1.0 Vendor Company Profile

Please use the "Response" column to provide your answer to each element in the table below.

	Company Profile	Response
1.01	Full Legal Company Name	
1.02	Address	
1.03	Remit to Address (if different than above)	
1.04	Primary Contact Name	
1.05	Primary Contact Telephone Number	
1.06	Primary Contact Email Address	
1.07	Company Web Address	
1.08	DUNS #	
1.09	Employer Tax Identification Number	
1.10	State of Incorporation	
1.11	Year Founded	
1.12	Number of Employees	
1.13	Type of Organization (Sole Proprietorship, Partnership, Corporation)	
1.14	Holding Status (Public, Private, Subsidiary)	
1.15	If Subsidiary, Parent Company Name and Address	
1.16	If Subsidiary, name of other subsidiaries owned by the parent company	
1.17	If Public, Exchange, and 52 Week High/Low	
1.18	If Private, List Principal Owners	
1.19	Does your company possess all licenses and/or permits required by local, state, or Federal authorities applicable to your business?	
1.20	Describe any pending legal action against your company or its officers, either individually or collectively.	
1.21	Describe whether there has been any state or federal government action or regulatory	

	enforcement taken against the company or its officers within the past 5 years, including, administrative fines/sanctions, cease and desist orders, administrative orders, revocations orders, corporate integrity agreements (CIA), OCR resolution agreements, suspensions, or exclusions from participating in government sponsored health care programs.	
1.22	Does your company utilize offshore resources and/or subcontractors who operate offshore? If so, please describe the offshore resources utilized including if they have previously received, processed, transferred, handled, stored or accessed Medicare beneficiary PHI.	
1.23	Years in which your Core System was first implemented to enable the administration of each of the following lines of business: Medicare Advantage (MA) D-SNP, Medicaid, Medi-Cal, and Commercial.	
1.24	Total number of clients who utilize your Core System to administer each of the following lines of business: MA D-SNP, Medicaid, Medi-Cal, and Commercial.	
1.25	Total number of cumulative covered lives serviced by your platform (across all clients) and the number of MA D-SNP covered lives serviced.	
1.26	Number of new clients who have implemented your Core System during the past 5 years?	
1.27	Number of clients who have terminated their contract with your firm during the past 5 years?	
1.28	Industry awards/recognition that you have received, the awarding party, and the date received.	

2.0 References

Please provide at least three (3) references from previous or current clients for whom your firm provided services similar to those requested in this RFP. The Vendor is encouraged to include clients having similar geographies and lines of business and industry as CenCal Health, particularly county-owned health plans and integrated D-SNPs. Please provide the following information for each reference:

- Client Name

- Contact Name
- Phone Number
- Email Address
- Plan Type
- Covered Lives
- Products
- Lines of Business
- Core System capabilities utilized
- Pricing Methodology, Start Date and, if applicable, End Date of the relationship

3.0 Financial Information

Please use the "Response" column to provide your answer to each element in the table below.

	Financial Information	Response
3.01	Please provide your annual revenue for the prior 3 fiscal years.	
3.02	Please provide your net income or (loss) for the prior 3 fiscal years.	
3.03	What percent of total revenue is generated from sales of the proposed Core System solution?	
3.04	Please provide your annual research and development (R&D) expenditures for the prior 3 fiscal years.	
3.05	Please provide your annual research and development (R&D) expenses as a % of Revenue for the proposed Core System for the prior year.	
3.06	Total number of customers each year for the last 3 years	
3.07	Percent of customers using the proposed Core System	

4.0 Detailed Business Requirements

Please indicate your organization's general agreement to the requirements below by indicating "Yes" in the table below. Please indicate "No" if there are general concerns with the requirement **and provide comments** to clarify.

All core system functionality must be able to, at a minimum, support the program requirements described in:

- DHCS Home and Community-Based (1915 (c) Waivers)
- DHCS Dual Special Needs Plans Contract and Policy Guide
- EAE D-SNP SMAC
- CMS PCUG February 2024
- CMS Medicare Managed Care Manual

Table 2

	Health Plan Functions	Description	Yes/No	Comments (limit 250 words)
4.01	Business Planning	Vendor will be required to engage in periodic business planning with the CenCal Executive		

