 WaTech Policies and Standards, and can complete the review process in Section 3.5.3 Security Assessment Requirements. Offerors should identify the proposed cloud service provider and hosting model in Submittal Form C. The Prime Contractor remains responsible for the solution meeting the contract's security, privacy, availability, and data protection requirements.
34	Section 3.6.4, page 49	Please clarify whether offshore resources may be used for functions that do not require access to production environments, PHI, or other sensitive data.	This contract is federally funded, all work must be completed in the US. Refer to RFP Section 3.6.4. Location of Work (last paragraph): All services under the resulting contract, by the Contractor and any Subcontractors at any tier, must be performed within the United States or its territories. Performing any work outside the United States without Comagine Health's prior written approval is a material breach of the resulting contract and may result in termination.

Question ID	RFP Section Reference	Question	Response
35	Attachment 3, Submittal Form F – Cost Proposal; Licensing (Tiered) tab; Section B Licensing / Subscription Rate Card	Please provide the estimated number of unique clients or lives expected to be managed in WA CIE at MVP launch, at the end of Phase 2, and at Phase 3 statewide maturity.	The initial MVP (Phase 1) launch of WA CIE will focus on onboarding all nine Washington State Community Care Hubs (CCHs) and their contracted social care network partners, representing approximately 150 health and social service organizations. To fully develop appropriate budget estimates for the initial MVP (Phase 1) implementation (as well as in future phases), we request that Offerors complete Section B: Licensing / Subscription Rate Card of Attachment 3: Submittal Form F — Cost Proposal in order to understand the costs for the expenses we can currently anticipate (e.g., number of Authorized Users). CCHs collectively served approximately 14,000 unique individuals for the year July 2025 - June 2026. We anticipate that number to increase as CCHs continue to scale their models.
36	Section 3.1.1, page 25	Can the Comagine Health team provide an estimated number of client records for Phase 1 MVP?	Please refer to the response for question #35.

Question ID	RFP Section Reference	Question	Response
37	Section 3.1.1, page 25	Will historical data be part of the initial integration for Phase 1-MVP?	The policy as to if and how much historical data will be part of MVP (Phase 1) is a governance decision currently under discussion with participating partner organizations. However, batch and bulk load is a required function, and in the event that the decision is made to provision WA CIE with an amount of historical client information for MVP (Phase 1) on or prior to day 1, the Contractor should be ready to do so.
38	Section 2.1.2, page 16	The RFP indicates that the MVP would start with the 9 Community Care Hub (CCH) regional centers who have the current operational referral processes via the Findhelp platform. We understand that the initial request will be to link that network to a statewide infrastructure. The state infrastructure would have a provider and client portal for all those not currently leveraging the Findhelp application. Can you clarify of those organizations participating in the network, how many are using the Findhelp application and how many would be requiring direct access into the new state provider portal?	The first participants of WA CIE will be the nine CCHs and as many of their 141+ regional social care network partners as possible. All of these CCHs are currently conducting care coordination activities on different technologies. They may be utilizing Findhelp or another commercial Information & Referral (I&R) platform for specific activities, but WA CIE will interoperate with them through standards-based exchange through their primary Client Management Systems. Similarly, WA CIE seeks to support mature, comprehensive care coordination workflows through mature, comprehensive Client Management Systems, not a simple I&R solution. However, WA CIE does expect the Contractor's solution to be interoperable with any commercial I&R solutions any participating partner may be using for that purpose.

Question ID	RFP Section Reference	Question	Response
39	Attachment 5 – Functional Requirements tab	In terms of the functional required components of the MVP, does the CCH network have all of those functional components in operation today and therefore it would require more of an integration mapping scope of work? Or does the MVP introduce new functionality into the current environment and therefore necessitate layered software solutions?	While some Washington CCHs may have significant functional overlap with WA CIE, this will not be the case for all CCHs. While existing CCH functionality should be interoperable with WA CIE where appropriate, CCHs will also be able to leverage WA CIE as shared infrastructure to support capabilities that are not currently available within their systems (e.g., closed-loop referrals). The intent is not for CCHs to replicate or build WA CIE functionality within their own systems, but rather to establish options for utilization in which users can continue to either work within their native CCH systems to trigger WA CIE capabilities through data integration, through WA CIE portal use, or a combination of both.
40	Section 1.2, page 8	What is the source of funding for the initial term and the renewal(s)? County, Federal, or other?	WA CIE is funded by the Medicaid Transformation Project (MTP 2.0) through an appropriation to HCA by the Washington State Legislature in 2024. Sustainability, including long term funding, is a priority of the WA CIE Advisory Board, the Lead Organization, and the Health Care Authority.

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41	Section 3.1.1, page 25; Attachment 3, Submittal Form F	The launch date is 6/30/27 but testing and stabilization is running through 9/30/27. Phase 2 is supposed to happen 6-9 months after stabilization (Sept '27), making it March to June of '28, but the cost form says Phase 2 is September 2027. Please clarify timelines.	Submittal Form F - Removed the “phase” language from the implementation milestone table to reduce any confusion with WA CIE phases (MVP, Phase 2, Phase 3). MVP go-live is planned for June 30, 2027. After launch, a stabilization period runs through September 30, 2027. During stabilization, the Contractor will resolve issues and provide a higher level of support. Implementation milestones in Submittal Form F are priced through the end of stabilization. Phase 2 work begins after stabilization, and the Phase 2 release is expected 6 to 9 months later, estimated spring 2028. The Phase 3 release is expected 6 to 9 months after Phase 2 stabilization, estimated spring 2029.
42	Section 3.6.1, page 46; Attachment 3, Submittal Form F	The contract is for an initial term of 24 months, but the cost form is asking for five (5) years of pricing. Please provide more information on escalation and renewal. Even though there are up to three (3) years for renewal possibilities, please provide clarification to inform cost rates four or five years out.	Five-year pricing is required to evaluate the full potential Contract period, including the initial twenty-four (24) months and three optional one-year renewals. Renewal is not guaranteed. Offerors must complete the CY 2027–2031 pricing requested in Submittal Form F – Cost Proposal, accounting for anticipated future-year costs in the annual M&O and T&M entries and identifying all pricing assumptions.

Question ID	RFP Section Reference	Question	Response
43	Section 1.1.2, page 7; Attachment 5	The RFP says a "(SaaS) model is preferred but not required", but the System Requirements file says "The solution must be delivered as a Software as a Service (SaaS) offering or as a fully cloud managed service (e.g., Azure, AWS, Google)." Please clarify.	The RFP language (“SaaS is preferred but not required”) refers to procurement flexibility — Offerors may structure their proposals in various ways, including consortiums, joint ventures, or solutions that incorporate third-party components. The System Requirements file (“must be delivered as SaaS or fully cloud-managed service”) refers to the technical deployment model. Regardless of how the proposal is structured, the final delivered solution must operate as a SaaS offering or a fully cloud-managed service (Azure, AWS, Google). The solution must be SaaS or cloud-managed.
44	Section 2.1.2, page 16	Will Comagine Health provide the Contractor with the names/connections with the organizations/participants (including tribal partners) to recruit or is the Contractor expected to identify and recruit them? It’s not totally clear where Comagine’s role ends and the Contractor’s begins for participant engagement and outreach.	Comagine Health will lead participant outreach and recruitment and help connect the Contractor with participating organizations, including Tribal partners, as applicable. The Contractor will work with Comagine Health and those organizations to support technical implementation, system integrations, onboarding, training, and adoption in alignment with the organizational change management approach.

45	Section 3.5.3, page 44	The RFP states that contractors must submit current HITRUST and SOC 2 certifications before the initial MVP launch and annually thereafter. Please clarify whether Comagine Health requires both HITRUST and SOC 2, or whether either certification may independently satisfy this requirement. Additionally, would an independent third-party assessment demonstrating compliance with the NIST SP 800-53 Moderate baseline, or another comparable security framework accepted by HCA/WaTech, be allowable in lieu of HITRUST and/or SOC 2?	HITRUST certification is not, by itself, a prerequisite for proposal submission or passage of the Security Design Review (SDR). HITRUST and other third-party security certifications or assessments may provide supporting evidence toward a positive SDR outcome. The SDR applies to the proposed CIE solution as a whole, rather than requiring each individual vendor participating in a multi-vendor solution to independently complete and pass an SDR. The selected Offeror is responsible for coordinating the resources and supporting documentation necessary to complete and pass the SDR for the proposed solution within no more than six (6) months of procurement of the State-supported CIE technology. The SDR includes completion of the required Data Security Questionnaire and Attestation, submission of applicable supporting documentation, including security policies, procedures, and third-party assessment reports such as SOC 2 Type 2, participation in collaboration meetings with Comagine Health and HCA, and final review by the Office of Cyber Security. WaTech does not provide a separate, prescriptive SDR checklist. Certifications and third-party assessments referenced in the RFP, including HITRUST and SOC 2 Type 2, are

Question ID	RFP Section Reference	Question	Response
			examples of evidence that may support a positive SDR outcome. Such certifications do not replace the requirement for the proposed solution to successfully complete and pass the SDR.
46	Section 3.1.1, page 25	The RFP mentions a statewide Resource Directory partner but also includes Resource Directory requirements for the Contractor for the MVP. Please clarify who is responsible for what components of the Resource Directory?	While the Contractor will not be responsible for curating or stewarding the resource directory, the WA CIE system must be capable of integrating with existing directory services to support WA CIE functions such as referral management, program enrollment, and care team population. WA CIE intends to integrate with a federated resource directory servicer rather than the Contractor establishing a directory within the CIE. We understand that Offeror's solutions may contain resource directory capabilities. Directory stewardship and ongoing curation are therefore not expected to fall within the contractor's scope. However, the contractor will be responsible for supporting the technical integration of directory services into WA CIE workflows, including referral workflows, to ensure directory information can be effectively used across CIE functions. Please refer to Referral Management and Resource Directory Requirements: RD08, RM03, RM03, and all other RD and RM requirements.

Question ID	RFP Section Reference	Question	Response
47	Section 1.2, page 8; Section 3.6.2, pages 46-47	Can you clarify Comagine's expectations regarding MCO, government, and provider engagement and financial participation required for access to a closed loop referral network? Or are these separate use cases that Washington intends to fund through additional procurements for use cases where "paying" entities require access to a closed loop referral network or community partners?	During the implementation MVP (Phase 1), WA CIE is being funded by the Medicaid Transformation Project (MTP 2.0) through an appropriation to HCA by the Washington State Legislature in 2024, to focus on the initial use case of interoperably connecting all of the CCHs (and their respective social care network contracted partners) to the WA CIE ecosystem. There will be an initial set of state agencies which will be planning to integrate during this phase (e.g., HCA, ProviderOne, ConsentLink, the state MPI), as well as statewide partner organizations who currently support the state (e.g., WA211, HCP OneHealthPort--the state designated HIE). The WA CIE governance structure will be developing a formal sustainability plan that will identify additional and future use cases and funders for the future phases of the more mature CIE beyond MVP (Phase 1).

Question ID	RFP Section Reference	Question	Response
48	Attachment 2, Submittal Form E	Regarding Form E and the WaTech requirements, is it just the prime contracting entity that needs to complete Form E and meet the WaTech requirements, or do all subcontractors need to attest as well? If all subcontractors need to attest, would Comagine like a separate Form E submitted for each subcontractor in addition to the prime contracting entity?	Form E must be completed by the Prime Contractor. However: Any subcontractor, consortium member, or third-party service provider that performs a material portion of the solution or provides a material security-relevant capability must also provide the required security attestations and documentation as applicable to its role and services. Comagine does not require a separate Form E for each subcontractor, but the Prime must include all required security information for each participating entity within its single Form E submission. If a Subcontractor or Third Party Service Provider has its own SOC 2 / HITRUST / ISO certifications, those should be included, as applicable, in the Prime's Form E package.

Question ID	RFP Section Reference	Question	Response
49	Section 3.5.3, page 44	In RFP Section 3.5.3 Security Assessment Requirements (p.44), it states: "As part of this process, contractors must submit current HITRUST and SOC 2 certifications, along with all required vulnerability scan and penetration testing reports, before the initial MVP launch and on an annual basis thereafter." Given the focus of the MVP that does not include sensitive data and the timeline to that launch, will Comagine accept a Contractor that holds current SOC 2 Type II certification, but has not yet obtained HITRUST r2 certification by MVP launch (June 30, 2027), provided the Contractor has initiated HITRUST certification processes and completes it for Phase 2 of the project?	Please refer to the response for question #45.

Question ID	RFP Section Reference	Question	Response
50	Section 1.12, page 11	The RFP Proposal Due Date is 4:00 p.m. 10/23/26. Given the opportunity to solicit new potential teaming off of the interest list that is due 10/9 and receive final Q&A 10/16/23, will Comagine please extend the due date to 11/13, or a similar extension, to allow for the clearest possible proposal inclusive of potentially new collaborators and any updates from the Q&A?	Comagine Health is unable to extend the proposal due date. Proposals remain due by 4:00 p.m. Pacific Time on October 23, 2026, as stated in RFP Section 1.4, Deadline for the Receipt of Proposals. Comagine Health will continue to post responses to questions as they are completed, with final responses posted by October 16, 2026. Offerors are encouraged to build their proposals using the current RFP, amendments, and published responses rather than waiting for the final set. Any future change to the schedule would be issued through a written amendment under Section 1.11, Amendments to RFP.
51	Section 1.7, pages 8-9	To allow vendors enough time to incorporate all solicitation information, including Att 4/SOW, and provide the best solution, would you please grant an extension of the due date by two weeks or more, past the release of the answers to questions?	Please refer to the response for question #50.

Question ID	RFP Section Reference	Question	Response
52	Section 1.7, pages 8-9	Since the SOW/Attachment 4 document has not yet been released, will you allow a second round of questions to be submitted to allow sufficient time to review the Attachment 4 document?	Comagine Health will not hold a second round of questions. Attachment 4 was released with Amendment #1, and questions were accepted on a rolling basis through the October 9, 2026 deadline (RFP Sections 1.6 and 1.7). All questions received by the deadline, including any about Attachment 4, will be answered in the final responses posted by October 16, 2026. Any proposed changes to the contract or Business Associate Agreement will be addressed during negotiations with the selected Offeror (Sections 6.4 and 6.5).
53	Section 3.6.4, pages 48-49	Are off shore resources permitted for non-development activities such as maintenance and operations services?	Refer to RFP Section 3.6.4. Location of Work (last paragraph): All services under the resulting contract, by the Contractor and any Subcontractors at any tier, must be performed within the United States or its territories. Performing any work outside the United States without Comagine Health's prior written approval is a material breach of the resulting contract and may result in termination.

Question ID	RFP Section Reference	Question	Response
54	Section 5.7, page 63	Can the State/Comagine Health confirm that the budget parameters put into place for the Evaluated Cost include all software (Subscriptions, assets), professional services, including labor and any minimum travel budget and any other cost items that may be required for this solution deployment and maintenance? No yearly budget is to be exceeded as defined by the RFP.	Yes. The annual funding ceilings in Section 1.2 cover all costs necessary to implement, operate, and maintain the proposed WA CIE solution, including software and subscriptions, professional services and labor, hosting, support, and other required costs. Offerors must include these costs in Submittal Form F – Cost Proposal and remain within the funding ceiling for each calendar year. Per Section 3.6.4 "The Offeror must include all anticipated travel costs associated with implementation in its firm-fixed-price implementation pricing in Submittal Form F – Cost Proposal and must identify its travel assumptions. Such travel costs are included in, and are not payable in addition to, the applicable firm-fixed-price amounts."

55	Section 2.1.2, page 16	Are any of the CCHs currently integrated with each other? If yes, please specify how many of the nine are integrated with each other. Are any of the CCHs integrated with their social care network partners and/or the select service providers (to be integrated at MVP)? If yes, how many of the 141+ regional social care network partners are integrated with their CCHs? What percentage of the health and social services providers (that will be integrated for the MVP) have APIs to facilitate integration across each other?	During the implementation of MVP (Phase 1), WA CIE will focus on the initial use case of interoperably connecting all of the CCHs (approximately six-to-eight connection feeds) – and their respective social care network contracted partners – to the WA CIE ecosystem. Currently, at least five of the Hubs are operating on the same technology vendor's solution, with some degree of visibility into each other's data, but not formal integration. But all the hubs are hosting technology solutions to which the majority of their social care network contracted partner organizations (few of which are FQHCs) have access. The six-to-eight integrations is an assumption for MVP (based on the CCHs and the technologies they share), we believe those will be a mix of different types of technology, none of which are currently integrated via API. These will represent all current CCHs and contracted partners who use their source systems, as well as the required integrations described in ConOps and Requirements. There will also be an initial set of state agencies (approximately five connection feeds) which will be planning to integrate during this phase, as well as statewide partner organizations (approximately three connection feeds) who currently support the state, bringing the estimated number of feeds to

Question ID	RFP Section Reference	Question	Response
			approximately 14-16. All integrations should have the ability to be bidirectional.
56	Section 2.1.2, pages 14-15	What mechanism has been designed to facilitate each service provider being accountable to timely present their APIs, etc to assess and facilitate integration into WA CIE in order to meet the launch date of the MVP?	Participation Agreements and the Participant Implementation Plans developed by Comagine Health in partnership with the MVP participating organizations and other integrated data sources will drive data integration activities, project timelines, DUA commitments, and project completion milestones. Additionally, the CCHs integration timelines for successful integration is determined by their contracted participation in the Washington State 1115 Waiver Program.

Question ID	RFP Section Reference	Question	Response
57	Section 3.5.4, pages 45-46; Attachment 4 – Section 15h, page 16	Ongoing support services, including security patches, are required throughout the duration of the engagement. Additionally, the Subcontractor must provide Extended Coverage for Professional Liability/Technology Errors and Omissions, as well as Crime and Cybersecurity and Privacy Liability coverage, for a period of 6 years following the expiration or termination of the Contract. This coverage is necessary to protect against claims that may arise after termination or expiration. To manage the risks associated with this extended exposure, can the Subcontractor offer specific relevant services during this 6-year period to effectively minimize its exposure to the associated risks?	Refer to RFP Section 3.5.4 (Support Requirements) and Sample Subcontract Agreement, Section 15d,h (Extended Coverage). Section 3.5.4 addresses ongoing maintenance and support services, including security patches, vulnerability remediation, and bug fixes, during the Contract term. Section 15d,h requires the Contractor to maintain Professional Liability/Technology Errors and Omissions, Crime, and Cybersecurity and Privacy Liability insurance coverage for six years following expiration or termination of the Contract. This requirement is a flow-down from Comagine Health's agreement with HCA. The six-year extended insurance requirement does not extend the Contractor's period of performance or require continued maintenance and support services for an additional six years. The requirement to maintain insurance coverage remains in effect regardless of whether services are being performed during that period.