	Health Plan Functions	Description	Yes/No	Comments (limit 250 words)
		Leadership Team to ensure alignment of yearly goals and priorities.		
4.02	Benefit Design	The system has flexibility to configure benefit plans to meet the specific requirements of D-SNP plans, including both Medicare and Medi-Cal components.		
4.03	Benefit Modeling	The system has tools for modeling and simulating different benefit plan scenarios to meet CenCal Division of Financial Responsibility (DOFR) agreements with providers.		
4.04	Business Continuity	The vendor has developed, continuously maintains, and periodically tests updated business continuity and disaster recovery plan(s) regarding its system.		
4.05	Claims Adjudication	The system must have the ability to adjudicate medical, behavioral, dental, non-emergency transportation, vision claims, and encounters from both traditional and non-traditional providers, including LTSS claims, in an accurate and timely manner, and submit payment via check and, preferably, Electronic Funds Transfer, with industry standard remittance advice (RA) / explanation of benefit (EOB). If appropriate, adjudication must include Member responsibility after benefits are applied. System must have the ability to administer and track sequestration adjustments.		
4.06	Claims Auditing	The system must have industry standard, timely claims auditing function to ensure claims adjudication accuracy and timeliness. The system must have the ability to record and report on results for the CenCal leadership team to access in a periodic and ad hoc manner.		
4.07	Community Supports	System must have the ability to administer Community Supports Services as required or permitted by federal and state regulations and described in the DHCS Home and Community-Based (1915 (c) Waivers)		

	Health Plan Functions	Description	Yes/No	Comments (limit 250 words)
4.08	Coordination of Benefits	The system must have capabilities to coordinate benefits, assuring Medi-Cal is the payer of last resort, establishing an order in which the system adjudicates claims following applicable State and Federal law, and assuring total payments do not exceed the total allowable expenses.		
4.09	Data Analytics and Reporting	The system must possess robust data and reporting capabilities that enable CenCal to effectively carry out the associated functions and provide performance data and reports as required. System must possess capability to provide comprehensive data to support plan-level planning, performance management and evaluation, and compliance functions.		
4.10	Data Exchange	System must have the ability to support data exchange between CenCal, Providers, Members, and Partners utilizing industry standards to include, but are not limited to: ANSI X.12, HL7, HL7 FHIR, and mutually agreed upon data file / exchange formats and APIs; and in a manner complying with HIPAA and 42 CFR Part 2 Security and Privacy regulations.		
4.11	Division of Financial Responsibility (DOFR)	System must have the ability to determine the financially responsible entity and direct the claims to them.		
4.12	Electronic Visit Verification	System must have the ability to perform or receive electronic visit verification in accordance with State and Federal requirements.		
4.13	Encounter Data Submission	System must have the ability to accurately submit encounter data to regulators (DHCS, CMS) inclusive of all claims and encounters received and adjudicated in the required format and timeframe. System must have the ability to correct the encounter submissions which are rejected by		

	Health Plan Functions	Description	Yes/No	Comments (limit 250 words)
		regulators and resubmit them for prior months. System must be able to withhold encounters where we are prohibited from sending them to regulators, such as in the case of a deeming period where the member is disenrolled in Medi-Cal but we continue to provide services for a set period (dually eligible members).		
4.14	Enrollment & Eligibility	System must have the ability to: • Parse, process, reconcile, and manage eligibility and enrollment files in State (834) and Federal file formats in an automated manner. • Validate and verify data accuracy within State and Federal enrollment files to ensure that Member enrollment is complete, and coverage is effective within required timeframes.		
4.15	Fraud and Abuse Monitoring & Prevention	System will have the ability to interact with Program Integrity programs that prevent, monitor, detect, investigate, and address fraud and abuse.		
4.16	Grievance & Appeals	System is compliant with regulatory requirements for managing grievances and appeals (G&A). System will have the ability to intake, and thoroughly process member and provider grievances and appeals. System will integrate with member eligibility, call center, authorizations and claims capabilities to process grievance and appeals, including capabilities to produce letters, create system tasks for users to complete actions, store pertinent medical records and any other components of the grievance or appeal file within the system, including Independent Review Entity forwarding and tracking.		

	Health Plan Functions	Description	Yes/No	Comments (limit 250 words)
		System will have the ability to generate system reports on G&A data with customization capabilities.		
4.17	Interoperability	System must enable CenCal to comply with State and Federal Interoperability, Patient Access, and Prior Authorization Final Rules. APL 22-026 (ca.gov)		
4.18	Letters	System must be capable of producing required letters for providers and members and for them to be sent by CenCal or a preferred partner.		
4.19	Member / Premium Reconciliation	The system must have the ability to reconcile premiums received for enrolled and eligible membership and report on any discrepancies that might be present.		
4.20	Member & Provider Fulfillment	System must have the ability to accurately develop and send member and provider mailings in a timely manner, per State and Federal requirements. This includes, but is not limited to: ANOC, Member Handbook, Summary of Benefits, Member ID cards, Enrollment Packets, Statement of Accounts, Evidence of Benefits, Notices of Adverse Decisions, Provider Manual, Provider Bulletins, Notices, and Alerts, Provider Training, and premium bills, if applicable. Vendor system has capability to translate member materials into required threshold languages.		
4.21	Member Services	System must have the ability to document member call / online chat information including but not limited to Call Center services, outbound calling, web tools, and service resolution for escalated issues. System must have the ability to track call center statistics including but not limited to average hold times, average speed of answer and rate of disconnection. System must be able to identify when interpretation services for non-English speaking members is noted, with a preference for staff whose language and		

	Health Plan Functions	Description	Yes/No	Comments (limit 250 words)
		cultural background are aligned with the target member population.		
4.22	Provider Call Center	System must have the ability to document provider call / online chat information including but not limited to Call Center services, outbound calling, web tools, and service resolution for escalated issues.		
4.23	Provider Data	System must have the ability to generate a 274 file to meet regulator requirements as well as HSD (ex. for CMS).		
4.24	Provider Dispute Resolutions (PDRs)	System must be compliant with State and Federal regulatory requirements for managing Provider Disputes. System must be capable of handling a high volume of Provider Disputes received through various communication channels (email, paper, etc.) and monitor time from receipt through intake and resolution.		
4.25	Paper Claim and Invoice Processing	The system must have the ability to transform a paper claim, paper invoice, or electronic invoice into an 837 electronic claim for adjudication and payment.		
4.26	Platform Configuration	System must permit CenCal to configure as required to enable the health plan functions cited herein to be performed accurately, efficiently, and consistently. This includes but is not limited to: provider data (demographics, contracts, fee schedules) management, benefit configuration, prior authorization configuration, care and disease management programs' configuration, Social Drivers of Health data capture, claims adjudication rules, and provider payment configuration.		
4.27	Primary Care Physician (PCP) Assignment	System must be able to programmatically assign new/returning members to PCPs based on an algorithm developed by CenCal. System must also support manual changes in PCP assignment when warranted. PCPs must		

	Health Plan Functions	Description	Yes/No	Comments (limit 250 words)
		have access to the list of members who have been assigned to them.		
4.28	Prior Authorizations	System must have the ability to accept referrals and authorizations via various methods (e.g., paper/fax, EMR, API, provider portal, data file) and accurately adjudicate claims based on prior authorization requirements. System must have the capacity to ingest authorization data from MHK and CenCal's Oracle system.		
4.29	Provider Contracting	System must have the ability load and maintain CenCal's provider network contract information, including alternative payment models and generate all required provider data to support State and Federal network submission files.		
4.30	Provider Credentialing	System will use a systematic approach to collect and verify CenCal network providers' professional qualifications, including, but not limited to relevant training, licensure, certification and/or registration to practice in a health care field, and academic background. The system must support a credentialing process that complies with NCQA standards.		
4.31	Provider Directory	System must have the ability to maintain and generate data to support the creation of an online and printed provider directory summarizing providers comprising CenCal's provider network inclusive of provider information required by contract, or State and Federal regulations.		
4.32	Premium Billing, Lockbox, & Remittance	System must have the ability to capture appropriate insurance premium billing functions and accept and adjudicate premium billing collections. Premium billing and payment remittance via electronic venues are required.		

	Health Plan Functions	Description	Yes/No	Comments (limit 250 words)
4.33	Regulatory & Contractual Compliance	System must have the ability to ensure compliance with contractual requirements and State and Federal regulations for CenCal' s EAE D-SNP and Medi-Cal lines of business. System must provide reporting that enables CenCal to oversee and monitor its performance and compliance with contractual requirements, State and Federal rules and regulations, policies and procedures. Vendor will support virtual meetings or conference calls with the CenCal leadership teams to review and discuss contractual and regulatory compliance, alignment with operations goals, and KPIs, etc. Vendor shall support CenCal Compliance Department with regulator inquiries and audits (at no additional cost). Vendor agrees to disclose to CenCal Compliance Department information related to ownership and control of Vendor, certain business transactions and activities by excluded individuals, pursuant to State and Federal contract requirements.		
4.34	Value-Based Provider Reimbursement	System must have the ability to model, test and implement innovative, value-based provider reimbursement methodologies, including but not limited to capitated payments, and accurately pay providers using such reimbursement methodologies.		

5.0 Health Plan Functions

Please use the "Response" column to answer each of the following questions.

	Benefit Configuration	Response
5.01	Describe the solution's capability for benefits configuration and setup spanning multiple lines of business.	
5.02	How does your managed care core system handle member benefit configuration, including benefit plan design, eligibility criteria, coverage rules, cost-sharing parameters, and benefit packages customization?	
5.03	Describe your system's capabilities for managing complex benefit designs, mental health services, preventive care, durable medical equipment, long term care and other specialized services.	
5.04	What tools and features does your system offer for member benefit verification, pre-authorization, utilization management, and claims adjudication within a managed care framework?	
5.05	Describe your approach to ongoing maintenance, updates, and version control of member benefit configurations within your system, ensuring accuracy and alignment with plan changes.	