Question ID	RFP Section Reference	Question	Response
58	Attachment 3, Submittal Form F, Licensing Tiered tab	License or other fees are tied to the specific "authorized-user tier". What criteria will be used to decide if a user is an "authorized user"? Who decides the pace at which the # of authorized users are integrated into WA CIE?	Authorized Users are staff members of an organization that is a WA CIE Participant Organization and who are authorized to access the CIE, either through the Participant Portal or through an integrated system. The number and types of authorized users will be determined based on each organization's programmatic, workflow, and service delivery needs, as identified through the organization's implementation plan.
59	Amendment 1, updated Forms A-D	The Amendment 1 and Questions 15-18 indicate that there were changes made to the Submittal Forms A-D file. However, it appears the old version is still what is posted on the website. Can you please verify that the updated version of this file was released, and if not, please post the updated version?	The updated Form A is available at https://comagine.org/program/washington-community-information-exchange

Question ID	RFP Section Reference	Question	Response
60	Attachment 1, Submittal Form A, Section 12	I see that the Washington Community Information Exchange page (https://comagine.org/program/washington-community-information-exchange) references the amendment 'updated Oct. 2, 2026' for Forms A–D. However, I do not see Section 12.2 as mentioned in the Q&A update: 'Updated Form A, Section 12: Reference Specifications to add ‘Endorsements’ and added Section 12.2 Letters of Support/Endorsement (see updated Form A).' Could you please clarify if there is another location or page where all post-amendment updated documents are listed?	The updated Form A is available at https://comagine.org/program/washington-community-information-exchange with the correct Section 12.2
61	Section 3.6.11, page 55	What is the process and the criteria under which an insurance variance would be given if the Contractor does not maintain the required limits, particularly for Cyber Liability / Information Security minimum limits?	Refer to 3.6.11 - Insurance Requirements, 3. Cyber Liability / Information Security Insurance: Comagine Health may consider a written request for an insurance variance supported by the Contractor's current coverage, risk profile, proposed architecture, hosting arrangement, data access, and other relevant factors. Requests will be evaluated on a case-by-case basis, and approval is not guaranteed. Any reduction or variance requiring HCA approval will be subject to HCA's prior written approval and will not be effective unless incorporated into the resulting Contract.

62	Attachment 4, Section 15, pages 15-17; Attachment 1, Submittal Forms A-D updated Oct. 2, 2026, Section 7, Criteria No. 3	Section 15 of the Sample Contract BAA appears to require each Subcontractor to maintain, among other coverage, $5million/$10 million Crime insurance and $25 million/$50 million Cybersecurity and Privacy Liability insurance. The proposed delivery model may include professional-services subcontractors performing functions such as program management, stakeholder engagement, workflow and use-case assessment, training, implementation coordination, or advisory services that do not host, store, process, or transmit WA CIE production data or provide the WA CIE technology infrastructure. Please clarify whether the insurance limits in Section 15 are intended to apply uniformly to all subcontractors regardless of role and risk exposure, or whether professional services/advisory subcontractors may maintain insurance appropriate to the nature and scope of their services and associated risk, consistent with Section 15(l) Lower-Tier Subcontractors. If the full limits do apply initially, may the Offeror propose role-based insurance requirements or obtain a modification/reduction pursuant to Section 15(m) prior to commencement of the applicable subcontractor's services? Please also confirm that where an Offeror identifies	No, role-based insurance requirements are not an option for Offerors. That said, an insurance variance is an available option. Refer to 3.6.11 - Insurance Requirements, 3. Cyber Liability / Information Security Insurance: Comagine Health may consider a written request for an insurance variance supported by the Contractor's current coverage, risk profile, proposed architecture, hosting arrangement, data access, and other relevant factors. Requests will be evaluated on a case-by-case basis, and approval is not guaranteed. Any reduction or variance requiring HCA approval will be subject to HCA's prior written approval and will not be effective unless incorporated into the resulting Contract.

Question ID	RFP Section Reference	Question	Response
		a professional-services subcontractor for which it intends to seek a role-based modification or reduction under Section 15(m), the Offeror may answer "True" to Mandatory Requirement #3 provided the subcontractor can obtain and maintain the insurance ultimately determined by Comagine Health/HCA to be applicable to its role.	
63	Attachment 4	You have provided the sample Data Sharing and Business Associate Agreement that is to be signed between Comagine as the Prime and the selected vendor as the Subcontractor. The terms outline the appropriate use and security required around the use of data by the Subcontract. Has the WA CIE also developed data use agreements that the participating partner organizations will sign to onboard to the CIE? Likewise have the client consent and/or authorization documentation been created for partners to deploy in onboarding clients to the CIE?	Yes, both the Data Use Agreement and Participation Agreement are in development with the WA CIE Interim Policy Workgroup and Advisory Board.

64	Q&A Response to Question ID#1	Software and volume estimates are required for an accurate cost proposal. The number of organizations have been estimated for the MVP at approximately 150, but can you provide an estimate for the number of clients that are likely served by those organizations and how many of those organizations are likely to be accessing the portal directly vs. those that would expect an integration to an existing system? Both the volume and the number of integrations that the 150 organizations represent will make the cost estimates more accurate.	During the implementation of MVP (Phase 1), WA CIE will focus on the initial use case of interoperably connecting all of the CCHs – and their respective social care network contracted partners – to the WA CIE ecosystem. CCHs collectively served approximately 14,000 unique individuals for the year July 2025 - June 2026. We anticipate that number to reflect the initial MVP (Phase 1) population and to increase as CCHs continue to scale their models. All the hubs are hosting technology solutions to which the majority of their social care network contracted partner organizations have access. These connected technologies represent all current ACHs, CCHs, and contracted partners who use their source systems, as well as the additional required integrations described in ConOps and Requirements (an initial set of state agencies, which we will be hoping to integrate during this phase, as well as statewide partner organizations who currently support the state). All integrations should have the ability to be bidirectional. Our intent is to grow in both the number of use cases and participant in future phases, as will be defined in the WA CIE product roadmap that will be developed by the Technology Utilization Committee, once it is empaneled.

Question ID	RFP Section Reference	Question	Response
65	Section 3.6.2, page 46; Attachment 3, Submittal Form F	For solutions built on a commercially available cloud platform, may platform subscription licenses be contracted directly between Comagine Health and the platform vendor, or must all licensing be procured and invoiced through the Prime Contractor?	Form F - Cost Proposal: All licensing should be procured and invoiced through the Prime Contractor.
66	Section 3.2, page 27; Attachment 3, Submittal Form F	Please define "authorized user" for the licensing bands in Form F. Does it include (a) Comagine Health staff, (b) participant portal users at CCHs and partner organizations, and (c) staff at connected organizations who use WA CIE functions through their own systems via API or single sign-on without logging in to WA CIE? Please also provide estimated user counts by type for the MVP and at full statewide scale.	For purposes of the licensing tiers in Submittal Form F, an Authorized User is an individual authorized to access or use WA CIE functionality based on assigned role-based access controls (RBAC). This may include Comagine Health WA CIE project and operational staff, participant portal users at CCHs and partner organizations, and authorized users at connected organizations who access WA CIE functionality through integrated systems, APIs, or single sign-on. Refer to the Utilization Model Table in Section 3.2 and Submittal Form F – Cost Proposal for additional information regarding access models and licensing tiers. Definitive user counts by type are not currently available. Offerors should use the licensing tiers provided in Submittal Form F for pricing purposes. Additional utilization information and estimates will be refined as WA CIE implementation planning and participant onboarding progress.

67	Section 3.5.2, page 44; Attachment 5, Non-Functional Requirements tab	Do the hosting and data residency requirements call for a government-specific cloud environment (for example, FedRAMP-authorized government regions), or will a commercial cloud environment with U.S. data residency and an executed BAA satisfy the requirement, subject to the WaTech Security Design Review?	A government-specific cloud environment (e.g., FedRAMP-authorized government regions) is not required. A commercial cloud environment with U.S. data residency and an executed Business Associate Agreement (BAA) will satisfy the requirement, subject to successful completion of the WaTech Security Design Review and the following conditions: ▪ Data Residency. All CIE data, including production data, databases, search indexes, logs, and backup and disaster recovery copies, must be stored and processed exclusively within the United States. The Contractor must enforce regional pinning and location controls in accordance with contracted policies, and must disable or restrict any automated replication, failover, or backup functions that could transfer data outside U.S. borders. ▪ Encryption Key Management. CIE data must be encrypted at rest and in transit. The Contractor must use customer-managed encryption keys (for example, keys held in a Contractor-controlled key management service or hardware security module) rather than cloud provider–managed keys. The Contractor must provide documentation demonstrating its control over key

Question ID	RFP Section Reference	Question	Response
			generation, storage, rotation, and access. ▪ Logical Segregation. Where the Contractor's cloud environment also supports other products, programs, or clients, the CIE must be logically segregated from them to prevent data leakage or commingling. Segregation measures should include, at a minimum, a dedicated tenant, account, or subscription; separate data stores; distinct encryption keys; and role-based access controls limited to authorized CIE personnel. CIE data may not be shared with, accessed by, or used for any other product, service, or purpose without the State's written authorization.
68	Section 5.10.1, page 65	For the system demonstration, will capabilities delivered through configuration of an existing, operational CIE implementation on the proposed platform be considered "currently available," provided Washington-specific extensions are clearly labeled as configuration or future implementation?	Yes, for Offeror's system demonstration, capabilities delivered through configuration of an existing, operational CIE implementation on the proposed platform will be considered "currently available" provided Washington-specific extensions are clearly labeled as configuration or future implementation.

Question ID	RFP Section Reference	Question	Response
69	Section 3.3.2, page 38; Section 3.6.2, page 46	Does Comagine Health expect the production environment and platform subscriptions to be held in Comagine Health's name from contract start, to support data portability and transition, or may they be held by the Contractor and transferred at transition?	The production environment and platform subscriptions may be held by the Contractor and transferred at the time of transition. Refer to the following sections of the RFP for supporting detail: ▪ 3.3.2 Deliverable Table, #22 - System Transition and Continuity Plan ▪ 3.5.5 Transition Requirements ▪ 3.613 Termination, Expiration & System Transition
70	Section 3.3.2, pages 33–35; Section 3.6.2, page 46; Attachment 5	Should Offerors treat the requirements tagged "MVP" in Form 05 as the fixed baseline for firm-fixed-price implementation pricing? If the Requirements Validation and Traceability Matrix deliverable results in added or reprioritized MVP requirements, will those be handled through change control and/or the time-and-materials provisions?	Performance Period: The initial contract is for 24 months, this includes MVP (Phase 1) and Phases 2-3. Comagine Health may, at its sole discretion, renew this Agreement for up to three (3) additional one-year periods, subject to continued funding, satisfactory Contractor performance, and the terms of this Agreement. Please refer to the RFP sections for supporting detail: ▪ 3 Scope of Work, paragraph 2 ▪ 3.1.1 Phased Implementation 3.5 WA CIE System Requirements - The requirements package is intended to establish a shared baseline understanding of the solution’s scope and direction; it is not exhaustive and will continue to evolve as implementation progresses.

Question ID	RFP Section Reference	Question	Response
71	Section 3.1.1, page 25	Must all MVP capabilities and all nine CCHs go live together by June 30, 2027, or may the Contractor propose incremental releases (for example, by capability or by hub) as long as the full MVP is live by that date?	Offerors may propose incremental releases by capability or Community Care Hub rather than a single simultaneous launch, provided the full required MVP scope and all nine CCHs are live by June 30, 2027. Offerors should describe their proposed release sequence, schedule, assumptions, dependencies, and technical risks in Submittal Form C, and their risk management and mitigation approach in Submittal Form D. Each release must satisfy applicable testing, security, acceptance, and go-live requirements. Please also refer to Question #72 regarding Security Design Review timing.
72	Section 3.4.2, page 40; Section 3.5.3, page 44	Can the WaTech Security Design Review and Privacy Threshold Analysis begin during design, before the solution is fully configured? What duration should Offerors plan for, and must the SDR be complete before user acceptance testing with synthetic data, or only before HCA data is loaded into production?	Yes. The WaTech Security Design Review and Privacy Threshold Analysis can begin while the design process is under way. However, the review must be successfully completed before the solution interacts with any of the other systems in the WA CIE ecosystem. Moreover, the contractor should be prepared and available to participate in SDR activities during different phases of design, testing, etc.

Question ID	RFP Section Reference	Question	Response
73	Attachment 5, Functional Requirements tab	Will Comagine Health or HCA provide defined specifications for MVP reports and dashboards (measures, MTP 2.0 reporting needs, equity disaggregation categories and small-cell suppression thresholds) before design begins, or is the Contractor expected to define them with governance during implementation?	Comagine Health, in partnership with HCA and WA CIE Participant Organizations, will define reporting requirements. Please refer to the Reporting & Analytics (RPT) Requirements section for additional details on required reports, which may include authorized user activity, client-level analysis, and CIE system analysis and evaluation.
74	Section 2.2.2, page 22; Section 2.2.3, page 23	The RFP indicates governance will set policies for consent, data retention and participation. Which policy decisions are expected to be finalized before the January 2027 contract start, and which will be made during MVP implementation? Configuration depends on several of these decisions.	A foundational, high-level consent and data management framework will be available by January 2027. Detailed policies governing the implementation, configuration, and enforcement of consent and data governance rules will be further defined and refined during the implementation period and following system launch.

Question ID	RFP Section Reference	Question	Response
75	Section 2.2.3, page 23; Attachment 5, Functional Requirements tab	For the MVP, is the client consent model expected to be opt-in, opt-out or a hybrid? Will HCA or Comagine Health provide approved consent forms and purpose-of-use categories before design?	For the MVP, the client consent model will follow an opt-in approach. In partnership with the WA CIE Governance Committees and the Health Care Authority (HCA), Comagine Health will provide all WA CIE Participant Organizations with an approved WA CIE Client Consent Form, along with the applicable legal agreements, including the WA CIE Participation Agreement, Data Use Agreement, Business Associate Agreement (BAA), and other relevant agreements. These documents will establish the requirements and conditions governing Participant Organizations' use of WA CIE, including client data use, access permissions, and compliance obligations.
76	Section 2.1.3, page 16	The RFP lists HCA's ECM/ConsentLink as a future interoperating system. Must WA CIE consent records align with or exchange data with ConsentLink at MVP, or is that a later-phase dependency?	Please refer to the response for question #25.
77	Section 3.1.1, page 25	Is there an existing statewide master person index or enterprise client identifier that WA CIE must use or align with at MVP, or is the Contractor expected to provide identity resolution within WA CIE? Which system will be the source of truth for client identity?	Please refer to the response for question #25.

Question ID	RFP Section Reference	Question	Response
78	Attachment 5, Functional Requirements tab & Non-Functional Requirements tab	Will data covered by 42 CFR Part 2 or other specially protected categories (for example, domestic violence or HIV-related information) be exchanged at MVP, or is that planned for a later phase? This significantly affects data segmentation design.	Please refer to the response for question #2.
79	Section 2.2.3, page 23; Attachment 5, Non-Functional Requirements tab	Are Tribal partners expected to participate at MVP? If so, will Comagine Health or governance define Tribal data sovereignty requirements (data ownership, access and segmentation rules) before solution design begins?	Comagine Health is currently in discussions with the leadership of Washington state's various Tribal Nations about their progress in forming a collective 'Tribal Hub' (which would be analogous to the CCHs participating in WA CIE), and/or any of the Tribal Nations' (or their Tribal-serving organizations) interest and readiness to participate individually in WA CIE, as soon as is reasonable. At this time, we do not have an expectation that any of the tribal or tribal serving organizations will directly participate in the MVP (Phase 1) implementation. However, in a future phase, we would expect the Contractor to be prepared to work on the implementation of the appropriate data segmentation and tribal data sovereignty policies, once those have been agreed upon with tribal partners and WA CIE governance.

Question ID	RFP Section Reference	Question	Response
80	Attachment 5, Non-Functional Requirements tab	Which languages must the participant portal support at MVP launch, and in later phases?	For MVP, the system must comply with established accessibility guidelines and provide language access for diverse user populations, including availability in key languages up to and including Washington State's top 15 spoken languages as defined in the Washington State Department of Social and Health Services Language Access Plan. Please reference the Requirements for additional details. Future phases may require additional languages.
81	Section 3.2.2, page 30; Section 3.3.2, page 35; Section 3.6.4, page 48	For training the roughly 150 MVP participant organizations, does Comagine Health expect the Contractor to train end users directly, use a train-the-trainer model with CCHs and Comagine staff, or both? Is any in-person training expected, given that work is primarily remote?	Please refer to the response for question #86. Additionally, training delivery methods will most likely be remote and there have been no in-person training needs identified at this time.

82	Section 3.5.4, page 44; Section 3.6.2, page 46	With Comagine Health providing Tier 1 help desk support, what ticket volume and support hours should Offerors assume for Contractor Tier 2 and Tier 3 support during MVP stabilization and ongoing operations? Should post-launch support be priced within the firm-fixed-price implementation, as maintenance and operations, or as time-and-materials?	WA CIE is a new system, so there is no historical ticket volume to share. For planning, MVP (Phase 1) will include the nine CCHs and their social care network partners, about 150 organizations (see the response to Question #1). CCHs served about 14,000 unique individuals from July 2025 through June 2026 (see the response to Question #35). Offerors should state their ticket volume and staffing assumptions in Submittal Form F – Cost Proposal. As described in RFP Section 3.5.4, Support Requirements, Comagine Health will provide Tier 1 help desk support, including 24/7 user-facing support. The Contractor will provide Tier 2 and Tier 3 support, including application support, defect resolution, root-cause analysis, escalation support, and help with triage when appropriate. Support hours and response times for Tier 2 and Tier 3 are governed by the service levels in Attachment 9 – Quality Assurance Plan. The project business hours in Section 3.6.4 do not limit those service levels. Support during MVP stabilization should be priced in the firm-fixed-price implementation. Section 3.6.2 defines the MVP implementation period as running from contract start through 60 days after MVP go-live. After that, ongoing Tier 2 and Tier 3 support should be priced as a

Question ID	RFP Section Reference	Question	Response
			firm-fixed recurring Maintenance and Operations charge. Time-and-materials pricing applies only to enhancements, change requests, or other work outside the baseline scope that Comagine Health authorizes in advance. Correcting defects or work that does not meet contract requirements is not billable as time and materials (see Section 3.6.7).