	Eligibility and Enrollment	Response
5.06	Does your Medicaid solution provide member enrollment linkage with other family members (parents, siblings, etc.)?	
5.07	Describe your system's search functionality. What are the items by which a user can search?	
5.08	Can your system efficiently parse, process, and manage DHCS Enrollment 834 files in an automated manner?	
5.09	Is your system capable of validating and verifying data accuracy within DHCS Enrollment 834 files?	
5.10	Does your system offer automated reconciliation and error resolution for DHCS Enrollment 834 files?	

5.11	Can your system accommodate customization and configuration for specific DHCS enrollment needs?	
5.12	Describe how your system submits the beneficiary's enrollment request to CMS through the BEQ process within 7 calendar days of receiving a completed beneficiary application.	
5.13	Describe how your system aligns the Medi-Cal on hold status with the Medicare deeming period allowing services to be authorized and claims paid during these periods.	
5.14	Describe how the system will generate and send to CMS enrollment requests from beneficiaries.	
5.15	Describe how your system will support all the CMS eligibility files as defined in the PCUG.	
5.16	Describe the system capabilities for reconciling the DHCS 834 enrollment and 820 Capitation files.	
5.17	Describe system capabilities to send enrollment files to any specified First tier and downstream vendors and subcontractors on a routine basis, including to Pharmacy Benefits Manager, delegated providers, etc.	
5.18	Describe how your system accepts and stores in an easily retrievable fashion the following LIS files Daily Transaction Reply Report (DTRR), Beneficiary Eligibility Query (BEQ) Response File, LIS/Part D Premium File, LIS History File (LIS HIST), LIS History File (LIS HIST), Monthly Full Enrollment Data File and the Monthly Membership Report (MMR), for detailed information on its beneficiaries and use for operational purposes.	

	Member Services	**Response**
5.19	Describe your system's search functionality. What are the items by which a user can search?	
5.20	Does your system provide real-time call monitoring and reporting capabilities?	

5.21	Can your system integrate with existing telephony systems for seamless call handling?	
5.22	Can your system provide analytics and insights into member call trends and performance metrics?	
5.23	Explain how your system displays detailed information on demand to Member Services staff and brokers about covered benefits to members and prospective members, including copays, deductibles, maximum enrollee cost limits, service limitations, and maximum plan benefit coverage for all benefits, including pharmacy coverage.	

	Grievances and Appeals	**Response**
5.24	Does your system offer collaboration tools for stakeholders involved in resolving grievances and appeals?	
5.25	Is your system capable of integrating with MHK case management systems for seamless workflow?	
5.26	Can your system accommodate customizable workflows for handling different types of grievances and appeals?	
5.27	Does your system provide real-time tracking and reporting of grievances and appeals statuses?	
5.28	Can your system provide analytics and insights into trends and performance metrics related to grievances and appeals?	
5.29	Does your system offer automated categorization and routing of grievances and appeals?	

	Utilization Management	**Response**
5.30	Describe the integration capabilities of your system with external authorization systems, specifically the MHK CareProminence® platform? Please detail how your system facilitates seamless data exchange and interoperability to ensure that authorization processes initiated in the MHK system are	

	accurately interfaced into the Core Managed Care System in real-time or near real-time.	
5.31	Explain how your System automates authorization workflows, including request submission, review processes, decision notifications, and appeals handling, while interfacing with the MHK system and proprietary Oracle based systems	

	Provider Data Management	**Response**
5.32	What is the architecture of your data management system, and how does it support scalability and data integrity?	
5.33	How does your system handle provider data, including demographics, credentials, specialties, affiliations, and contract information, ensuring accuracy and completeness?	
5.34	Describe the solution's standard hierarchy around network providers associations for locations, groups, facilities, and ancillary providers. How does National Provider Identifier (NPI) link to individuals / groups?	
5.35	What workflows are available to support onboarding of providers and data configuration?	
5.36	Can your system support value-based payment models, population health management initiatives, and risk-sharing arrangements with providers through robust data management capabilities?	
5.37	Describe your system's capability to interface/import provider data managed in an external system.	
5.38	Can your system seamlessly integrate with existing platforms such as Oracle, Cactus (utilized for credentialing) and what is your approach to data migration during system transitions?	
5.39	What tools and features does your system offer for provider performance evaluation, quality measurement, outcome reporting,	

	and value-based care initiatives within a managed care framework?	
5.40	Can your system integrate with external provider systems, such as electronic health record (EHR) systems, practice management software, telemedicine platforms, and analytics tools, to facilitate data exchange and interoperability?	
5.41	Provide details about your system's data governance and integrity practices for provider data, including data standardization, deduplication, validation, and maintenance of provider directories.	
5.42	How does your system ensure compliance with regulatory requirements related to provider data management, including CMS guidelines, state regulations, accreditation standards, and data privacy laws?	

	Provider Dispute Resolution	**Response**
5.43	Does your system provide automated categorization and routing of Provider Disputes?	
5.44	Can your system provide customizable workflows for handling Provider Disputes?	
5.45	Does your system offer tools for collaboration and communication among stakeholders involved in resolving Provider Disputes?	
5.46	What mechanisms does your system have in place to track and monitor provider disputes, including logging grievances, tracking resolution timelines, and reporting on outcomes?	
5.47	How does your system support regulatory compliance and adherence to industry standards in the provider dispute resolution process, including CMS guidelines, state regulations, and accreditation requirements?	
5.48	Describe how your system facilitates collaboration and communication between providers and CenCal during the dispute resolution process, including online portals, secure messaging, and document exchange capabilities.	

	Contact Relationship Management (CRM)	Response
5.49	Describe your capabilities related to contact management (e.g., Lead management, campaign management, pipeline management, etc.).	
5.50	What customization options does the CRM offer to tailor it specifically to the requirements on EAE D-SNP plan?	
5.51	Can the CRM support the unique data and compliance needs associated with an EAE D-SNP, including member eligibility and enrollment details?	
5.52	How do you handle CRM lead generation communication and follow-up with potential enrollees throughout the process?	
5.53	Describe how system accepts and processes the Agent Broker Compensation Report Data File to compliantly compensate CenCal sales agents and brokers.	

	Claims	Response
5.54	Describe how your system aligns benefits configuration with its claims processing and adjudication rules to ensure claims are properly paid.	
5.55	Describe how your system applies matching or decision logic for the submitting/rendering provider listed on the claim form to ensure accurate and appropriate payment of the claim.	
5.56	Describe the processes to load and maintain the Medicare & Medi-Cal Fee-For-Service professional and ancillary fee schedules, Medicare Provider Pricer tools, inpatient MS-DRG (Medicare Severity-Diagnosis Related Group) and outpatient APC (Ambulatory	

	Payment Classifications) grouper tools for provider claims.	
5.57	Describe how your system incorporates the Medicare National Correct Coding Initiative (NCCI) edit logic to promote proper coding methodologies and to control improper coding leading to inappropriate payment.	
5.58	Describe how your system applies claims interest that aligns with Medi-Cal and Medicare regulatory requirements	

	Medicare Risk Adjustment & Stars	**Response**
5.59	Describe your system's risk adjustment methodologies, including HCC (Hierarchical Condition Categories) coding, RAF (Risk Adjustment Factor) calculation, and predictive modeling capabilities.	
5.60	How does your system integrate and aggregate data from various sources (e.g., claims data, clinical data, pharmacy data) to support risk adjustment and Stars performance measurement?	
5.61	What measures does your system employ to validate risk scores, ensure data quality, and identify and address coding discrepancies or gaps in documentation?	
5.62	How does your system support retrospective chart reviews, concurrent coding reviews, and prospective risk capture initiatives to improve risk score accuracy over time?	
5.63	5.63 How does your system ensure compliance with CMS (Centers for Medicare & Medicaid Services) guidelines and regulations related to risk adjustment and Star Rating reporting, including documentation requirements, coding guidelines, and audit readiness?	
5.64	Can your system provide actionable insights and interventions to help improve risk adjustment accuracy and stars measures? Can these be combined at the member and provider levels, such as member outreach	

	campaigns, provider performance reports, and gap closure workflows?	
5.65	Can your system generate accurate and timely submissions for CMS risk adjustment data validation (RADV) audits and Star Rating data validation (DV) audits?	
5.66	5.67 What reporting and analytics tools does your system offer to track and analyze risk adjustment trends, Stars performance metrics, RAF scores, gap closures, and quality improvement initiatives?	

6.0 Implementation, Support and Training

	Implementation, Support and Training	Response
6.01	Provide a description of your general approach to system implementation.	
6.02	What is the estimated time to complete implementation of the Core System? Please clearly explain how you define when implementation is completed. Please provide a generic sample timeline / project schedule for a typical installation. (It is understood this is an approximation.)	
6.03	Describe your methodology in gathering health plan and product specific requirements.	
6.04	Describe the initial training offered as part of the implementation.	
6.05	What is the approach for ongoing training and support needs? Is the cost for training included in the cost of the system?	
6.06	Describe all available guidance (online help) and support accessible to the users of your solution.	
6.07	Outline any administrative responsibilities which would fall on our staff for implementation, integration, and on-going management of the systems.	
6.07	Describe your customer and product support capabilities – i.e. help desk and support. What Service-Level Agreements do you support regarding: defects, system-down times, backend corrections, etc.	
6.08	Does your organization provide a designated service team for client members? Please describe your organization's approach to client management.	