83	Section 3.6.5, page 49; Section 3.6.6, page 49	May a joint venture or teaming arrangement submit as the Offeror, and may Key Personnel be provided by named subcontractors rather than the Prime Contractor? Is there a minimum share of work the Prime Contractor must perform directly?	Joint Venture or Consortium arrangements: ▪ In the case of a Joint Venture arrangement - One unified legal entity is formed (LLC, partnership, etc.) the answer is YES. In this case the Joint Venture (entity) is the Prime Contractor with Comagine Health. ▪ In the case of a Consortium – A Consortium is a collaborative partnership of multiple vendors who coordinate to deliver the solution, but do not form a new legal entity - one vendor must be the named Prime Contractor. All other vendors are either subcontractors or Third Party Service (TPS); their contractual relationship is with the Prime Contractor (not directly contracted with Comagine Health/state of Washington). Yes, Key Personnel may be a combination of the both Prime Contractor and Subcontractors No, there is no minimum threshold of workshare specified for the Prime Contractor as distribution will vary, based upon the volume of subcontractors. Offerors/vendors need to determine the appropriate specifications for their respective proposals. Workshare specifications are included – Submittal Form A, Section 4.

Question ID	RFP Section Reference	Question	Response
84	Section 3.6.2, page 46; Section 3.6.3, page 48; Attachment 3, Submittal Form F	May Offerors propose their own firm-fixed-price milestone structure and payment schedule tied to deliverables and MVP acceptance, or will Comagine Health define the milestones? If Offerors propose them, should they appear in Form F or in the technical proposal?	No, the implementation is milestone based and mapped to the RFP deliverables (Sec. 3.3 Deliverables) and phased MVP model (Sec. 3.1 Initiative Overview & Objectives). Refer to the specified RFP sections for supporting detail. Submittal Form F - Cost Proposal, Read Me, and Implementation Milestones worksheets align with the above referenced sections of the RFP.
85	Attachment 1, Submittal Forms A-D updated Oct. 2, 2026, Section 7, Criteria #9	Is requirement #9 is intended to apply to every subcontractor regardless of role or workshare, or only to the Prime Contractor and/or subcontractors with material technology, hosting, operational, or financial responsibility?	Yes, that is correct. The requirement applies to the Prime Contractor and all related subcontractors, if requested.

Question ID	RFP Section Reference	Question	Response
86	Section 3.3.2, pages 35-36	Beyond development of the Participant Onboarding, Training, and Adoption Plan, what onboarding, training, adoption, and change management activities is the Contractor expected to perform?	In coordination with Comagine Health, the Contractor will be expected to develop materials and curriculum desk aids, training strategy, content development, train-the-trainer content, instructor-led delivery, end-user training, and videos related to technical and functional use of WA CIE. Contractor training materials will be reviewed and edited by Comagine Health to be in alignment with existing and complimentary materials. The Contractor may also be requested to participate in user feedback sessions or other human centered UX/UI design input gathering sessions.
87	Section 3.2.2, page 30	What training responsibilities are expected of the Contractor (e.g., training strategy, content development, train-the-trainer, instructor-led delivery, end-user training, job aids, videos)?	Please refer to the response for question #86.

Question ID	RFP Section Reference	Question	Response
88	Section 3.2.2, pages 35-36	What onboarding, training, adoption, and change-management responsibilities will remain with the HCA/Comagine Health?	In collaboration with the HCA and WA CIE Participant Organizations, and in coordination with the Contractor, Comagine Health will develop supporting collateral, desk aids, and training materials to facilitate organizational change management; Participant Organization implementation planning; CIE readiness and onboarding; and ongoing adoption, utilization, and compliance. These materials will complement and supplement the Contractor's technical and functional training resources, providing additional guidance and support to ensure effective implementation and sustained use of WA CIE.
89	Attachment 3, Submittal Form F, Implementation Milestones tab	Instructions are to enter data into BLUE boxes. This tab has clear boxes (no fill). Are the %'s exhibited fixed by the RFP or are those %'s flexible to our approach to each deliverable? Are the current figures example figures or is the customer asking partners to match those inputs?	The only value the Offeror needs to enter on the Implementation Milestones worksheet is in cell G21 - Total Fixed Implementation Costs; all other values in column G are calculated based upon the formulas in G8 - G20.
90	Concept of Operations (ConOps) – Appendix II, page 41	Is there an estimated volume/record count for the HHS Coalition MPI?	Community Care Hubs (CCHs) collectively served approximately 14,000 unique individuals for the year July 2025 - June 2026. We anticipate that number to reflect the initial MVP (Phase 1) population and to increase as CCHs continue to scale their models.

Question ID	RFP Section Reference	Question	Response
91	Section 1.6, page 8; Section 1.7, pages 8-9	If Bidders seek to submit any exceptions/amendments to the Att. 4 Subcontract Agreement documents, should those proposed exceptions be submitted in the same form as questions? And will those concerns be addressed to all potential Bidders, or will those proposed exceptions be addressed only to the Bidders who submitted them?	Suggested revisions to Attachment 4 will be addressed as part of the contracting process with the successful Offeror, rather than negotiated through the public Q&A process.
92	Section 1.13, page 11; Section 3.6.5; Attachment 1, Submittal Form A, page 49	Question: Sec. 1.13 allows a subcontractor to take part in more than one Offeror's proposal. Please confirm (a) whether Form A or any other form requires a subcontractor's concurrent participation on other proposals to be disclosed, and (b) whether any exclusivity or conflict-of-interest limits apply to a specialty subcontractor named by competing Offerors.	Regarding subcontractor participation in multiple proposals: (a) whether Form A or any other form requires a subcontractor's concurrent participation on other proposals to be disclosed - There are no required disclosures for a subcontractor participating on multiple proposals. (b) whether any exclusivity or conflict-of-interest limits apply to a specialty subcontractor named by competing Offerors. - No, there are no exclusivity, and/or conflict of interest issues/limits for specialty subcontractors participating in multiple proposals.

Question ID	RFP Section Reference	Question	Response
93	Section 2.2.2, page 21; Attachment 5	Is a participant-facing access audit and revocation capability (who accessed what, when, and the ability to revoke downstream access) an MVP requirement? Or is it expected to be met by identity and consent services alone? If it is required, may it be delivered as a modular subcontractor or Third-Party Service Provider component within the Prime's architecture?	Tracking and reporting on Authorized User activity within the CIE to support auditing and access reviews are required MVP capabilities. However, during the MVP phase, these tracking and reporting functions will need to be accessible only to Comagine Health. Functionality that enables WA CIE Participant Organizations to independently access and manage these reports will be expected in subsequent phases. Client Consent Management (CST) and Client Identity Management are other capabilities outlined in the requirements that while integrated with Identity & Access Management, may be part of a modular framework.
94	Section 3.1.1, page 25; Section 2.1.2, page 14	For the "approximately six to eight interoperability partners" at MVP (target June 30, 2027), which partner types are expected in scope (e.g., CCH client-management platforms in Table 3, MCO Findhelp instances, Crisis Connections/2-1-1 intake)? Will Comagine publish a prioritized interface list before proposals are due, or should Offerors propose an assumed MVP integration set in Form C?	Offerors should propose an assumed MVP integration set in Form C based upon the technologies represented for current ACHs, CCHs, and contracted partners who use their source systems, as well as the additional required integrations (an initial set of state agencies, which we will be hoping to integrate during this phase, as well as statewide partner organizations who currently support the state) as described in the ConOps and Requirements . Also please refer to the response for question #55.

Question ID	RFP Section Reference	Question	Response
95	Section 2.2.1, page 19; Attachment 5	For MVP referral management, will Comagine prescribe a statewide referral-status vocabulary and implementation guide (e.g., HL7 FHIR / Gravity Project patterns)? Or may Offerors propose a mapping layer that normalizes referral statuses across existing CCH/MCO platforms and the portal, then conforms to the standards governance adopts (targeted by May 2027)?	The Contractor may propose a data mapping layer; however, the WA CIE data model should align with the Gravity Project Referral Implementation Guide (IG) when possible, and other relevant data standards to the greatest extent practicable, recognizing that some existing data elements may require modification and additional elements may need to be incorporated into the WA CIE data set.
96	Section 2.1.2, page 14; Section 3.1.1, page 25	Does MVP scope include bi-directional referral exchange with clinical systems used by safety-net medical and dental providers (e.g., FHIR R4 APIs), or is clinical interoperability, including the state-designated HIE, expected only in Phase 2 or 3? The answer affects which subcontracted capabilities Offerors should price as MVP and which as optional phases.	All Non-Functional Requirements must be active and operating on Day 1 of MVP (Phase 1). This includes all sections of NFR10: Open, published, and freely accessible technical standards and integrations (including sections c, d, e, and f). The CCHs have some healthcare partners as part of their Social Care Networks, with which they exchange referral information. We intend these healthcare partners to be part of the MVP scope. As part of onboarding, interoperability definition will be confirmed.

Question ID	RFP Section Reference	Question	Response
97	Section 3.6.11, page 53	The RFP sets Cyber Liability at $25M per occurrence / $50M aggregate for the Contractor. Please confirm whether these limits flow down to subcontractors. For a narrowly scoped subcontractor that does not host the client record and works under the Prime's BAA, may lower subcontractor limits apply, backed by the Prime's coverage and contractual indemnification, or under an approved variance?	Refer to 3.6.11 - Insurance Requirements, 3. Cyber Liability / Information Security Insurance: Comagine Health may consider a written request for an insurance variance supported by the Contractor's current coverage, risk profile, proposed architecture, hosting arrangement, data access, and other relevant factors. Requests will be evaluated on a case-by-case basis, and approval is not guaranteed. Any reduction or variance requiring HCA approval will be subject to HCA's prior written approval and will not be effective unless incorporated into the resulting Contract.
98	Section 5.10.1, page 65	May an Offeror demonstrate MVP scenarios using a Prime platform plus named subcontractor components, provided each capability is clearly labeled as current product, configuration, or future work? Will modular architectures be scored on the same basis as single-platform solutions?	Yes, Offerors may demonstrate MVP scenarios using a Prime platform plus named subcontractor components, provided each capability is clearly labeled as current product, configuration, or future work. Yes, modular architectures will be scored on the same basis as single-platform solutions.

Question ID	RFP Section Reference	Question	Response
99	Section 2.2.2, page 21	The RFP notes WA CIE is in discussions with a statewide directory partner. Should Offerors assume integration to a designated directory API for MVP? Or should they price a directory connector that can be swapped out, and assume directory stewardship stays outside the Contractor's scope until a partner is designated?	WA CIE intends to use a federated approach leveraging existing directory services. Therefore, directory stewardship is not expected to be within the Contractor's scope. The Contractor will be responsible for providing and supporting Directory data integration into Referral Management capability. Please also refer to the response for question #24 and #46.
100	Section 3.6.6, page 51; Attachment 3, Submittal Form F, Section D	Section 3.6.6 names roles for personnel beyond the required Key Personnel and allows for the Offeror to propose a staffing model. However, form F Cost Proposal Section D T&M Labor Rate Schedule lists predefined labor categories. The predefined labor categories may not align with the Offeror's staffing model. Are the Section D labor categories required to be staffed exactly as listed or can the Offeror propose a staffing model and align it to Section D?	No, you are not required to use the existing labor categories in "Labor Rate Schedule" worksheet; Offerors may edit, add, and/or remove any of the existing labor categories on this worksheet to appropriately describe their proposal.

101	Section 3.1.1, page 25; Attachment 5	For pricing the required platform hosting and M&O through CY2028, please provide available planning ranges for: (a) peak concurrent dashboard/reporting users and reporting service hours, (b) daily record or data volume across the planned feeds, and (c) retained historical data and anticipated annual growth. If these figures are not available, may Offerors state explicit baseline assumptions and price capacity increases through defined tiers or change control?	Specific planning ranges for (a) peak concurrent dashboard/reporting users and reporting service hours, (b) daily record/data volumes across planned feeds, and (c) retained historical data volumes and annual growth are not currently available. The RFP and WA CIE Concept of Operations contemplate phased onboarding and growth in participation, integrations, and data complexity. The solution must therefore be scalable to accommodate growth as WA CIE matures. Yes. Offerors may identify reasonable baseline capacity assumptions used to develop their platform hosting and M&O pricing. Assumptions should be clearly stated and should identify any capacity thresholds, dependencies, or conditions that materially affect pricing. Offerors may also propose clearly defined pricing tiers or unit-based pricing for capacity above the stated baseline, where appropriate. Material capacity increases beyond the assumptions and services incorporated into the resulting Contract may be addressed through the Contract's applicable change-control process. The final pricing structure and any accepted capacity assumptions or tiers will

Question ID	RFP Section Reference	Question	Response
			be incorporated into the resulting Contract as appropriate.

102	Attachment 2, Submittal Form E	For a consortium response in which different consortium members are responsible for different aspects of the proposed CIE solution, can you please clarify how Submittal Form E – WaTech Security Questionnaire & Attestation should be completed? The form instructions state that the Offeror/Bidder must attest to compliance; however, the individual WaTech requirements distinguish between responsibilities assigned to "Agencies" and those assigned to "Vendors." Should the consortium provide a single set of attestations demonstrating that the applicable requirements are satisfied across the consortium, with individual members responsible for the requirements applicable to their respective scopes of work? Or is each consortium member expected to independently complete/attest to the requirements? For requirements that specifically concern the technology environment—such as hosting/infrastructure, network security, application development, encryption, logging, vulnerability management, backup, and other technical controls—may the	A consortium should submit one consolidated Submittal Form E on behalf of the Offeror. The prime Offeror remains responsible for demonstrating that all applicable requirements are satisfied across the proposed solution and delivery model. Consortium members may support individual attestations and provide documentation for requirements within their respective scopes. For technical controls involving hosting, infrastructure, network security, application development, encryption, logging, vulnerability management, backup, and similar functions, the consortium may rely on the responsible technology provider's compliance and supporting documentation. However, the prime Offeror remains accountable for the completeness and accuracy of the consolidated response and for overall compliance under the resulting Contract. Requirements identified in the form as agency responsibilities should not be independently attested to by consortium members unless the form specifically requests an Offeror response. For example, the data-sharing requirement in Section 4.2 is marked "DO NOT RESPOND, HCA TO COMPLETE." The Notes column may be used to identify:

Question ID	RFP Section Reference	Question	Response
		consortium rely on the technology vendor's compliance and supporting documentation where those controls are within the vendor's scope of responsibility? Conversely, for requirements that specifically assign responsibilities to the "Agency," should those requirements be addressed by the consortium member responsible for the applicable agency/contracting functions? If responsibilities may be allocated among consortium members, please also confirm whether the Notes column may be used to identify the consortium member responsible for satisfying each requirement and/or providing the supporting documentation for the Security Design Review.	▪ the consortium member responsible for each requirement; ▪ the applicable system, service, or component; ▪ how the requirement will be satisfied; ▪ any shared responsibility or dependency among consortium members; and ▪ the entity expected to provide supporting evidence during the Security Design Review. Where a response is anything other than "Yes, currently compliant," the form already requires explanatory notes describing how the requirement will be met during implementation or why it will not be met. Passing the Security Design Review is required before HCA data may be shared. Separate Submittal Form E workbooks from each consortium member are not required unless Comagine Health requests them during evaluation, clarification, contract negotiations, or the Security Design Review.

Question ID	RFP Section Reference	Question	Response
103	Section 3.5.4, page 44	Can the State please provide the current and anticipated volumes related to Service Desk operations over: 1. Phone 2. Email 3. Chat	Please refer to the response for question #82.
104	Section 3.1.1, page 25; Section 3.6.2, page 47	Is it correct to assume that the SLAs will take effect during the MVP Implementation period?	Operational service levels in Attachment 9 - Quality Assurance Plan, Sections 4.4 and 4.5, apply beginning at MVP go-live. All other performance standards in Attachment 9, including those in Sections 4.1, 4.2, 4.3, and 4.6, apply from Contract commencement. Service levels will also be documented in the Operations Guide (RFP Section 3.3.2, Deliverable 16), which must be finalized before go-live. This response does not modify Attachment 9 or the RFP. The resulting Contract will govern.
105	Section 3.1.1, page 25	Would the State be willing to allow a six month SLA baseline period after Phase 1/2/3 implementation so that both the vendor and the State can further refine the appropriate SLAs	Comagine Health, not the State of Washington, will be the contracting party for this procurement and will hold the resulting Contract with the selected Offeror.

Question ID	RFP Section Reference	Question	Response
106	Section 4.4, page 6	Are the specific SLAs and Performance listed in Section 4.4 Availability, Performance, and Interoperability —System Uptime, Screen response time, API Availability)—currently being met in the existing system	
107	Section 4.5, page 6	Will the state be open to a monthly cap on the max applicable remedy credits.	Comagine Health will not provide a six-month SLA baseline period following any implementation phase. As stated in the response to question #104, operational service levels in Attachment 9, Quality Assurance Plan, Sections 4.4 and 4.5, apply beginning at MVP go-live. All other performance standards in Attachment 9 apply from Contract commencement. This response does not modify Attachment 9 or the RFP. The resulting Contract will govern.
108	Section 3.5.4, page 45	Typically, clients require Service Desk support Monday through Friday, excluding holidays. Could the State clarify its expectations for support and activities required on Saturdays and Sundays? 2. Does the State have a preference for Ticketing System?	Comagine Health, not the State of Washington, is the contracting party for this procurement. Tier 1 24/7 support will be provided by Comagine Health including a user-facing support structure. The Contractor is responsible for Tier 2 and Tier 3 support. Contractor support coverage, including evenings, weekends, and holidays, must be sufficient to meet the service levels in Attachment 9, Quality Assurance Plan.

Question ID	RFP Section Reference	Question	Response
109	Section 3.6.2, page 47	Typically, supporting M&O and delivering enhancements require different resources with varying skill sets and experience levels. Would the State be open to using two separate blended hourly rates to calculate the annual cost for each category?	Offerors should reflect their staffing assumptions in the required pricing components of Submittal Form F. Baseline M&O must be priced as firm-fixed recurring charges. Enhancements outside the baseline scope must be priced using the T&M Labor Rate Schedule and applicable not-to-exceed amounts, with prior written authorization. Separate blended hourly rates do not replace the required pricing structure.
110	Section 3.1.1, page 26	Can the State please clarify if there are any Post production warranty periods for Phase 2 and Phase 3 Implementation?	No separate Phase 2 or Phase 3 post-production warranty duration are defined. The resulting Contract will govern applicable warranty and support obligations. Correction of nonconforming work for any release is required at no additional cost under Section 3.6.7, except as otherwise provided in the Contract.

111	Section 4.4, page 6	1. Will SLA penalties apply if outages are caused by underlying cloud provider issues (AWS, Azure, GCP)? 2. What is the scheduled maintenance window and window for Emergency fixes? 3. Will failures in Integration with the State tools affect the SLAs?	1. Cloud Provider Outages Yes. A cloud hosting provider relied upon to deliver the WA CIE solution is a Third-Party Service Provider under RFP Section 1.14.3. Use of a Third-Party Service Provider does not relieve the Prime Contractor of responsibility for meeting the requirements of the resulting Contract, including availability and performance requirements. Outages caused by the Contractor's cloud hosting provider are therefore not excluded from the service levels in Attachment 9, Quality Assurance Plan, Section 4.4. 2. Planned Maintenance and Emergency Fixes Under Attachment 9, Quality Assurance Plan, Section 4.4, system uptime excludes only approved planned downtime. Offerors should describe their proposed planned maintenance approach, including timing and advance notice, in Submittal Form D. Planned maintenance will be documented in the Operations Guide (RFP Section 3.3.2, Deliverable 16), and any planned downtime must be approved by Comagine Health before it is excluded from uptime. Emergency changes will be addressed in the Release and Deployment Management Plan (Deliverable 11). The applicable requirements and timeframes for emergency fixes will be governed by the RFP and resulting Contract.

Question ID	RFP Section Reference	Question	Response
			Service or security patches that address a vulnerability must be fully deployed within 24 hours of authorization to deploy (Attachment 9, Section 4.6). 3. Integration Failures Outages or failures caused by State systems or participant systems outside the Contractor's control and not attributable to the Contractor's solution, interfaces, or performance will not be counted against the Contractor's uptime or API availability service levels. The Contractor remains responsible for the availability and performance of the solution and the interfaces it provides, and for monitoring, incident response, and notification, and it would be preferred that in the event of a failure, that the system degraded gracefully.

112	Attachment 4	The Sample Contract Agreement does not contain a limitation of liability provision, and Section 15(n) states that the insurance requirements do not limit the Contractor's liabilities or obligations. Section 8.6 of the Data Sharing and Business Associate Agreement makes the Contractor responsible for breach-response costs, in each case without limit. As drafted, the Contractor's exposure is unlimited in amount, unlimited in duration, and includes indirect and consequential damages. (1) Will Comagine Health amend the Sample Contract Agreement to add a limitation of liability provision that (a) excludes indirect, incidental, special, consequential, exemplary and punitive damages, including lost profits, lost revenue and loss of goodwill, for both parties; and (b) caps each party's aggregate liability for direct damages at the total compensation payable under the Contract, with carve-outs for third-party intellectual property infringement, bodily injury and damage to tangible property, misuse of confidential information, government fines arising from the Contractor's breach of laws applicable to it as a service provider, amounts payable by Comagine Health for services rendered,	Comagine Health acknowledges the requested revisions to the limitation-of-liability provisions of the Sample Contract Agreement. (1) Limitation of Liability. As contemplated by RFP Section 3.6.10A, limitation-of-liability provisions, including any exclusions of damages, aggregate liability caps, and applicable exceptions or carve-outs, may be addressed during final contract negotiations with the selected Offeror. Comagine Health does not agree to the proposed limitations through this Q&A. (2) Application to Contractual Remedies. The applicability of any negotiated limitation of liability to indemnification obligations, data breach response costs, performance remedies, and other monetary obligations will be determined through final contract negotiations. The existing provisions of the Sample Contract and its attachments remain applicable unless modified in the resulting Contract. Any recovery for the same loss or event will be subject to the applicable contractual provisions prohibiting duplicative recovery. (3) Data Security Liability. Comagine Health may consider an appropriately structured limitation of liability for data-security-related damages during final contract negotiations,

Question ID	RFP Section Reference	Question	Response
		fraud, and liability that cannot be limited under applicable law? (2) Will Comagine Health confirm that the cap applies to all monetary remedies under the Contract and its attachments, including Section 8.6 and Section 17.4 of the Data Sharing and Business Associate Agreement and the performance remedies under Section 24(d), and that the same facts will not give rise to recovery under multiple provisions? (3) If a cap for all categories of loss is not acceptable, will Comagine Health indicate whether a separate, higher cap for data-security-related damages would be considered, and at what level?	taking into account the nature of the Services, applicable HCA requirements, and the associated risks. Comagine Health is not establishing a specific liability cap or alternative coverage amount through this Q&A.

113	Attachment 4, Section 14, page 14	Section 14(c) requires the Contractor to indemnify and defend but does not give the Contractor control of the defense of indemnified claims. Section 14(b) contains no exclusions from the intellectual property indemnity. Section 14(a) applies to claims "arising out of or resulting from" specified conduct, without apportionment where loss is caused in part by others. (1) Will Comagine Health amend Section 14(c) to provide that the indemnified party will give prompt written notice, tender sole control of the defense and settlement to the Contractor, and provide reasonable cooperation at the Contractor's expense, with the Contractor's obligations reduced to the extent it is prejudiced by a failure to do so? Comagine Health's existing protections against settlements admitting fault or imposing non-monetary obligations would be retained. (2) Will Comagine Health amend Section 14(b) to exclude claims arising from (i) modification of an item by a party other than the Contractor; (ii) combination or use with products, data or materials not supplied by the Contractor; (iii) designs, specifications or instructions provided by Comagine Health or HCA; (iv) third-party or open source	The Sample Contract is subject to final negotiations. Comagine Health has reviewed the requested clarifications regarding indemnification and will address appropriate procedural and risk-allocation language in the final Agreement. (1) Control of defense and settlement Comagine Health is willing to clarify the indemnification procedures during final contract negotiations, but does not agree at this time to the proposed language in its entirety. - Section 14(c) currently requires Comagine Health to provide the Contractor reasonable notice of an indemnified claim and reasonable cooperation in the defense. It also provides that the Contractor may not settle a claim in a manner that admits fault or liability on behalf of Comagine Health, imposes non-monetary obligations on Comagine Health, or materially affects Comagine Health's rights without Comagine Health's prior written consent. - Comagine Health is willing to consider additional language addressing the Contractor's management of the defense of an indemnified third-party claim, including appropriate provisions concerning notice, cooperation, selection of counsel, and settlement authority, provided that the final provisions preserve Comagine Health's right to

		components specified by Comagine Health or HCA; and (v) continued use after a non-infringing update or replacement has been made available? (3) Will Comagine Health amend Section 14(a) so that the indemnity applies "to the extent" claims arise from the specified conduct?	participate in the defense and protect its interests, including where a conflict of interest exists or a proposed settlement may affect Comagine Health's rights or obligations. (2) IP indemnity exclusions Comagine Health does not agree at this time to incorporate all of the proposed exclusions as categorical exceptions, but is willing to address appropriate causation-based exclusions during final contract negotiations. - Section 14(b) applies to third-party claims alleging that technology, software, Services, deliverables, or other materials provided by the Contractor infringe or misappropriate third-party intellectual property rights. It also gives the Contractor several mechanisms for addressing an actual or anticipated infringement claim, including obtaining continued-use rights or modifying or replacing the affected item so it is non-infringing without materially reducing functionality. - The Agreement separately requires the Contractor to identify third-party materials incorporated into or required for the WA CIE solution and to obtain and maintain the licenses and permissions necessary for those materials. It also requires the Contractor to warrant that it has the rights, licenses, permissions, and authorizations necessary to

			provide the Services and grant the contractual rights and licenses. Comagine Health is willing to consider reasonable exclusions where an infringement claim results from a modification, combination, specification, material, or continued use for which the Contractor is not responsible, provided that any exclusion does not apply to circumstances within the Contractor's responsibility or control under the final Agreement. (3) Proportionate responsibility No amendment is presently necessary. - Section 14(a) already limits the general indemnification obligation for the identified third-party claims by providing an exception "to the extent caused by the negligence or wrongful acts of Comagine Health." Accordingly, the existing clause already addresses allocation where Comagine Health contributes to the claimed loss rather than imposing indemnification for loss attributable to Comagine Health's own negligence or wrongful acts. Comagine Health may consider clarifying language during final contract negotiations if necessary to avoid ambiguity, provided that any revision does not diminish the Contractor's

Question ID	RFP Section Reference	Question	Response
			responsibility for claims attributable to the Contractor or its personnel, subcontractors, or agents.

114	Attachment 4, Section 13, pages 41-42	Section 13(c) provides that ownership of WA CIE Work Product "shall be determined in accordance with the applicable requirements of the Prime Contract." The Prime Contract has not been released, so Offerors cannot determine what intellectual property rights they are being asked to transfer, or price accordingly. Section 13(d) grants Comagine Health and HCA license rights in the Contractor's own technology without stating the scope or restrictions of that license. (1) Will Comagine Health amend Section 13(c) to state the ownership rule on the face of the Contract and confirm that: a. Comagine Health will own the copyright in works of authorship created specifically for WA CIE under the Contract, upon payment in full for the applicable services; b. the transfer is limited to copyright, and no patent, trademark or trade secret rights are assigned or licensed; c. work product excludes the Contractor's pre-existing technology and any improvement, enhancement or derivative work of it, consistent with Section 13(b); and d. the Contractor retains a non-exclusive, irrevocable, royalty-free license to use the work product, and the general skills,	Comagine Health appreciates the request for clarification. The Sample Contract distinguishes between the Contractor's pre-existing technology and WA CIE-specific work product, and Attachment 6 identifies the State and federal ownership and license-right requirements applicable to the Contractor. The Sample Contract remains subject to final negotiations, but Comagine Health cannot agree to limitations that would conflict with applicable HCA, State, or federal ownership and license requirements. (1) No. The Sample Contract already distinguishes between Contractor pre-existing technology, which remains the Contractor's property, and WA CIE Work Product created specifically for WA CIE. Comagine Health cannot limit ownership of WA CIE Work Product solely to copyright because applicable HCA and federal requirements may require broader ownership and license rights. Attachment 6 requires the Contractor to provide the ownership, license, access, use, reproduction, modification, transition, and other rights necessary to satisfy applicable Prime Contract requirements. (2) No. Contractor ownership of pre-existing technology is preserved under Section 13(b), but the license rights in Section 13(d) must be

Question ID	RFP Section Reference	Question	Response
		knowledge and experience gained in creating it, in performing services for others? (2) Will Comagine Health amend Section 13(d) to state that the license in the Contractor's pre-existing technology is non-exclusive, non-transferable, limited to Comagine Health's and HCA's internal use in connection with the WA CIE solution, and does not include rights to sell, distribute, sublicense for value, create derivative works, or reverse engineer? (3) Separately, will Comagine Health identify the specific license-rights requirements applicable under the Prime Contract, including any arising under 45 C.F.R. § 95.617 and 42 C.F.R. Part 433, Subpart C, which are referenced in Section 16 of the Sample Contract Agreement?	sufficient for Comagine Health and HCA to operate, maintain, transition, and continue using WA CIE and to satisfy applicable State and federal requirements. The parties may clarify the scope of those rights during final contract negotiations, provided any limitations remain consistent with those requirements (3) Yes. Attachment 6 identifies the applicable State and federal license-right framework. Section 9 requires that applicable royalty-free, nonexclusive, irrevocable government license rights not be impaired, and Section 10 addresses the ownership and other rights necessary to satisfy HCA requirements. Where applicable, 45 C.F.R. § 95.617 requires State ownership of software, modifications, and associated documentation developed with Federal Financial Participation and reserves specified license rights to the Federal Government, while providing an exception for qualifying proprietary vendor software. 42 C.F.R. Part 433, Subpart C identifies 45 C.F.R. Part 95, Subpart F as part of the federal framework governing applicable Medicaid systems.

115	Attachment 4, Sections 1.6, 4, 7, 8, 15	(1) Section 1.6 requires Offerors to identify objectionable provisions by October 9, 2026. Several documents that establish binding obligations have not been released: • the Prime Contract (HCA Contract No. K8582), which Section 7(a) states will be attached to the final Agreement; • Prime Contract Amendment 1, referenced in Section 15(i) of the Sample Contract Agreement as modifying insurance requirements for certain named subcontractors; • Any applicable HCA Flow-Down provisions; • Exhibit B (Data Sharing and Business Associate Agreement) of the Prime Contract, which the Data Sharing and Business Associate Agreement states it incorporates; • the HCA Data Security Requirements and WaTech Security Policies and Standards referenced in Sections 8(b) and 8(c) of the Sample Contract Agreement and Section 4.4 of the Data Sharing and Business Associate Agreement. (2) Will Comagine Health release these documents and establish a supplemental question and exception period running from the date of their release, so that Offerors can review them before proposals are due?	(1) Comagine Health has included in the RFP materials the contractual, flow-down, data security, privacy, and WaTech requirements applicable to Offerors through the Sample Contract and applicable RFP attachments and submittal forms. HCA Flow-Down Requirements. Attachment 6 identifies requirements of HCA Contract No. K8582 that Comagine Health is required to flow down to the WA CIE Contractor. Attachment 6 expressly states that obligations imposed upon the "Contractor" under the Prime Contract apply to the WA CIE Contractor only to the extent those obligations are expressly stated in Attachment 6 and applicable to the Contractor's performance of the Services. Data Sharing/BAA Requirements. Attachment 5, Data Sharing and Business Associate Agreement, establishes requirements governing the Contractor's access to, use, disclosure, protection, retention, and disposition of WA CIE information and expressly incorporates applicable requirements of Exhibit B, Data Sharing and Business Associate Agreement, of HCA Contract No. K8582.

		(3) Pending their release, will Comagine Health confirm that (a) a Prime Contract provision is binding on the Contractor only if it has been provided to the Contractor in writing before execution, consistent with Section 7(b); and (b) where a change to the referenced requirements after the Effective Date materially increases the Contractor's obligations, cost or schedule, the change will be implemented through the change control process in Section 25?	HCA/WaTech Security Requirements. Submittal Form E provides the WaTech contractual security requirements applicable to Offerors and requires Offerors to attest to their compliance with those requirements. The requirements address, among other subjects, data classification and security, encryption, network security, access security and authentication, application security, operations management, security monitoring and logging, and incident response. Submittal Form E also identifies the Security Design Review requirement and states that passing the Security Design Review with the Office of Cyber Security is required before HCA data may be shared. Accordingly, Offerors should base their proposals, exceptions, assumptions, and pricing on the requirements contained in or incorporated through the RFP documents. The inclusion of a requirement in the Prime Contract does not, by itself, make every provision of the Prime Contract directly applicable to the WA CIE Contractor. (2) Comagine Health does not anticipate establishing a supplemental question and exception period solely on the basis identified in this question because the applicable HCA

			flow-down, data-sharing/BAA, and WaTech contractual security requirements have been provided through the RFP materials. If Comagine Health subsequently issues additional requirements that materially affect Offerors' obligations before proposals are due, Comagine Health will address any corresponding amendment, schedule adjustment, or additional opportunity for questions or exceptions through the RFP process. (3)(a) Applicable Prime Contract requirements imposed upon the WA CIE Contractor are those expressly incorporated into the final Agreement or identified in Attachment 6 or another incorporated contract/RFP document, to the extent applicable to the Contractor's Services. Attachment 6 specifically provides that obligations imposed upon the "Contractor" under the Prime Contract apply to the WA CIE Contractor only to the extent expressly stated in Attachment 6 and applicable to the Contractor's performance. This does not preclude application of new or revised requirements after the Effective Date where the Agreement requires Comagine Health to flow down such requirements or otherwise requires compliance with applicable

Question ID	RFP Section Reference	Question	Response
			HCA, WaTech, legal, regulatory, or governmental requirements. (3)(b) The Sample Contract provides that if HCA modifies the Prime Contract or otherwise imposes a new or revised requirement that Comagine Health is required to flow down to the Contractor, Comagine Health will notify the Contractor of the applicable requirement. The parties will execute an amendment when reasonably necessary to incorporate the required change, including any mutually agreed adjustment to Services, schedule, or compensation resulting from a material change in the Contractor's obligations. The Sample Contract's Change Control provisions further provide that when a change is required because of a change to the Prime Contract, an HCA or WaTech requirement, applicable law or regulation, or another governmental requirement applicable to WA CIE, the parties will cooperate in good faith to implement the required change. Any applicable adjustment to compensation or schedule will be determined in accordance with the Agreement and documented in writing when applicable.