	Implementation, Support and Training	Response
6.09	Please describe any post-implementation and maintenance resources needed from the client.	
6.10	Describe the process for any post implementation customer enhancement requests. Do enhancement requests require a new SOW or are they included in the ongoing agreement.	

7.0 Core System Information

	System Information	Response
7.01	Core System Name	
7.02	When was the Core System initially released and what is the current release/version available? % of installed client-base using the most current version/release.	
7.03	How long has the current version been on the market?	
7.04	Please describe the long-term vision, or the 5-year development plan for the Core System you are proposing. Provide a 12-24 month release schedule and list of upcoming feature enhancements and or capabilities.	
7.05	Describe your company's commitment to product support, enhancements, and continuous alignment with state and federal regulation updates.	
7.06	Describe the key health plan functions supported by your system	
7.07	What is the largest number of concurrent users currently using the Core System? Are system resources shared among all clients (e.g. multi-tenanted implementation) or is there dedicated server/ bandwidth for each implementation?	
7.08	What size managed care plans use this product (smallest, largest, typical)?	
7.09	Does your Core System currently support Medi-Cal Managed Care Plans? Other Medicaid plans? Medicare Advantage (MA) D-SNPs? Exclusively Aligned Enrollment (EAE) D-SNPs? Please provide specific information regarding each of the above product types including health plan functions supported and number of users.	
7.10	Has your Core System been implemented by a client(s) to administer a D-SNP plan in conjunction with a different Core System used to administer a complementary Medi-Cal/ Medicaid plan? If so, please provide details regarding points of	

	System Information	Response
	integration, data exchange, and data sharing required to successfully utilize multiple Core Systems to administer complementary lines of business.	
7.11	Describe your product warranties and representations, including interfacing with third-party software.	
7.12	Describe any typical third-party interfaces that must be developed to interface with your Core System.	
7.13	Describe interfaces to third-party systems that you've already developed which can be leveraged by interested clients. For each, please indicate whether there's an additional cost to leverage the interface.	
7.14	Please briefly elaborate on your product's competitive advantages.	
7.15	Please list all product system or sub-system NCQA certifications or pre-certifications that are presently active. Please report each type of certification earned and the date that each certification expires.	

8.0 System Architecture, Design and Hardware

	Architecture, Design and Hardware Requirements	Response
8.01	Describe how the Core System is deployed. (Cloud, hosted, on-premises, etc.). If cloud-based or hosted, where is it hosted and is a separate instance implemented for each client or are multiple clients sharing a single multi-tenanted instance? If on-premises, summarize the client software and hardware requirements to support an optimal implementation.	
8.02	If cloud-based or hosted, what is the third-party platform, e.g., AWS, Azure, etc.? What is physical location of the data? Is any data housed offshore?	
8.03	Describe your Core System and reporting architectures, including subsystems, database engine(s), and data schemas.	
8.04	Is data managed by your system encrypted at rest and in transit? If so, what encryption algorithms/methods do you leverage?	
8.05	If browser-based UI, what browsers and related versions are supported?	
8.06	Does the solution support integration with other systems? If so, please provide a list of systems your solution has integrated with.	
8.07	Does the solution come with an image viewer to view claims, attachments, medical records, etc.?	
8.08	How does the solution support integration with MHK, Symplr, Agiloft and other mainstream systems – including EHR,	

	Architecture, Design and Hardware Requirements	Response
	Enrollment Management, PBM, CRM, UM, population health, analytics, portal management, etc. List currently available / supported application programming interfaces (APIs).	
8.10	How does your solution support member portal functionality?	
8.11	How does your solution support provider portal functionality?	
8.12	How does your solution support broker portal functionality?	
8.13	What are the top long running batch jobs/processes? Describe them and how long they take for a client of similar size.	
8.14	Can users be accessing the system while large batch processing is occurring without degradation of system performance? At what point will the system show signs of performance stress and what are those metrics?	
8.15	Does the system allow for 24x7 accessibility? Please explain system requirements for maintenance and upgrades and if any downtime is required. Please provide at least 24 months-worth of availability time % data.	
8.16	What has your system up-time availability over the past 24 months been?	
8.17	Can you describe how the system scales in terms of data, batch jobs, users, etc.? Please provide specific metrics and benchmarks.	
8.18	Does the system support all standard HIPAA transactions, including: Claims Submission (837), Claims remittance (835), Eligibility Inquiry/Response (270/271), Enrollment (834), Claims Status (276/277), Payment Order (820), and others?	
8.19	Does the system support required data exchange between Medi-Cal managed care plans (MCPs) and California Department of Health Care Services (DHCS)?	
8.20	Does the system support required data exchange required to support Exclusively Aligned Enrollment (EAE) D-SNP health plans?	
8.21	Does the system support established and emerging healthcare data interchange standards, including HL7, FHIR, CCDA, Direct, CDA, and others?	
8.22	Does the system support CMS' Interoperability and Patient Access Final Rule? If so, please describe how.	
8.23	Is your system poised to support CMS' Interoperability and Prior Authorization Final Rule? If so, describe your intentions.	
8.24	What mechanisms does your core system employ for data security and privacy, including role-based access controls, audit trails, encryption, and compliance with HIPAA/HITECH regulations?	