116	Attachment 4, Sections 8.1, 8, 9.9, 17.3, 3.2, 13.2, 2.4, 12.3	(1) Section 8.1 requires notification within 24 hours of discovery of actual or suspected events, applied uniformly to Protected Health Information and to data that is not PHI. Section 8(e) of the Sample Contract Agreement separately provides for notification of a breach of unsecured PHI within 60 days, consistent with 42 U.S.C. § 17932. Will Comagine Health reconcile these provisions and confirm that notification obligations will follow the standard applicable to each category of data (i.e., for PHI, the standard in 45 C.F.R. § 164.410 (without unreasonable delay and in no case later than the period specified in that section after discovery), and for other data, the Offeror's standard commercial security incident notification commitments)? (2) Will Comagine Health also confirm: a. that notification is not required for unsuccessful security incidents of the kind routinely experienced by providers of information technology services, such as pings, port scans, denied log-in attempts and blocked malware, or for interference with system operations not involving unauthorized access to data; b. that the HIPAA-derived obligations in Section 8, including risk assessment under	(1) No. Section 8.1 establishes a contractual 24-hour initial notification requirement for specified security, privacy, and data incidents so that Comagine Health can timely evaluate and satisfy applicable HCA, WaTech, HIPAA, and other requirements. For a breach of unsecured PHI, 45 C.F.R. § 164.410 separately requires notification without unreasonable delay and no later than 60 calendar days after discovery. The 24-hour contractual notice does not replace the applicable HIPAA breach determination or notification requirements. (2)(a) Comagine Health is willing to clarify during final contract negotiations the treatment of routine unsuccessful security events that do not compromise Data or materially affect WA CIE systems, provided that any clarification preserves reporting required under applicable HCA, WaTech, contractual, or legal requirements. (2)(b) Yes, as to HIPAA-specific requirements. The HIPAA breach analysis concerns PHI, and Section 8.3 expressly identifies additional reporting content for incidents involving PHI. Other contractual security and incident requirements remain applicable to non-PHI Data as specified in the Agreement.

		45 C.F.R. § 164.402 and the specified report content, apply only to incidents involving PHI; c. that Section 9.9 requires compliance with Covered Entity obligations only where the Contractor has expressly agreed in writing to carry out a specified Covered Entity obligation, and that the Contractor does not otherwise assume Covered Entity status; d. that the conflict rule in Section 17.3 does not extend an obligation applicable to PHI to data that is not PHI, and does not override the limitation of liability provisions of the Contract; e. that data classification obligations under Section 3.2 apply to each category of data according to its own classification, with the highest classification applying only where categories are commingled and cannot reasonably be distinguished; f. that the return and destruction obligations in Section 13.2 are subject to data the Contractor is required to retain by law or legal hold, and to data residing in routine backups or archives that cannot be selectively deleted, with such data remaining protected under the Attachment; g. that Section 2.4 does not restrict the use of machine learning or similar technologies forming part of the proposed solution as described in the Statement of Work, or	(2)(c) Section 9.9 applies only to the extent the Contractor performs an obligation of a Covered Entity under 45 C.F.R. Part 164, Subpart E. It does not provide that the Contractor generally assumes Covered Entity status. Comagine Health may clarify this provision during final contract negotiations if necessary. (2)(d) Section 17.3 applies the provision providing greater protection to the affected Data when specified conflicts arise. It does not state that non-PHI Data becomes subject to requirements applicable solely to PHI. Any interaction with limitation-of-liability provisions will be governed by the final Agreement and its applicable order of precedence. (2)(e) Yes. Section 3.2 requires Data to be protected according to the highest classification applicable to that Data. Section 4.6 separately provides that where HCA Data is commingled and segregation is not technically feasible, the commingled information must be protected at the level required for HCA Data. (2)(f) The Attachment already recognizes legally required retention and requires retained PHI to remain protected until it can be returned or destroyed. Comagine Health is willing to consider reasonable clarification

Question ID	RFP Section Reference	Question	Response
		security, fraud-detection, monitoring and operational tooling incorporating such technologies, provided the Contractor does not use the data to train or improve models made available to other customers; and h. that a failure to meet a notification timeframe will not of itself constitute a material violation supporting expedited termination under Section 12.3 where the Contractor exercised reasonable diligence and notified promptly on becoming aware?	concerning legal holds and routine backup or archival copies during final contract negotiations, provided retained Data remains protected and is not used for unauthorized purposes. (2)(g) Section 2.4 permits AI, machine-learning, or similar functionality to the extent it is expressly within the Services and authorized in accordance with the Agreement and applicable HCA and Comagine Health requirements. Comagine Health does not agree to a broader categorical exception outside that authorization framework. (2)(h) Section 12.3 provides that a material violation may constitute grounds for suspension or termination, including expedited termination where permitted by the Agreement and reasonably necessary to protect Data or satisfy Comagine Health's obligations to HCA. It does not state that every failure to meet a notification timeframe automatically constitutes a material violation supporting expedited termination. No further clarification is necessary.

117	Attachment 4, Section 15, page 42	Commercial insurers generally do not extend additional insured status or waivers of subrogation under umbrella, professional liability, or employers' liability policies, and extended reporting period coverage of six years beyond a five-year term is not generally obtainable under global insurance programs maintained on annual renewal. (1) Will Comagine Health amend Section 15 to: a. reduce the Cyber/Privacy Liability limits in Section 15(f) to an amount proportionate to the contract value and the data risk profile; b. limit additional insured status and primary and non-contributory coverage under Section 15(i), and waivers of subrogation under Section 15(j), to the Commercial General Liability and Business Automobile Liability policies, with the subrogation waiver excepted where loss is caused by the gross negligence or willful misconduct of the beneficiary; and c. reduce the extended coverage period in Section 15(h) from six years to two years, and confirm it may be satisfied through continued maintenance of the Contractor's existing programs rather than engagement-specific tail coverage?	(1)(a) Not at this time. The Cyber/Privacy Liability limits stated in the RFP and Sample Contract reflect the insurance requirements applicable to the WA CIE procurement. The RFP permits the selected Contractor to request an insurance variance based on its current coverage, risk profile, proposed architecture, hosting arrangement, data access, and other relevant factors. Any variance requiring HCA approval is subject to that approval and must be incorporated into the resulting Contract. (1)(b) Not at this time. The Sample Contract applies additional-insured, primary-coverage, and waiver-of-subrogation requirements to the extent required by the applicable policies and HCA flow-down requirements. Requested modifications may be considered during final contract negotiations through the insurance-variance process and are subject to HCA approval where required. (1)(c) Not at this time. The six-year extended-coverage requirement may be satisfied through continuous coverage, an extended reporting period, or other coverage sufficient to protect against claims made following expiration or termination, provided such coverage applies to claims arising from Services performed under the Contract and remains in effect for the required period. Accordingly, the RFP does not

Question ID	RFP Section Reference	Question	Response
		(2) Will Comagine Health also confirm whether the insurance relief available to "certain named subcontractors under Prime Contract Amendment 1," referenced in Section 15(i), is available to the Contractor selected under this RFP?	require engagement-specific tail coverage as the sole means of compliance. (2) No automatic insurance relief or variance applies to the Contractor selected under this RFP based on relief provided to another subcontractor under the Prime Contract. The selected Contractor may request a modification or variance under the insurance provisions applicable to this procurement. Any such request will be evaluated based on the selected Contractor's circumstances and is subject to HCA approval where required.

118	Attachment 4, Sections 4, 18, 22, 23	Payment for implementation milestones is conditioned on acceptance under Section 4(b), but acceptance criteria are to be established in documents not provided in final form. Section 23(i) requires correction at no additional cost and preserves all other remedies cumulatively. Section 23 contains no disclaimer of implied warranties. Section 18(a) permits termination for convenience on thirty days' notice with no payment for committed costs. Section 22(c) requires continued services for up to 365 days after termination without stating the applicable charges. (1) Will Comagine Health amend the Sample Contract Agreement to confirm that: a. acceptance under Section 4(b) is determined solely against the objective acceptance criteria stated for the applicable milestone or deliverable; Comagine Health will accept or reject in writing, specifying criteria not met, within ten business days of delivery, failing which the item is deemed accepted; and re-review following correction is limited to criteria previously identified as not met; b. the remedies in Section 23(i) are the exclusive remedies for breach of warranty, supplemented by a right to terminate the affected services or deliverables and receive	(1)(a) Not as proposed. Acceptance will be based on the applicable Contract requirements, milestone/deliverable acceptance criteria, and Quality Assurance Plan. The Cost Proposal identifies an acceptance basis for each implementation milestone, and the Sample Contract conditions payment on satisfaction of applicable acceptance requirements. Comagine Health does not agree to deemed acceptance after ten business days or to limit re-review solely to deficiencies previously identified. Appropriate acceptance procedures and review timeframes may be finalized during contract negotiations. (1)(b) No. The Sample Contract provides correction, repair, replacement, or reperformance for breach of warranty and expressly states that those remedies are in addition to other rights and remedies under the Agreement. Comagine Health does not agree to make warranty remedies exclusive. (1)(c) Not at this time. Comagine Health does not agree through the RFP Q&A to add the proposed disclaimer of implied warranties. Any proposed revisions to the warranty provisions may be considered during final contract negotiations.

		a refund where correction is not achieved within a reasonable period; c. Section 23 includes a disclaimer of implied warranties, including merchantability, fitness for a particular purpose, title and non-infringement; d. the professional performance warranty in Section 23(b) is measured against the requirements of the Contract rather than undefined "applicable industry standards," and the compliance warranty in Section 23(g) applies to laws applicable to the Contractor as a provider of the Services; e. on termination for convenience under Section 18(a), Comagine Health will pay for services performed and deliverables accepted or in progress, charges for licenses and subscriptions committed for the then-current term, and reasonable documented non-cancellable third-party commitments; and f. continued services under Section 22(c) are chargeable at the rates in the Pricing and Payment Schedule, or the Contractor's then-current rates for services not priced there?	(1)(d) Not as proposed. The professional-performance warranty requires performance in a professional and workmanlike manner by appropriately qualified personnel and in accordance with applicable industry standards and Contract requirements. The compliance warranty is tied to the Contractor's performance of the Services. Comagine Health may consider appropriate clarifying language during final contract negotiations but does not agree to the proposed limitations through the RFP Q&A. (1)(e) No. Upon termination, the Sample Contract provides for payment for Services satisfactorily performed and accepted through the effective date of termination and authorized transition Services, subject to applicable contractual rights and remedies. It expressly provides that Comagine Health has no obligation to pay for unperformed Services, lost profits, or anticipated revenue resulting from termination. Comagine Health does not agree to expand those payment obligations as proposed through the RFP Q&A. (1)(f) Clarification is not necessary. The Sample Contract already provides that transition Services within the Contractor's existing obligations are provided at the applicable prices established under the Agreement.

Question ID	RFP Section Reference	Question	Response
			Additional transition services outside the existing Scope of Work must be authorized in writing and are compensated at the applicable Agreement rates or as otherwise agreed in writing by the parties.

119	Attachment 4, Sections 4, 18, 22, 23	Payment for implementation milestones is conditioned on acceptance under Section 4(b), but acceptance criteria are to be established in documents not provided in final form. Section 23(i) requires correction at no additional cost and preserves all other remedies cumulatively. Section 23 contains no disclaimer of implied warranties. Section 18(a) permits termination for convenience on thirty days' notice with no payment for committed costs. Section 22(c) requires continued services for up to 365 days after termination without stating the applicable charges. (1) Will Comagine Health amend the Sample Contract Agreement to confirm that: a. acceptance under Section 4(b) is determined solely against the objective acceptance criteria stated for the applicable milestone or deliverable; Comagine Health will accept or reject in writing, specifying criteria not met, within ten business days of delivery, failing which the item is deemed accepted; and re-review following correction is limited to criteria previously identified as not met; b. the remedies in Section 23(i) are the exclusive remedies for breach of warranty, supplemented by a right to terminate the affected services or deliverables and receive	Duplicate question -- please refer to the response for question #118.

Question ID	RFP Section Reference	Question	Response
		a refund where correction is not achieved within a reasonable period; c. Section 23 includes a disclaimer of implied warranties, including merchantability, fitness for a particular purpose, title and non-infringement; d. the professional performance warranty in Section 23(b) is measured against the requirements of the Contract rather than undefined "applicable industry standards," and the compliance warranty in Section 23(g) applies to laws applicable to the Contractor as a provider of the Services; e. on termination for convenience under Section 18(a), Comagine Health will pay for services performed and deliverables accepted or in progress, charges for licenses and subscriptions committed for the then-current term, and reasonable documented non-cancellable third-party commitments; and f. continued services under Section 22(c) are chargeable at the rates in the Pricing and Payment Schedule, or the Contractor's then-current rates for services not priced there?	

120	Attachment 4, Sections 7, 8, 12, 22, 26	Section 12(b) provides audit access at no additional cost without frequency, scope or confidentiality limits, and contemplates that the Contractor's records may be subject to disclosure under the Washington Public Records Act. Section 8(c) permits security assessments, testing and remediation by four separate authorities at the Contractor's cost without frequency or notice limits. Section 7(f) imposes a most favored customer commitment. Sections 22(g) and 26(a) address assignment. (1) Will Comagine Health confirm or amend as follows: a. that audits under Section 12(b) occur no more than once in any twelve-month period absent regulatory requirement or identified non-compliance, on reasonable prior notice, by representatives who are not competitors of the Contractor and who are bound by confidentiality, and that they do not extend to the Contractor's internal cost, margin and pricing build-up records for firm fixed price services, its internal audit materials, or other customers' data or environments; b. that before disclosing the Contractor's confidential information or trade secrets in response to a public records request, Comagine Health will give the Contractor reasonable advance notice and an	(1)(a) Not as proposed. Audit and records-access rights must remain sufficient to satisfy applicable HCA, State, and federal oversight requirements. Attachment 6 already provides that applicable records are available upon reasonable notice for examination, inspection, copying, or audit by Comagine Health, HCA, the Washington State Auditor, and authorized State or federal officials with applicable authority. Comagine Health may consider reasonable confidentiality and scope protections during final contract negotiations, provided they do not restrict required governmental audit or oversight rights. (1)(b) Comagine Health may consider appropriate procedures during final contract negotiations for notice regarding legally required disclosure of Contractor Confidential Information, to the extent permitted by applicable law. Comagine Health does not agree through the RFP Q&A to limit obligations arising under applicable public-records or disclosure laws. (1)(c) Not as proposed. The DSA/BAA requires cooperation with privacy, security, data-use, and compliance reviews reasonably required under the Agreement or Prime Contract, while Attachment 6 requires cooperation with security reviews, audits, risk assessments,

		opportunity to assert applicable exemptions or seek protective relief; c. that security assessments under Section 8(c) and records access under Section 7.3 of the Data Sharing and Business Associate Agreement are subject to the same procedural protections, and that remediation materially exceeding the requirements stated in the Contract is addressed through change control under Section 25; d. that Section 7(f) will be removed, or alternatively that compliance may be evidenced by a written certification from an officer of the Contractor rather than by audit of the Contractor's books and records or of other customers' agreements; e. that an assignment under Section 22(g) is conditioned on the assignee assuming all obligations, including accrued payment obligations, and not being a competitor of the Contractor; and f. that Section 26(a) permits assignment, on written notice and without consent, to an affiliate or to a successor in connection with a merger, acquisition, reorganization, or sale of the business to which the Contract relates, where the assignee assumes the obligations and has the capability to perform?	control assessments, remediation activities, and other governmental security-oversight activities. Comagine Health cannot impose procedural restrictions that would interfere with applicable HCA, WaTech, State, or federal oversight requirements. (1)(d) No. The Most Favored Customer provision will not be removed through the RFP Q&A. Attachment 6 applies the provision only to substantially similar customers receiving the same or substantially similar services under substantially similar qualifications, requirements, volumes, and circumstances. (1)(e) Not as proposed. The Sample Contract provides for assignment to HCA or HCA's designee in connection with expiration or termination and provides that the assignee assumes Comagine Health's rights and obligations under the Agreement to the extent assigned. Comagine Health does not agree to condition such an assignment on the assignee not being a Contractor competitor. (1)(f) No. The Sample Contract requires Comagine Health's prior written consent before the Contractor assigns, delegates, or transfers the Agreement or a material right or obligation, and expressly treats specified change-of-control transactions as assignments. Comagine

Question ID	RFP Section Reference	Question	Response
			Health does not agree through the RFP Q&A to establish an automatic assignment right for affiliates, mergers, acquisitions, reorganizations, or sales of the applicable business.
121	Attachment 3, Submittal Form F, Section C	The software licensing/subscription cost estimates do not allow for growth over time. It keeps the same subscription fees each year. Is there an option to assume a 25-40% increase each year given the projected growth plan?	The cost estimate submission is intended to address the initial users and allow for comparison between offerors. Software licensing and subscription costs in Submittal Form F, Section C, are linked to a single authorized-user band (Tier 2) on the Licensing tab. Offerors should not apply an assumed annual growth percentage to those amounts. Any assumptions about how the pricing structure was completed should be added to the pricing assumptions in form F - Cost Proposal.
122	Section 4.3, page 59; Attachment 3, Submittal Form F, Section A	Is the $2,500,000 implementation amount pre-filled in Submittal Form F a placeholder, a ceiling, or a required value?	Cell G21 is the only value the Offeror needs to enter on Submittal Form F - Cost Proposal, Implementation Milestones. All other cells in column G are calculated based upon the value in cell G21.

Question ID	RFP Section Reference	Question	Response
123	Section 3.6.11, pages 53-55	Insurance Requirements is required to cover several risks in addition, the Contractor must provide Extended Coverage of several tens of millions of dollars for various risks including cybersecurity of $10,000,000 per occurrence and $50,000,000 in the aggregate. This Extended Coverage is required for a period of 6 years after termination or expiration of the Contract. Funding has been approved for two years. The Contract value for two years is approximately $5,000,000 (fixed fees) plus time and materials for two years at capped hourly rates, for an approximate total of $7,000,000. Assuming a 2-year project timeline and 6-year extended coverage (after expiration), what is the basis of the insurance limits in particular those for cybersecurity? Is there flexibility for an insurance variance to be considered to right size the costs to deploy WA CIE plus meet insurance requirements relative to the fee structure?	The insurance requirements reflect the coverage requirements applicable to the WA CIE Contractor under the HCA Prime Contract and the risk associated with operating the WA CIE solution, including its handling of sensitive data. Attachment 6 expressly provides that the insurance requirements are subject to a modification or variance approved in writing by Comagine Health and HCA, where HCA approval is required. Yes, an insurance variance may be considered. The selected Contractor may request modification or reduction of one or more insurance requirements in accordance with the RFP and Sample Contract. Any approved variance must be documented in writing and is subject to HCA approval where required. Clarification: The Sample Contract requirement for Cybersecurity and Privacy Liability is $25 million per occurrence and $50 million aggregate, not $10 million per occurrence. The required Professional Liability/Technology E&O, Crime, and Cybersecurity/Privacy Liability coverage must be maintained for six years following expiration or termination

Question ID	RFP Section Reference	Question	Response
124	Section 4.3, page 59; Attachment 3, Submittal Form F, Section A	Is the $2,500,000 implementation amount pre-filled in Submittal Form F a placeholder, a ceiling, or a required value?	Duplicate question -- please refer to the response for question #122.
125	Section 5.7, pages 63–64	The Evaluated Cost definition lists Year 1 M&O and the full 5-year recurring total separately. Is Year 1 M&O counted twice?	No. Year 1 M&O and support costs will be counted only once. Evaluated Cost will equal the fixed-price implementation total plus the CY 2027–2031 recurring total in Submittal Form F, including licensing/subscription, M&O, support, and T&M not-to-exceed amounts. Licensing will be evaluated using the 500–750 Authorized User band. Year 1 costs are already included in the five-year recurring total and will not be added separately.

Question ID	RFP Section Reference	Question	Response
126	Section 4.3, page 59; Section 3.6.2, page 47; Attachment 4, Section 27, page 26	The RFP states "Offerors must identify all pricing assumptions, dependencies, and conditions applicable to the proposed pricing." Where should narrative related to these assumptions be included? It is not explicitly asked for in other submittal narrative sections, nor is there a clear place for it in the pricing submittal form. Also, given Attachment 4 Section 27, how will these assumptions be incorporated into the resulting contract?	Submittal Form F – Cost Proposal has been enhanced to accommodate Offerors' pricing assumptions, dependencies, and conditions. Offerors should provide the applicable information in the revised Cost Proposal. Refer to Amendment #3 for supporting detail and the revised Submittal Form F. Pricing assumptions submitted by the selected Offeror do not independently modify the RFP or resulting Contract. Any pricing assumptions accepted by Comagine Health will be addressed, as applicable, in the resulting Contract and its incorporated attachments. The Contract's order-of-precedence provisions will govern in the event of any conflict or inconsistency among Contract documents.
127	Section 3.1.1, page 25; Attachment 3, Submittal Form F, Section A	Is the MVP go-live June 30, 2027 (RFP Sec. 3.1.1) or July 31, 2027 (Form F milestones M9/M10)?	The planned MVP go-live date is June 30, 2027, consistent with RFP Section 3.1.1. Submittal Form F has been revised to correct the conflicting dates for milestones M9 and M10. Please use the revised workbook and refer to the response for question #41.

Question ID	RFP Section Reference	Question	Response
128	Section 2.2.2, page 22	If a statewide directory partner will provide resource directory services, should Offerors price resource directory capabilities as base scope, as optional, or exclude them?	Offerors should provide pricing for integrating their client record and referral management functionality with a statewide directory partner. No additional resource directory functionality will be required. However, if an offeror would like to provide what their resource directory option would cost, it will not count against them.
129	Attachment 6, Section 8.2.1, page 28 and Appendix II, page 41; Attachment 7, Appendix B, page 42	Should Client Identity Management federate with the HHS Coalition MPI / state of Washington eMPI, or serve as the authoritative identity index for WA CIE?	Please refer to the response for question #25.

Question ID	RFP Section Reference	Question	Response
130	Attachment 6, Sections 5 and 5.1.4	Can Comagine Health confirm that an intended function of the CIE platform will be to both collect and distribute information such as Consent Status, Resource Directory Information, and data elements from a given Client record back down to Local Systems? If yes, does this include determining the most accurate or recent information to persist centrally, or is the CIE expected to append records with the most recent information received from any given local system (i.e., treat information agnostically from all sources)? Please also elaborate on the distribution of data back down to local systems. Is the CIE intended to push data to local systems on a consistent, agnostic basis, or is it expected to broker information between local systems to avoid pushing data that might not be helpful and would create noise? For example, Local System A has an older resource directory entry but keeps pushing that older data up to the CIE. The CIE has more recent and accurate information about that entry, and so refuses to publish the older information and/or propagate it down to Local Systems. Is this an expected function, or should Local Source data always be trusted and taken "as it comes" into the system?	WA CIE is intended to provide shared infrastructure for cross-sector care coordination through use of the WA CIE Portal and system-to-system interoperability. Data governance policies and implementation decisions related to data management (e.g. data storage, historical tracking, data provenance, and overwrite logic) will be developed in collaboration with the HCA, WA CIE Participant Organizations, and CIE Governance Committees. Data shared with WA CIE Participant Organizations will reflect the current information available in the WA CIE Client Record. Each Participant Organization will apply its own data governance and data management policies, including overwrite logic, to determine how incoming WA CIE data is ingested, reconciled, and managed within its own systems.

Question ID	RFP Section Reference	Question	Response
131	Section 3.1.1, page 25	Does Washington State currently have an existing Enterprise Master Patient Index (EMPI) or statewide identity management solution that the CIE platform is expected to integrate with? If so, can you provide details on the existing solution, available APIs or integration methods, and whether it will serve as the authoritative source for statewide client identity resolution? If no existing EMPI is available, should the proposed solution include the implementation of a new EMPI capability?	Please refer to the response for question #25.
132	Section 3.5.3, page 44; Attachment 2, Submittal Form E	Is HITRUST certification required for every hosted component, including Subcontractor platforms? Will a HITRUST roadmap with a target date be accepted if certification is in progress at MVP? Where the solution includes two hosted platforms, should Offerors submit one combined Form E or one per platform?	Please refer to the response for question #45.

Question ID	RFP Section Reference	Question	Response
133	Section 3.1.1, pages 25–26	We understand that the Phase 1 MVP is expected to support approximately 150 health and social service organizations. The RFP also states that the MVP will include approximately six to eight interoperability partners. Please clarify whether an interoperability partner represents an individual organization, technology platform, system instance, or distinct production interface. Additionally, please identify the anticipated number of production interfaces the Contractor will be responsible for implementing and confirm whether all approximately 150 organizations must be operationally onboarded by the June 30, 2027 MVP launch date or whether onboarding may continue during the stabilization period.	Please refer to the responses for questions #55 and #94.
134	Section 2.1.3, pages 16–17; Section 3.3.2, Deliverable 6, page 34	Has Comagine Health identified the systems, vendors, and individual system instances expected to be included in the six to eight MVP interoperability partnerships? If so, please provide the available interface inventory, including the organizations involved, source and target systems, existing integration capabilities, available APIs or file-exchange methods, and the anticipated direction of data exchange.	The six to eight CCHs who will be participating in the MVP are currently using the following technologies for the client management systems: Ready Computing, CCH Health, VisionLink, Julota, and Elora. Work is currently underway to collect more specific information regarding available APIs or file-exchange methods for bi-directional exchange.

135	Section 3.6.11, pages 54-55; Attachment 1, Submittal Form A, Section 7	The cyber insurance liability limits required are significantly higher than the industry standard for the type and function of technology being deployed, based on our direct experience with similar deployments in at least five states. The RFP states "...the Contractor shall maintain Cyber Liability / Information Security insurance covering, as applicable." Can Comagine clarify what is considered "applicable" given the scope and function of this specific software service in relation to HCA Contract K8582?	The phrase “as applicable” refers to the cyber/privacy risks and coverage components applicable to the Contractor’s WA CIE solution and Services. It does not make the required Cybersecurity and Privacy Liability coverage or stated limits optional. The Sample Contract requires coverage appropriate to the technology, hosting, data, and security risks associated with the WA CIE solution, including the specified categories of first-party costs and third-party claims, as applicable. The insurance requirements reflect requirements applicable to the WA CIE Contractor under HCA Contract K8582. Attachment 6 expressly provides, however, that those requirements are subject to a modification or variance approved in writing by Comagine Health and HCA, where HCA approval is required. Accordingly, an Offeror may request an insurance variance if it believes the required limits are not proportionate to its proposed solution, scope, or risk profile. Any variance will be evaluated based on the proposed solution and supporting rationale and will be subject to HCA approval where required. Until a variance is approved, Offerors should assume the stated insurance requirements apply.

136	Section 3.6.11, page 55; Attachment 1, Submittal Form A, Section 7, page 11; Attachment 4, Section 15, page 15	RFP Sec. 3.6.11 states that "Comagine Health may consider a written request for an insurance variance." Can Comagine clarify how and when such a request should be submitted, and how to respond to Submittal Form A, Section 7, item 3 if a respondent intends to submit one? May required limits be met in combination across the Prime Contractor and its Subcontractors? Please also confirm that insurance for lower-tier subcontractors may be set by the Prime Contractor based on each subcontractor's scope.	An Offeror seeking an insurance variance should identify the requested variance and supporting rationale with its proposal, so that the request can be considered during evaluation and, if the Offeror is selected, finalized during contract negotiations. Any variance is subject to Comagine Health's approval and, where required under HCA Contract K8582, HCA's prior written approval. Until a variance is approved in writing, the stated insurance requirements remain applicable. For Attachment 1, Submittal Forms A-D, Section 7, item 3, the Offeror should answer True only if the Offeror and applicable subcontractors can obtain and maintain the required insurance, subject to any variance ultimately approved in writing. If the Offeror cannot satisfy the requirement absent a requested variance, the Offeror should answer False and explain the requested variance in the Explanation section. The form expressly requires supporting detail for “False” responses and permits supporting detail for “True” responses. Required insurance limits may not be assumed to be satisfied by combining coverage limits across the Prime Contractor and its subcontractors unless such an arrangement is

Question ID	RFP Section Reference	Question	Response
			expressly approved as part of an insurance variance. The Prime Contractor remains responsible for satisfying the resulting Contract's insurance requirements and for the performance and compliance of its subcontractors. For lower-tier subcontractors, the Sample Contract provides that the Prime Contractor must require approved lower-tier subcontractors and service providers to maintain insurance appropriate to the nature and scope of the services they perform and the associated risks, including any insurance requirements required to be flowed down under the Prime Contract. Accordingly, lower-tier insurance need not automatically mirror every limit applicable to the Prime Contractor unless the applicable flow-down requirements require it.

Question ID	RFP Section Reference	Question	Response
137	Section 3.2, page 27	1. How will batch processing failures be classified—Critical, High, or another severity level—given their operational importance? 2. Can the State share historical batch failure patterns to calibrate M&O staffing and escalation models?	1. Batch processing failures will be considered of a “High” severity level and must be monitored and alerts sent when abnormal values or failures occur (see NFR9). 2. WA CIE represents a completely novel addition to the social care data integration in Washington State. There is no previous or existing system that could provide analogous data engineering or software systems failure patterns for comparison.
138	Section 3.5.4, page 44	Can the state please let us know the expected No. of ETL Jobs/month, No. of Tickets/month, No. of User Queries/month, No. of Reports/month, Training Hours / Month, User Onboarding and decommissioning/month, Access privileges/month, Upgrades/patches/Vul remediation (per month) and Performance tests to be conducted per month	WA CIE is a new system, and definitive monthly volumes for the requested activities are not currently available. Offerors should develop their staffing and pricing based on the RFP scope, required service levels, and proposed solution, and clearly document volume and workload assumptions in Submittal Form F. Reporting frequencies are specified in Attachment 10. Maintenance, vulnerability remediation, and testing must meet the applicable requirements regardless of assumed monthly activity counts. Please also refer to the response for question #82 for support-volume guidance.

139	Section 1.5, page 8; Attachment 1, Submittal Form A, Sections 12 and 12.1	Section 12.1 asks for three business references for the Offeror. When the Offeror proposes subcontractors, must three references be provided for each subcontractor as well, or are three references in total for the proposing team sufficient? May subcontractors provide one or more of the required references, including to satisfy the Section 12 Reference Specifications such as two production implementations of the main proposed technology solution?	Three business references in total are required; three separate references are not required for each proposed subcontractor. References may include relevant experience of the Prime Offeror or a proposed subcontractor where that entity will perform the corresponding work under the proposed WA CIE solution. The references submitted collectively must demonstrate compliance with the Reference Specifications in Section 12, including two successful production implementations within the last five years of the main proposed technology solution, referenceable experience creating APIs between disparate systems for secure information exchange, and referenceable experience evaluating the effectiveness of technology solutions in meeting program goals. Accordingly, a proposed subcontractor may provide one or more of the three required references, including references supporting the required production implementations of the main proposed technology solution, provided the Offeror clearly identifies the entity whose experience is being presented and that entity's role in the proposed WA CIE solution. This is also consistent with Submittal Form B, which expressly permits similar-project

Question ID	RFP Section Reference	Question	Response
			experience to have been developed and implemented by the Offeror, a proposed subcontractor, or proposed Key Personnel, with the Offeror identifying how its proposed team was involved.
140	Attachment 1, Submittal Form A, Section 12.2	Are Endorsements under Submittal Form A, Section 12.2 intended to be from organizations that will be served by the Washington State CIE only, organizations from Washington State only, or are they unrestricted?	Endorsements under Submittal Form A, Section 12.2, Letters of Endorsement, are optional and are not restricted to organizations in Washington State or to organizations that will be served by WA CIE. As stated in Section 12.2, endorsements may come from partners, customers, or community organizations that express support for the Offeror or its proposed solution.

141	Section 1.1.2, page 7; Section 3.2.2, page 30; Sections 5.4, 5.5, 5.10.1, pages 60-64; Q&A Responses to Question IDs #4 and #6	Section 1.1.2 states that Comagine Health seeks a "configurable, pre-existing solution" and prefers "a proven, commercially available solution that can be configured to meet WA CIE requirements rather than one built from the ground up." Section 3.2.2 asks Offerors to explain "how the proposed solution's components and capabilities work together" to meet the System Requirements. Q&A #4 addressed the standard/configured/customized breakdown but not the following: (1) If an Offeror proposes a solution made of separate commercially available products, each proven in production, but those products have not yet been deployed together as one integrated solution, will the PEC treat that as a configurable, pre-existing solution under Section 1.1.2? How will this affect scoring under Section 5.4 (Experience and Qualifications, Form B) and Section 5.5 (Technical Understanding and Approach, Form C), and which product is the "main proposed technology solution" for the Form A minimum qualification addressed in Q&A #6?	Offerors are welcome (and largely expected) to partner with other vendors and bring forth proposals for an integrated solution(s). However, all individual technological parts of the larger proposed integrated solutions need to have been used, tested, and proven to be fit for purpose. We understand that not all the tools in a proposed tech stack may have been previously deployed together so, in response to (1) YES, the PEC will treat that as a configurable, pre-existing solution. However, Offerors should make it amply clear which technology in the stack they are designating the main proposed technology. For the second question (2), requiring Offerors to show the "proposed solution's current capabilities," we would expect the Offeror to demonstrate how each component operates (along with their integration points), and how those tools would and could interact together to complete the series of capability workflows.

Question ID	RFP Section Reference	Question	Response
		(2) For the System Demonstrations in Section 5.10.1, which require Offerors to show the "proposed solution's current capabilities," may an Offeror demonstrate each component separately along with the integration points between them, or must the demonstration show the components working as one integrated system?	
142	Attachment 1, Submittal Form D, page 25; Attachment 10, pages 1-2	Can Comagine Health share the intended process and/or outcome metrics it anticipates reporting on, to measure both the success of the technical implementation this RFP seeks proposals for and the success of the CIE overall (for example, population health and/or quality improvement metrics)?	Please refer to the response for question #73.

143	Section 3.5.3, page 44; Attachment 5; Attachment 9, pages 8-9	Section 3.5.3 states that “contractors must submit current HITRUST and SOC 2 certifications” before the initial MVP launch and annually thereafter, and Attachment 9 Section 4.6 requires a SOC 2 Type 2 report at go-live. Please confirm whether both are required, or whether a current SOC 2 Type II report will meet this requirement without HITRUST certification. If HITRUST is required, please also clarify: (a) which HITRUST assessment level will meet the requirement — will an e1 (Essentials, 1-year) or i1 (Implemented, 1-year) certification be accepted, or is an r2 (Risk-based, 2-year) certification required; (b) if r2 is required, how the annual submission requirement in Section 3.5.3 applies, given that r2 certification runs on a two-year cycle with an interim assessment in between; (c) whether the requirement applies to the Prime Contractor only, or also to each Subcontractor and Third-Party Service Provider as defined in the Glossary; and (d) whether an Offeror that does not hold HITRUST certification at proposal submission will be considered responsive if it commits to achieving certification at the required level before the initial MVP launch.	Please refer to the response for question #45.

Question ID	RFP Section Reference	Question	Response
		For SOC 2: A Type 2 report requires an observation period of 6–12 months, which the WA CIE production environment will not have accrued by the MVP launch date. Please confirm that a current SOC 2 Type 2 report covering the Offeror's platform and hosting environment satisfies the go-live requirement, with a SOC 2 Type 1 report or bridge letter for the WA CIE instance.	
144	Attachment 9, Section 4.1, page 4; Attachment 10, page 2	Is the monthly Annual Business Plan progress report due the third Friday (QAP Section 4.1) or the fourth Friday (Attachment 10)?	The monthly Annual Business Plan Progress Report is due to Comagine Health by the third Friday of each month. This deadline supports Comagine Health's subsequent reporting to HCA. Attachment 10 will be amended to match Attachment 9, Section 4.1.

Question ID	RFP Section Reference	Question	Response
145	Attachment 9, Section 4.3, page 5 and Section 6, page 12	For the deliverable timeliness remedy ($2,500 per Business Day until delivered and accepted), does the late-day count pause during Comagine Health's review period and during any resubmission cycle?	Comagine Health will not count its own review period under Attachment 9, Quality Assurance Plan, Section 6, as days late under Section 4.3. Late days under Section 4.3 accrue each Business Day from the approved due date until the Contractor submits a deliverable that conforms to the acceptance criteria, excluding any Business Days during which the deliverable is under Comagine Health review. A deliverable that does not conform to the acceptance criteria is not considered timely delivered. If Comagine Health identifies a deficiency, late days resume on the next Business Day after the Contractor receives written notice of the deficiency and continue until a conforming deliverable is resubmitted.