	Architecture, Design and Hardware Requirements	Response
8.25	How does your system facilitate seamless integration with third-party applications, APIs, and external data sources to support interoperability, data enrichment, and workflow automation?	
8.26	How does your system incorporate artificial intelligence (AI) technologies such as machine learning, natural language processing (NLP), and predictive analytics to enhance decision support, automate workflows, and improve care outcomes?	

9.0 Data Management and Reporting

	Data Management and Reporting	Response
9.01	Describe your reporting capabilities, including how data are structured, normalized, and stored.	
9.02	Additionally, please comment on the following questions: Does the system have a reporting model/database included that can be used for developing customized reporting and analytics? Does the system provide the ability to connect and write reports directly off the engine's database? Is there a recommended method to allow SQL developers to leverage the engine's database? Does your system have the capability of reporting over different time zones?	
9.03	Is the system compatible / integrated with any third-party reporting/BI applications (e.g., Tableau, Power BI, Domo, Crystal Reports)? If so, please explain how the system will integrate with these tools.	
9.04	Describe the system's data integration capabilities with external data sources/applications. Can the system interface/integrate with multiple data sources? E.g., databases external to the product database, excel spreadsheets. Is there an impact to the pricing to have multiple data stores/sources interfaced with the product? Describe how data can be tracked back to its source?	
9.05	Describe how the system handles data storage, including: Does the system require data from other sources to be written directly to the database or can data from other sources be accessed through other interfaces like an API? Is all data entered on the front end of the system collected and available for reporting?	
9.06	Does the system support enterprise-wide metadata? Please explain.	

	Data Management and Reporting	Response
9.07	Does the system have reporting capabilities built into the front end? If so, please describe the capabilities of the reporting tool. Does the system provide standard industry Health Plan reporting (NCQA, California MCAS, STAR Ratings, etc.)? Please describe. Does the tool have drilldown/data exploration capabilities? Please describe. For Dashboard reporting, describe the templates available within the tool. Also describe the process to create and modify or customize the Dashboard template. Describe other reporting templates available. Does the system allow for trending and statistical analysis? Please describe. For Dashboards and other reports, are benchmarks or targets incorporated? Describe the process to maintain benchmarks and change targets. What is the ad hoc query and/or reporting capabilities exist? What skillsets / languages are required to create complex reporting? Are all fields reportable for the front-end users? (i.e. SQL intermediate level, multiple joins of tables if not against the metadata layer). What are the report export / distribution options? Is email an option? Can reports be scheduled to run at specific times? Is reporting available for edits made to fields (for example if following dates are changed: received date, letter send date).	
9.08	What types of documentation (data dictionary, ERDs) are available for users related to the back-end databases' data schemas?	
9.09	List the standard – out of the box – reports and dashboards available.	
9.10	Describe the process for requesting new/custom reports and dashboards. Are there additional costs for new/custom reports? If so, provide approximate figures and an average timeline to satisfy requests for new/custom reports and dashboards.	

10.0 Security

	Security	Response
10.01	Does your system comply with the HIPAA Security Rule requirements? If so, please describe the methods for end-user identification and authentication.	
10.02	Do you conduct a Security Risk Analysis as required under the HIPAA Security Rule?	
10.03	Describe your system's data access security and audit capabilities – i.e. how does the system constrain access to data for each end-user and how does the system tracks and stores changes to data (username/date/historical data/etc.).	
10.04	Do you follow the National Institute of Standards and Technology (NIST) and NIST Cybersecurity Framework (CSF)?	
10.05	Describe your solution's cyber security framework in detail. Does your system support Multi Factor Authentication (MFA)? Does the system support the Microsoft Active Directory Security model? Does your solution support Zero Trust Network Access (ZTNA)? Does the system meet OWASP guidelines?	
10.06	Describe and delineate the relevant provisions and limits of Vendor's cyber insurance policy. Include exclusions contained in the policy such as whether government fines/penalties and settlements are covered.	
10.07	If your system is hosted, please describe backup and data security policy. Describe your disaster recovery & contingency planning process.	
10.08	If hosted, describe the data breach notification process used by the hosting party. Describe if the data are segregated by client and easily identifiable to determine if specific individuals' data are impacted by a breach.	
10.09	Does the system support varying levels of security, including Role-Based Security? If so, please explain.	
10.10	Does the system support Single Sign-On (SSO)? If so, list the types of SSO supported – e.g., SAML, OAuth, OIDC, etc.	
10.11	Does the system support security access at the menu option level, the screen level, and the field level?	
10.12	Does the system possess any security certifications that ensures the confidentiality, availability, integrity and privacy of your systems and sensitive information, such as SOC 2 or HITRUST? If so, please provide a copy of the report(s).	
10.13	What are the reporting capabilities for access, permission audits, or monitoring for security related activities?	
10.14	What is the password policy? How is it enforced?	