146	Section 1, page 7; Attachment 9, Section 4.7, page 10; Attachment 4, Section 16, page 16; Q&A Response to Question ID #28	RFP Section 1 identifies MTP 2.0 Section 1115 waiver funds as the current WA CIE funding source, while Attachment 4 Section 16 requires compliance with 45 CFR 95.617 and 42 CFR Part 433 Subpart C (federal financial participation), and Attachment 9 Section 4.7 applies CMS Streamlined Modular Certification remedies of up to $250,000 per month "to the extent WA CIE is subject to CMS review or certification." Q&A #28 confirmed Section 4.7 is conditional but did not state whether the condition is met. Please confirm whether HCA has submitted, or intends to submit during the contract term, an Advance Planning Document claiming enhanced Federal Financial Participation for WA CIE under 42 CFR 433.112 or 433.116, such that CMS Streamlined Modular Certification would apply. If not, will Attachment 9 Section 4.7 be marked inapplicable in the resulting contract? If so, please identify the anticipated certification scope and timeline so Offerors can price certification support.	Attachment 9, Section 4.7 is conditional and applies only to the extent WA CIE is subject to CMS review or certification, including Streamlined Modular Certification or Conditions for Enhanced Funding. If CMS certification requirements become applicable to WA CIE, the applicable certification requirements, scope, schedule, and Contractor responsibilities will be established in coordination with HCA and incorporated into the Contract as appropriate. Section 4.7 provides that certification support is performed according to the approved integrated project work plan. If WA CIE is not subject to CMS review or certification, the requirements and remedies in Section 4.7 would not apply by their express terms.

Question ID	RFP Section Reference	Question	Response
147	Attachment 9, Section 4.4, page 6	Are outages and interface failures caused by participant systems, State systems, or other third parties outside the Contractor's control excluded from the uptime and API availability calculations?	Please refer to the response for question #111.
148	Section 3.4.4, page 40; Attachment 5, Functional Requirements tab	RA03 requires reporting to include “anticipated CMS and HCA reporting requirements.” Please identify the CMS reporting obligations (for example, MTP 2.0 Section 1115 monitoring, evaluation, or milestone reports) that WA CIE data must support, and confirm whether report specifications will be provided during Requirements Validation (Milestone M2).	The Contractor will be provided whatever MTP 2.0 monitoring, evaluation, or milestone reports are ready at the time of contracting. They should be prepared to provide the tools and support to develop between 10-20 additional formatted report templates that will be used during and beyond the MVP phase.
149	Attachment 9, Section 4.4, page 6	For API availability measured "per interface," does an interface mean each API exposed by the solution or each connected participant system?	The Offeror should list and specify and count both the number of possible API that could be connected by the CCH’s systems (6-8), as well as those that would expose capability components to network-accessible, public or partner-facing access allowing external applications or third-party services to interact with outside its normal internal trust boundary. For the purposes of measurement an interface in this case refers to each API exposed by WA CIE.

Question ID	RFP Section Reference	Question	Response
150	Attachment 9, Sections 4.3, page 5 and Section 6, page 12	Section 4.3 assesses $2,500 per Business Day until a deliverable is “delivered and accepted,” and Section 6 provides Comagine Health ten Business Days to review, extendable by ten. Please confirm that the lateness clock is suspended during Comagine Health’s review period and during any period in which a deliverable is awaiting Comagine Health inputs, decisions, or dependent third-party actions, and that it resumes only if a resubmission following a documented deficiency is late.	Please refer to the response for question #145
151	Attachment 9, Section 4.7, page 10	Please confirm whether CMS certification (Attachment 9 Section 4.7) applies to WA CIE. If so, will the $250,000 per month remedy be limited to reductions in Federal Financial Participation caused solely by the Contractor's failure?	Please refer to the response for question #146 for supporting information.

Question ID	RFP Section Reference	Question	Response
152	Section 3.3.2, Deliverable 6, page 34; Section 3.6.2, pages 46–47	Please clarify whether the Contractor is responsible for costs charged by participating organizations or their technology vendors to enable, configure, test, or maintain integrations, including API access, connector licensing, vendor professional services, and interface fees. If these costs are the Contractor's responsibility, should they be included in the fixed-price implementation milestones or identified separately as assumptions or pass-through expenses?	The Contractor is responsible for all costs to design, build, configure, test, and maintain the WA CIE side of each required integration. This includes the WA CIE APIs, connectors, transformation and mapping, and any third-party products the Contractor relies on (RFP Section 1.14.3). These costs must be included in the Contractor's firm-fixed-price implementation milestones and recurring charges in Submittal Form F – Cost Proposal. The Contractor is not responsible for costs that participating organizations or their technology vendors charge to enable, configure, test, or maintain integrations on the participant side. These costs should not be included in the Contractor's pricing. Participant readiness and integration commitments will be addressed through Participation Agreements and Participant Implementation Plans developed by Comagine Health, as described in the response to question #56.

Question ID	RFP Section Reference	Question	Response
153	Section 3.6.10A, page 53; Attachment 4, Section 14, page 14; Attachment 9, Sections 7.4-7.5, page 13	Offeror requests that the limitation of liability negotiated under RFP Sec. 3.6.10A cover the indemnification in Attachment 4 Section 14, with a defined cap for any breach-related carve-outs. Offeror also requests negotiation of QAP Section 7.5 (remedies outside the limitation of liability) and Section 7.4 (program-related cost recovery).	Comagine Health acknowledges the requested changes. The allocation of liability, including the scope of any limitation of liability, applicable exclusions or carve-outs, indemnification obligations, and the treatment of QAP remedies and program-related cost recovery, may be addressed during final contract negotiations with the selected Offeror. The Sample Contract's indemnification provisions and the QAP remedy provisions remain applicable as issued unless modified in the resulting Contract. Attachment 9 currently provides that program-related financial consequences are recoverable only to the extent attributable to Contractor failure and prohibits duplicative recovery for the same event. It also currently states that QAP performance-based remedies are separate from and do not count against a limitation of liability in the Agreement. Accordingly, Comagine Health does not agree through this Q&A to a specific liability cap, to include indemnification within such a cap, or to establish a separate cap for particular carve-outs. Any agreed changes will be reflected in the final Contract.

Question ID	RFP Section Reference	Question	Response
154	Section 3.3.2, Deliverable 7, page 34; Section 3.5.1, page 43	Please identify the minimum datasets and data elements that each MVP interoperability partner will be expected to exchange. Will Comagine Health provide approved minimum data requirements, canonical data models, terminology standards, and required source-to-target mappings before implementation, or will the Contractor be responsible for developing these through requirements validation?	A minimum data set is being collaboratively developed with the CCHs and partner organizations participating in the MVP. This minimum data set will be provided to the Contractor by Comagine Health. Moving forward, the coordination of this and all other data sets and standards will be the responsibility of the Data Governance Committee. The contractor will be responsible for developing and implementing the outputs of these activities with guidance from Comagine and the Data Governance Committee.
155	Section 3.2.2, page 30; Section 3.3.2, Deliverable 7, page 34	When participant data does not meet WA CIE data-quality, completeness, terminology, or formatting requirements, will the Contractor be responsible only for identifying and reporting the issue, or will the Contractor also be expected to cleanse, correct, or remediate data within participant source systems? Please clarify the respective responsibilities of the Contractor, Comagine Health, and participating organizations.	WA CIE interoperability capabilities are designed to "meet CIE participants where they are," enabling integration with data in both standardized and non-standardized formats. While the Contractor will not be responsible for cleansing, correcting, or remediating data within participant source systems, the WA CIE technical infrastructure must support the mapping, translation, normalization, and transformation of incoming data as needed to integrate it into the WA CIE system and associate it with the appropriate client records.

Question ID	RFP Section Reference	Question	Response
156	Attachment 4, Section 13, page 13 and Section 16, page 17	Which prime contract terms govern ownership of work product developed for WA CIE? How does 45 CFR 95.617 apply to pre-existing commercial platforms and their configurations?	The intellectual property and work product provisions applicable to the Contractor are set forth in Attachment 4, Section 13, Data, Work Product, and Intellectual Property Rights, together with the applicable HCA flow-down requirements incorporated into the RFP and resulting Contract. Pre-existing commercial software, platforms, tools, methodologies, and other intellectual property owned or licensed by the Contractor are not converted into WA CIE-owned work product solely because they are used or configured in performing the Contract. Ownership and applicable rights in configurations, customizations, interfaces, documentation, and other materials developed under the Contract will be governed by Attachment 4, Section 13 and applicable federal requirements, including 45 CFR 95.617. Offerors should identify any pre-existing or third-party intellectual property incorporated into their proposed solution and any associated licensing or use restrictions as required by the RFP. The resulting Contract will govern the parties' respective ownership and license rights.

Question ID	RFP Section Reference	Question	Response
157	Section 3.2, pages 27–30; Section 3.6.2, pages 46–47; Attachment 3, Submittal Form F	Does Comagine Health have established criteria for categorizing participant integrations by size or complexity, such as small, medium, and large? If not, may Offerors propose their own definitions based on factors such as number of interfaces, exchange direction, data volume, integration method, transformation complexity, security requirements, and testing effort?	Comagine Health has an existing framework for assessing the complexity and level of effort associated with WA CIE interoperability (please reference Concept of Operations Appendix III, https://www.hca.wa.gov/assets/program/wa-cie-concept-of-operations.pdf). This framework will be refined in partnership with the Contractor, incorporating technical input informed by the WA CIE system design and development process. The Contractor is encouraged to share any existing definitions, methodologies, or frameworks for assessing integration complexity in relationship to the WA CIE Utilization Models.
158	Section 3.1.1, pages 25–26; Section 3.6.2, pages 46–47	Please clarify whether integrations added after the initial six to eight MVP interoperability partners are expected to be included within the proposed fixed recurring maintenance and operations fees, priced as separately authorized time-and-materials work, or handled through a new fixed-price milestone or contract amendment.	It is the intent of WA CIE to grow its ecosystem of integrated participant organizations in future phases beyond MVP. Integrations beyond the initial MVP cohort should be priced as separately authorized time-and-materials work.

Question ID	RFP Section Reference	Question	Response
159	Section 3.5.1, page 43; Section 3.6.8, pages 51–52	Section 3.5.1 states that the functional requirements are not exhaustive and will continue to evolve, while Section 3.6.8 states that refinement, elaboration, or clarification of requirements within the existing scope does not necessarily constitute a compensable scope change. Please clarify how Comagine Health will distinguish requirements refinement within the fixed-price implementation scope from a new or materially expanded requirement eligible for change-control authorization.	As stated in section 3.5.1, “The functional requirements provides a list of mid-level functional requirements, implementation phase, and the core capability to which it relates.” The initial scope document provided to the contractor will focus on the implementation of MVP – Phase 1, and all “refinement, elaboration, or clarification of requirements” should be limited and relative to operationalizing and adjusting those requirements’ role in deploying the core capabilities in that initial phase (MVP). As the work progresses in future phases (2+), greater definition of the product road map will be developed with Comagine Health, WA CIE Technology Utilization Workgroup (and Community of Practice) in collaboration with Contractor. At that point section 3.6.8 will be far more instructive in identifying which may be those “Changes that materially affect the scope of work, deliverables, schedule, price, or other contractual obligations”, and would be eligible for change-control authorization.

Question ID	RFP Section Reference	Question	Response
160	Section 2.2.2, pages 21–22; Section 3.1.1, page 25; Section 3.3.2, Deliverable 7, page 34	Does Washington currently have an approved statewide client identifier, master person index, identity-resolution service, or authoritative identity source that the Contractor must use for the MVP? If not, is the Contractor expected to implement the client identity-matching capability, and what matching accuracy, duplicate-rate, or manual-review thresholds will apply?	Please refer to the response for question #25.

161	Section 3.6.13, pages 57-58; Attachment 4, Section 22, pages 21-22	Is the up-to-365-day transition period after expiration or termination paid at the contract's recurring rates? Does it apply after a termination for convenience? Offeror also requests negotiation of the advance consent to assignment of subcontracts to HCA.	Yes. Under Attachment 4, Section 22, transition services that are part of the Contractor's existing obligations will be compensated at the applicable prices established under the Contract, including applicable recurring rates for continued recurring services. Additional transition services outside the existing Scope of Work must be separately authorized in writing and will be compensated at the applicable Contract rates or as otherwise agreed in writing. The transition requirements apply following expiration or termination of the Contract and are not limited to termination for default. Accordingly, they may apply following a termination for convenience to the extent transition services are required. Comagine Health may require applicable services to continue for up to 365 days following expiration or termination, or for a shorter period specified by Comagine Health. With respect to assignment, the advance-consent provision implements HCA's right, upon expiration or termination, to require assignment of the applicable agreement or System Operations services to HCA or its designee to support continuity of WA CIE operations. The RFP similarly states that the resulting Contract will provide for assignment

Question ID	RFP Section Reference	Question	Response
			of applicable System Operations subcontracts or agreements consistent with HCA's rights under Contract No. K8582. Comagine Health is not revising this requirement through this clarification. Offerors may identify requested contract exceptions or proposed revisions in accordance with the RFP's contract negotiation process.
162	Section 2.2.2, pages 21–22; Section 3.1.1, page 25; Section 3.3.2, Deliverable 6, page 34	Will the MVP integrate with an existing consent-management service or repository, or must the Contractor provide and configure the system of record for client consent? Please identify any existing consent systems, required consent standards, and participating organizations expected to exchange consent information during the MVP.	Please refer to the response for question #25. All organizations participating in MVP who are currently collecting consent information are expected to share/exchange this data.
163	Section 3.3.2, Deliverables 9 and 10, page 35; Section 3.4.6, page 42	Will participating organizations and their technology vendors be required to provide test environments, technical resources, representative test data, and timely support for interface development and acceptance testing? How will schedule or acceptance obligations be handled when a participant or third-party vendor is not ready or delays required access, testing, or approvals?	Only the Contractor will be responsible for providing a test and production/live environments, with technical resources and appropriate synthetic data for acceptance testing. Comagine Health will be responsible for scheduling and coordinating with participant organizations and/or their third-party vendors.

Question ID	RFP Section Reference	Question	Response
164	Section 3.5.4, pages 44–45; Section 3.3.2, Deliverable 6, page 34	Please clarify whether the Contractor’s Tier 2 and Tier 3 support responsibilities include participant-owned systems and third-party integration endpoints, or whether the Contractor is responsible only for the WA CIE platform and interfaces under its direct control. How will incidents involving multiple vendors be assigned and measured against service levels?	The Contractor's Tier 2 and Tier 3 support responsibilities apply only to the WA CIE platform and the integrations to partner systems. The Contractor is not responsible for providing Tier 2 or Tier 3 support for participant-owned systems or third-party systems outside the Contractor's scope. For incidents involving multiple systems or vendors, the Contractor is expected to support troubleshooting, incident coordination, testing, and resolution for the WA CIE platform and its integrations, including working with Comagine Health and applicable third parties to identify the source of the issue. Service levels will apply to the Contractor's responsibilities under the RFP and resulting Contract.

165	Section 2.1.2, page 16; Sec. 2.2.2, page 22; Section 3.1.1, page 25; Section 3.2, pages 27-29; Section 3.2.2, page 30; Section 3.3.2, pages 34-35; Section 3.5.1, page 43; Section 3.6.2, page 47	1. How many internal users, external users, and administrators are expected to use the system? 2. How many organizations will use the portal directly, and how many will access it through integrations? 3. What are the expected volumes of client records, referrals, assessments, and care coordination activities? 4. Which existing systems need to be integrated at go-live, and will the integrations be one-way or bi-directional? 5. Which integrations require real-time data exchange, and which can use scheduled synchronization? 6. Which existing systems require historical data migration, and how many years of data need to be migrated? 7. What is the estimated volume of records, documents, and attachments, and will existing vendors provide data exports? 8. How many intake forms, assessments, consent forms, and organization specific workflows need to be configured at launch? 9. How many organizations and users need to be onboarded and trained before go-live? 10. How many standard reports, custom reports, and dashboards are required at launch? 11. Will existing statewide client identity and consent management systems be used,	For Questions 1-4, 9, and 11: Please refer to the response for questions #35, #67, #82, and #25. Q5: All Care Coordination and Referral Management data should strive to be as close to real-time as possible. All other capabilities' scheduling synchronization can be negotiated. Qs 6-7: Please refer to the response for question #26. Q8: Information on workflows, assessments, and necessary forms to be shared are currently being collected from the CCHs and will be shared with the Contractor when available. Q10: Please refer to the response for question #148.

Question ID	RFP Section Reference	Question	Response
		or must the selected vendor implement these services?	
166	Attachment 3, Submittal Form F, Implementation Milestones tab	Submittal Form F instructions state the "Cells in BLUE are inputs to be completed by the offeror. All other values are formulas." The tab 'Implementation Milestones" has editable values in the "Fixed Price" and "% of total" cells. These cells are not shaded BLUE. "Fixed Price" values are calculated based upon the "% of total". Are the values stated in the "% of total" sample values and are they are editable input by the offeror?	Please refer to the response for question #89.

Question ID	RFP Section Reference	Question	Response
167	Section 3.6.2, pages 46-47	What baseline number of integrations and onboarding activities must be included in fixed-price implementation and recurring operations? May offerors specify quantities and unit prices for additional interfaces or onboarding waves, and when would these be authorized through change control?	For number of estimated MVP (Phase 1) implementations, please refer to the response for question #35. However, Offerors are welcome to propose specific quantities tiers and unit prices for additional interfaces in future phases or onboarding waves. Interfaces to additional participating organizational systems would be authorized through change control in later phases, after MVP (Phase1) has been successfully completed (possibly within 90 days of contract start date).
168	Section 2.2.2, pages 21–23	ConOps §8.2.1 anticipates use of existing statewide services. Which identity, consent, directory, and exchange services will actually be available for MVP, and which must the offeror supply?	The Contractor must provide all foundational capabilities functionalities described in the WA CIE Concept of Operations: SEC 7.2 Capabilities and User Research Mapping Table (with the exception of a Resource Directory) that will be needed for onboarding, cross organization coordination, and consistent statewide information-sharing at the beginning of the MVP (Phase 1). All capabilities (including Resource Directory, whose resource data will be provided interoperably from a state contractor) should be integration-ready and able to connect with states systems (MPI, ConsentLink, ProviderOne, etc.) as soon as they are interoperable and available.