	Security	Response
10.15	Describe whether there has been a past security or privacy incident or breach that has involved federal or state government intervention or enforcement within the past 5 years, including what intervention was taken by the government and whether any fines, penalties, sanctions were imposed or a resolution agreement was enforced.	

11.0 Performance

Within the following table, please cite your average performance across your Managed Medicaid and D-SNP health plan clients served during the past 2 years for each performance measure and add any additional measures by which you monitor and report performance regarding your Core System.

	Health Plan Functions	Performance Measure	Vendor(s)' Performance
11.01	Claims Adjudication	Claims Processing auto-adjudication rate	
11.02	Claims Adjudication	Average number of days to pay pended claims by claim type	
11.03	Claims Adjudication	% of claims processed within 30 days, 45 days, and 90 days	
11.04	Claims Adjudication	% of claims processed with financial accuracy	
11.05	Claims Adjudication	% procedural accuracy of claims processed	
11.06	Encounter Data Submission	% of encounters submitted within 30 days	
11.07	Encounter Data Submission	% of encounters rejected for error resolution	
11.08	Encounter Data Submission	% of pended encounters resolved within 30 days	
11.09	Encounter Data Submission	% of encounters rejected by DHCS	
11.10	Encounter Data Submission	% of encounters rejected by DHCS resolved / corrected within 30 days	
11.11	Encounter Data Submission	% of encounters rejected by CMS	
11.12	Encounter Data Submission	% of encounters rejected by CMS resolved / corrected within 30 days	

	Health Plan Functions	Performance Measure	Vendor(s)' Performance
11.13	Customer Service	% of calls answered within 30 seconds	
11.14	Customer Service	% of calls abandoned (15 seconds, 30 seconds, 45 seconds, 60 seconds+)	
11.15	Customer Service	% of calls waiting to be answered exceeding 10 minutes – (Medi-Cal)	
11.16	Customer Service	% of calls waiting to be answered exceeding 2 minutes following the IVR system – (Medicare)	
11.17	17 Customer Service	Average Handle Time (hold + talk time)	
11.18	Customer Service	Average Hold Time	
11.19	Customer Service	Average Daily Call Volume (8:00am – 5:00pm) by Day of Week	
11.20	Customer Service	Average Daily Call Volume (5:00pm – 8:00pm) by Day of Week	
11.21	Customer Service	% of email inquiries responded to within 24 hours	
11.22	Eligibility Administration	% of enrollment/eligibility files processed within 24 hours of receipt	
11.23	Eligibility Administration	% of monthly enrollment/eligibility reconciliation completed on time	
11.24	Eligibility Administration	% of initial PCP assignments made within 30 days of enrollment	
11.25	Member and Provider Fulfillment	% of Member Welcome Packets sent within first 7 days of enrollment	
11.26	Member and Provider Fulfillment	% of Notices of Adverse Denial letters sent to members timely	

11.27 Provide a description of the process for developing and delivering accurate reports to CenCal Compliance, including the process for ad hoc report requests.

12.0 Release Management

	Development	Response
12.01	Please describe your release management approach, including any flexibility for clients' release schedules.	
12.02	Describe the frequency of new releases/upgrades to your product. Describe	

	Development	Response
	the process for customer driven enhancements versus general upgrades. Describe the coordination efforts provided to customers for advanced release notification, documentation, user and technical training, and production deployment. Describe system availability during releases or patch upgrades	
12.03	Are there additional fees or charges for system releases, upgrades, fixes, etc. or are they offered through the general maintenance agreement fees?	

13.0 Vendor Pricing

13.01 Please provide a high-level breakdown of proposed fees spanning years 1-5 associated with implementing, maintaining, and using the Core System to enable CenCal's D-SNP line of business clarifying fixed vs variable costs and pricing variability based on usage or scalability.