Question ID	RFP Section Reference	Question	Response
169	Section 3.3.2, Deliverable 12, pages 35–36	Please provide planning estimates for organizations and authorized users to be onboarded by MVP and in subsequent years, distinguishing portal-only participants from system-integrated participants. What onboarding waves or minimum participation targets should offerors price?	Please refer to the responses for questions #165 and #167.
170	Section 2.2.2, pages 21-23; Q&A Response to Question ID #24	Under the federated resource directory approach noted in the Vendor Q&A question #24, will Comagine Health/HCA secure the required data-sharing agreements and API credentials with third-party directory providers (Findhelp, Unite Us, WA211, others), or is the Contractor responsible for negotiating vendor access?	Yes. As the Lead Organization of WA CIE, Comagine Health will be responsible for negotiating and securing all required data-sharing agreements and API credentials with third-party directory providers.
171	Section 2.2.2, page 22	Is OpenReferral HSDS the required directory standard (NFR28), and which version? Is a particular service taxonomy expected (211/AIRS, Open Eligibility)?	WA CIE's federated Resource Directory approach will be built upon open, published, and freely accessible standards, including OpenReferral HSDS. In addition, as there are a variety of taxonomies currently being used across Washington State (Inform USA Standards (Version 10.0), 211HSIS, etc.), this approach will necessitate a Contractor who will be able to collaborate with resource directories across the state to coordinate, transform, and normalize I&R resource data across taxonomies.

Question ID	RFP Section Reference	Question	Response
172	Sec. 3.1, page 25	What transaction volumes (participant portal and data feeds) and concurrent users should we size for at MVP and in Phases 2–3?	Please refer to the responses for questions #22, #35, and #101.
173	Sec. 3.1.1, page 25 (and pages 17, 18, 19, 20, 21, 22, 24, 27, 34, 39)	Who makes the data steward decisions on manual matches, merges and unmerges: the vendor, Comagine, or participants?	Data governance rules and policies and procedures for data storage, sharing, handling, and other management will be developed and iterated upon through LO and HCA led WA CIE Advisory and working committees, as well as input from WA CIE Participants and other community input channels. Comagine Health and the Contractor will share responsibility for completing the merge and unmerge actions.
174	Section 2.1.2, page 16	Is ConsentLink meant to become the consent system of record when it is integrated with the Washington CIE in Phases 2 and 3?	WA CIE will maintain and manage independent consent capabilities for its participant ecosystem. However, it is expected that WA CIE will exchange consent data with the state's ConsentLink system as soon as ConsentLink's system is interoperable and available to integrate.
175	Section 3.1, page 25	Is the intention to leverage the CIE to create a Health Information Exchange (HIE) in the future?	No. WA CIE is not intended to become a Health Information Exchange (HIE). The CIE will interoperate with existing state of Washington health and social care infrastructure, including the state-designated HIE, to support the capabilities and use cases described in the RFP.

176	Section 3.5.3, page 44	Is HITRUST certification required by proposal submission, or only before MVP launch as Sec. 3.5.3 implies? Will a certification in progress be accepted? Will FedRAMP Moderate or GovRAMP authorization be considered equivalent or supplemental evidence? If a HIPAA environment is available and the platform aligns to NIST, ISO 27001 and PCI standards will that suffice	HITRUST certification is not, by itself, a prerequisite for proposal submission or passage of the Security Design Review (SDR). HITRUST and other third-party security certifications or assessments may provide supporting evidence toward a positive SDR outcome. The SDR applies to the proposed CIE solution as a whole, rather than requiring each individual vendor participating in a multi-vendor solution to independently complete and pass an SDR. The selected Offeror is responsible for coordinating the resources and supporting documentation necessary to complete and pass the SDR for the proposed solution within no more than six (6) months of procurement of the State-supported CIE technology. The SDR includes completion of the required Data Security Questionnaire and Attestation, submission of applicable supporting documentation, including security policies, procedures, and third-party assessment reports such as SOC 2 Type 2, participation in collaboration meetings with Comagine Health and HCA, and final review by the Office of Cyber Security.

Question ID	RFP Section Reference	Question	Response
			WaTech does not provide a separate, prescriptive SDR checklist. Certifications and third-party assessments referenced in the RFP, including HITRUST and SOC 2 Type 2, are examples of evidence that may support a positive SDR outcome. Such certifications do not replace the requirement for the proposed solution to successfully complete and pass the SDR.

177	Section 3.5.3, page 44; Attachment 5, Non-Functional Requirement NFR19	Section 3.5.3 and Attachment 5 NFR19 require current HITRUST and SOC 2 certifications. Please confirm: (1) whether the certifications must be held by the Prime Contractor, the proposed application/platform, the hosting provider, or collectively across the solution stack; (2) the required certification levels, including whether HITRUST r2 and SOC 2 Type II are required; (3) whether the certifications must exist at proposal submission, contract execution, completion of the Security Design Review, or before MVP launch; and (4) whether an Offeror may select "not currently compliant, but will be compliant before June 30, 2027" in Form E for these certifications without being deemed nonresponsive.	HITRUST certification is not, by itself, a prerequisite for proposal submission or passage of the Security Design Review (SDR). HITRUST and other third-party security certifications or assessments may provide supporting evidence toward a positive SDR outcome. The SDR applies to the proposed CIE solution as a whole, rather than requiring each individual vendor participating in a multi-vendor solution to independently complete and pass an SDR. The selected Offeror is responsible for coordinating the resources and supporting documentation necessary to complete and pass the SDR for the proposed solution within no more than six (6) months of procurement of the State-supported CIE technology. The SDR includes completion of the required Data Security Questionnaire and Attestation, submission of applicable supporting documentation, including security policies, procedures, and third-party assessment reports such as SOC 2 Type 2, participation in collaboration meetings with Comagine Health and HCA, and final review by the Office of Cyber Security.

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			WaTech does not provide a separate, prescriptive SDR checklist. Certifications and third-party assessments referenced in the RFP, including HITRUST and SOC 2 Type 2, are examples of evidence that may support a positive SDR outcome. Such certifications do not replace the requirement for the proposed solution to successfully complete and pass the SDR.

178	Section 3.6.2, page 59	Please define “authorized user” for the subscription band in Submittal Form F. Specifically: is the band based on named or concurrent users? Do organization administrators, read-only users, providers who only update directory listings or accept/close referrals, and system or API service accounts each count as authorized users? Can you provide counts for these?	For purposes of Submittal Form F, an “Authorized User” means an individual granted access to the WA CIE application based on an assigned role and associated permissions. The authorized-user tiers are intended to provide a standardized basis for budgeting and comparison of Offeror subscription pricing. WA CIE does not currently have definitive user/participant counts or a final distribution of users by role. Accordingly, Offerors should use the authorized-user bands provided in Submittal Form F to establish their tiered subscription pricing. The 500–750 Authorized User tier identified in Submittal Form F will be used for budgeting and cost comparison purposes and should not be interpreted as a commitment or guarantee regarding the actual number of WA CIE users. For purposes of pricing, Authorized Users are human users granted role-based access to the WA CIE application. System, integration, API, and other non-human service accounts should not be counted as Authorized Users. Pricing for any such technical accounts or services necessary to operate the proposed solution should be included in the applicable subscription, hosting, or other pricing identified in Submittal Form F.

179	Section 3.6.11, pages 53–56; Attachment 4, Section 15, pages 14–16	Will a proposal remain responsive if the Offeror does not currently carry the stated $25 million per occurrence/$50 million aggregate cyber liability coverage or $5 million per occurrence/$10 million aggregate crime coverage but requests an insurance variance? Please specify when the variance request should be submitted, the supporting information required, any minimum acceptable coverage levels, and whether Comagine Health can decide the request before contract award.	Offerors are not required to submit Certificates of Insurance (COIs) with their proposals. As required by Submittal Form A, Section 7, Mandatory Requirements & Certifications, Question 3, an Offeror must confirm that it and its related subcontractors can obtain and maintain all necessary insurance required for the project. The Offeror selected for award must provide COIs evidencing the required insurance coverage within ten (10) business days following the Notice of Intent to Award and, in all cases, prior to Contract execution. Section 3.6.11 provides that if the selected Contractor does not maintain the specified Cyber Liability limits, Comagine Health may consider a written request for an insurance variance. The request must be supported by information regarding the Contractor's current coverage, risk profile, proposed architecture, hosting arrangement, data access, and other relevant factors. Any reduction or variance requiring HCA approval is subject to HCA's prior written approval and is not effective unless incorporated into the resulting Contract. No minimum alternative Cyber Liability coverage level is specified in the RFP. The RFP also does not expressly extend the Cyber

Question ID	RFP Section Reference	Question	Response
			Liability variance provision to the Crime coverage requirement. Please also refer to the answers for questions #61, #62, and #123.
180	Section 2.1.2, page 16; Section 3.6.2, page 47	To price consistently, please provide the expected number of participating organizations and authorized users at MVP launch (June 2027), Phase 2, Phase 3, and each contract year through 2031. This should include the 9 CCHs, their 141+ network partners, and the "limited number" of additional social service providers.	Please refer to the responses for questions #35 and #178.
181	Section 3.2, pages 27-29	Under models 4–6, organizations work only from their own systems through data integration, without logging in to WA CIE. Do these organizations need licensed users? Should system-to-system connections or API transaction volume be priced separately from the user band?	While, for the most part, WA CIE connected organizations who will be participating in the workflows associated with models 4, 5, and 6 of the Utilization & Access Models (SEC. 3.2 of the WA CIE RFP), will be accessing WA CIE data and working within their native system environments, it is still expected that each of those organizations will require a nominal number of system users who will require participant portal access to WA CIE in order to complete functions such as organizational administration, analytics, or reporting.

Question ID	RFP Section Reference	Question	Response
182	Section 3.5.4, page 45	Should Comagine Health Tier 1 helpdesk staff, HCA staff, and governance or committee members who need system access be counted in the authorized-user band?	Yes. All estimated authorized users (including Tier 1 helpdesk staff, HCA staff, and governance or committee members, etc.) should be included in estimates listed in Section B: Licensing / Subscription Rate Card of Attachment 3: Submittal Form F.
183	Section 3.5.4, page 45	If actual users exceed the proposed band during the contract, how should Offerors structure true-up pricing? Will Comagine accept an alternative licensing metric, such as organization-based or platform pricing, if it is clearly stated in the Form F assumptions?	Offerors should provide monthly pricing for each authorized-user band in Submittal Form F, including pricing for more than 1,000 Authorized Users, and clearly describe any proposed true-up terms, thresholds, and pricing assumptions. The 500–750 Authorized User band will be used for budgeting and cost comparison. Any adjustments during the Contract will be governed by the resulting Contract. An organization-based or platform-based pricing assumption does not replace the required authorized-user pricing or constitute acceptance by Comagine Health. Offerors must complete Submittal Form F as instructed. Pricing assumptions may not conflict with the RFP requirements.

Question ID	RFP Section Reference	Question	Response
184	Section 5.7, pages 63-64	Evaluated Cost is defined in two ways. The first is the total over the full potential term, including T&M not-to-exceed services. The second is implementation, plus Year 1 M&O, plus the full 5-year recurring total, which appears to count Year 1 twice and may exclude T&M. Please confirm which formula governs and whether T&M not-to-exceed amounts are included.	Please refer to the response for question #125.

Question ID	RFP Section Reference	Question	Response
185	Attachment 3, Submittal Form F	The Submittal Form F, includes an Authorized Users licensing concept. Per the Concept of Operations, Users can include organizations from CCHs to 988, to AAAs and FQHCs as well as the public. In the future state (ConOps 6.1) care coordinators either: a. uses their local care coordination system that has integrated with WA CIE APIs for governed data access and exchange; or b. uses the WA CIE participant portal. In addition, many users (e.g. CCHs, Health Systems) have existing closed loop referral platforms which will not be funded by this RFP, but will be connected and integrated into the larger CIE. How then should these (CCH, health plan, health system) users be accounted for in the CIE "per user" model? And how are users defined given different types of access? Due to the complexity of defining a user (direct user, API user, visibility user) and the number of entities (e.g. MCOs, 988, CCH. 211) we suggest a change to either an entity-based pricing model, or an 'all in' or phased-in approach (e.g. 20% in year 1, 50% in year 2, 75% in year 3, 100% in year 4). This will simplify pricing, provide price predictability and encourage broad usage.	Offerors must complete the authorized-user pricing tiers in Submittal Form F. The Tier 2 band of 500–750 Authorized Users is used for budgeting and cost comparison. Offerors must clearly identify their licensing assumptions and any conditions affecting pricing. Organizations accessing WA CIE through integrated systems are expected to need some participant portal accounts for functions such as administration, analytics, or reporting. This does not establish that every user of a connected organization's existing system requires a separate WA CIE license. Please also refer to the response for question #181.

Question ID	RFP Section Reference	Question	Response
186	Section 3.1.1. page 25	Please list by name the “approximately six to eight interoperability partners” planned for MVP. For example, does this include each CCH client management platform (Connect2 Coordinator, CCS Health, Elora, Julota, VisionLink)?	The six to eight interoperability partners planned for MVP are listed by name in Appendix IV: ACH/CCH Current Landscape of the WA CIE Concept of Operations. Each CCH client management platform is listed in SEC. 2.1.3 CURRENT ARCHITECTURE of the RFP. Please refer to the response for question #134 for additional information.
187	Section 2.1.2, page 16	The RFP says the WA 211/Crisis Connections intake pathway and the two-way referrals between CCHs and MCO Findhelp instances are expected to be replicated in the initial phase. Are these included in the six-to-eight MVP count? Is each MCO’s Findhelp instance counted as a separate integration?	No. The 6-8 organizations participating in MVP are Community Care Hubs (and their contracted partner organizations). WA 211/Criss Connections will be participating as an integration partner to provide the statewide Resource Directory services which the contractor will have to interoperate with in order to operationalize Referral Management capabilities.
188	Attachment 3, Submittal Form F	How will Comagine evaluate Tier I and Tier 3 license prices? Would Comagine be open to including an unlimited tier?	Tier 2 pricing for 500–750 Authorized Users is used for budgeting and cost comparison. Tier 1 and Tier 3 pricing is requested for informational purposes and is not separately scored. Offerors must complete all required pricing bands in Submittal Form F. Comagine Health is not adding an unlimited-user tier, but offerors are encouraged to describe any assumptions that impact pricing in form F.

Question ID	RFP Section Reference	Question	Response
189	Section 3.2, pages 27-28	For each MVP integration, please identify the expected exchange method (real-time bidirectional API, batch, file-based, or secure messaging) and the utilization model (3, 4, 5, or 6) it is meant to support.	Information on expected utilization model and exchange methods are currently being collaboratively developed with the CCHs and partner organizations participating in the MVP. This will be provided to the selected Contractor by Comagine Health.
190	Attachment 3, Submittal Form F	Will CBOs be considered authorized users for pricing purposes? If so, the number of authorized users will depend greatly on the breath of the network?	Yes. Staff at participating community based organizations who are authorized to access or use WA CIE functionality are included as Authorized Users. User counts will depend on each organization's needs and implementation plan. For proposal pricing, Offerors must use the authorized-user bands in Submittal Form F rather than assume every organization or staff member in the broader network requires a license. Please refer to the responses for questions #58 and #66.
191	Section 2.2.2, pages 22	Sec. 2.2.2 mentions discussions with a statewide resource directory partner. Is the resource directory itself in the Offeror's MVP scope and pricing, or is the Offeror's scope limited to integrating with the partner's directory?	No. The Offeror's scope is limited to integrating with the partner's directory.

Question ID	RFP Section Reference	Question	Response
192	Section 3.1.1, page 25-26	How should Offerors price integrations added after MVP in Phases 2 and 3? Options include fixed-price per interface in Form F, T&M under the not-to-exceed rate schedule, or another approach.	Integrations added after MVP that are outside the contract and RFP described scope should be priced as separately authorized time-and-materials work in Submittal Form F, subject to an applicable not-to-exceed amount. Work may begin only with Comagine Health's prior written authorization. Any material change to contractual obligations requires a written amendment under Section 3.6.8.
193	Section 3.6.11, pages 53-56	Can an Offeror request the cyber liability insurance variance during the proposal phase? Does not currently holding $25M/$50M cyber limits affect whether a proposal is deemed responsive?	Please refer to the response for question #179.
194	Section 1.5, page 8	Must the three required business references be for a statewide or regional CIE specifically? Will comparable configurable-platform implementations for government or health and human services agencies qualify? Can references come from a subcontractor or consortium member?	No. The three required business references do not need to be exclusively for statewide or regional CIE implementations. Comparable configurable-platform implementations for government or health and human services organizations may qualify if they demonstrate relevant experience performing the Core Services and meet Submittal Form A, Section 12, including the requirement for two successful production implementations of the main proposed technology solution within the last five years.

Question ID	RFP Section Reference	Question	Response
195	Section 1.14.3, page 12	Is a solution that integrates third-party components acceptable? Examples are a master person index, identity resolution, a consent engine, or a FHIR gateway. During demonstrations, will integrated third-party products count as “currently available”?	Please refer to the response for question #141.
196	Section 2.1.3 page 16	Would the CIE integrate with any state databases such as a Medicaid Management Information System in order to maintain a current member roster?	Refer to SEC. 2.1.3 CURRENT ARCHITECTURE of the RFP (Other technology and systems used by CCHs or their partner organizations during care coordination workflows)
197	Section 3.6.10A, page 53	Will Comagine share the limitation-of-liability terms and the Contractor Technology/IP definitions from HCA Contract K8582 before proposals are due? Can Offerors submit exceptions to Attachment 4 with their proposals, or must exceptions be raised now under Sec. 1.6?	Comagine Health will not provide Contract K8582 as part of this solicitation. Refer to revised Section 3.6.10A. The specific limitation of liability terms, including any monetary cap, exclusions, and carve-outs, will be negotiated and finalized with the Offeror selected for award and incorporated into the resulting Contract. Comagine Health is not establishing a specific limitation of liability amount or formula for purposes of proposal submission. Offerors should submit any comments, concerns, or requested exceptions to other provisions of Attachment 4 during the question period in accordance with Sections 1.6 and 1.7.