Answers to questions pertaining to CHIP Administrative Services RFP

The following are answers to the questions that were posed during the public comment period on the draft CHIP Administrative Services RFP. Because the final version of the RFP does not include a dental claims deliverable, the questions pertaining to this deliverable are not addressed. The answers also reflect current federal guidance and are subject to change based on changes in that guidance. Such changes will be posted to the HHSC website as soon as possible following federal notification is received by HHSC.

Section I: Introduction and Conditions

1. The contract is valid for three years from the date of its execution. Is this three years inclusive or exclusive of the five months of systems development and testing?

Answer: It is inclusive of systems development and testing which occur after the contract is fully executed.

2. Systems development and testing refers to "5 months". Is this from the Contract Award date?

Answer: No. Systems development and testing will occur the first five months immediately following execution of the contract by both parties.

3. It is unclear if a conflict of interest occurs if an entity is currently doing business with THKC or a health plan associated with THKC.

Answer: Conflicts of interest must be determined on a case-by-case basis. A current or former business relationship with THKC does not necessarily result in a prohibited conflict of interest for purposes of performing administrative services for CHIP. For example, if an entity currently is providing administrative services to THKC, Medicaid, or a health plan associated with THKC or Medicaid, there is no inherent conflict. If an entity has a *financial interest in a health plan* (so that the entity is entitled to participate in any profits accruing from the health plan, for example), a conflict exists.

4. Readiness Review shows "15 days." Is this prior to the designated first date that services are to be provided by the contractor (i.e. call center operation?)

Answer: "15 days" refers to the time in advance of operations at which readiness will have been determined. The five month period prior to the 15 days includes systems development and testing, readiness review, and implementation of any indicated corrective action plans..

5. Can written questions and answers be submitted via e-mail as an attachment document in the acceptable format specified?

Answer: While the RFP suggests a diskette, an e-mail attachment satisfies the requirement that questions be submitted electronically. However, a written version must still be faxed, mailed, or hand-delivered with authentication of the designated representative of the entity submitting the proposal.

6. Must the system already be in use by the bidder or is a demonstration by the vendor of a system (or software package) to be purchased contingent upon award of the contract acceptable? Must the demo be at the Agency's location, or can the demo be performed at the bidder's site if it is within 35 mile range of Austin, Texas?

Answer: HHSC anticipates requesting demonstrations only of systems already in use in another comparable setting such as another state children's health insurance program. In fairness to all bidders, any requested demonstrations will occur at a neutral site to be specified by HHSC.

Section II: Program Information

1. When do operations begin—May 1, 2000, or April 2, 2000 (we assume the April 2, 1999, date is a misprint)?

Answer: Health insurance coverage is scheduled to commence May 1, 2000. However, certain administrative functions must begin on or before April 2, 2000. These include the call center and the business processes related to application data entry and referral, eligibility determination, and enrollment.

2. Is it the State's intent to phase in "statewide implementation of CHIP" by county or will the entire State be implemented simultaneously?

   Will the CHIP Phase II program be rolled out across the entire state simultaneously or will there be a region by region implementation schedule?

Answer: The entire state will be implemented simultaneously.

3. Is it the State's expectation that 440,000 children will be enrolled 18 months after implementation?

   Does the estimate of 440,000 children include CHIP Phase I or is it only CHIP Phase II? What percentage of the 440,000 children is expected to actually enroll in the program? Over what period of time?

   Please clarify what "full enrollment" means. Does the Agency expect full enrollment after 18 months of the program? How was the 440,000 estimated derived? Is this an estimate of the total number of children who fall within the eligibility guidelines for CHIP? What is the likelihood that enrollment will reach this level?

Answer: The reference to 440,000 children is an estimate of the number of eligible children who will be enrolled in CHIP Phase II health plans 18 months after the May 1, 2000 start of health insurance coverage. "Full enrollment" means the figure at which enrollment stabilizes following an 18 month period of steady expansion. This figure was derived by analyzing Texas Medicaid enrollment, projecting the impact of an aggressive and multi-faceted outreach effort and a simplified generic application process, and estimating the number of CHIP-eligible uninsured children in Texas. The figure represents the state's best estimate as of the date of the issuance of the RFP, utilizing the data and assumptions described above.

Regarding the likelihood that enrollment will reach this level, please refer to the following text in Section VI(F) of the RFP: "The information about anticipated enrollment outlined in Section II(A) is provided to assist proposers in estimating the capacity and staff they will need to meet the requirements of this RFP. However, proposers are advised that HHSC makes no guarantee as to the actual enrollment or volume of applications that will be processed during any of the years of the contract."

4. Will the State provide an estimated enrollment schedule over the three year period for the purposes of sizing and costing?

Answer: Enrollment will be an incremental process with full enrollment anticipated after 18 months. . Please refer to the monthly enrollment estimates to be made public as part of the HMO RFP to be issued August 2. Please note also that the caveat referred to above also applies to the monthly estimates.

5. "The AGENCY estimates that 60,000 children will enroll in the Medicaid program as a result of the CHIP screening and referral process." Will the 60,000 children enrolled in Medicaid be enrolled as a result of applications sent to the CHIP administrator within the first 18 months of implementation (beginning May 1, 2000)?

Answer:Yes.

6. Is the bidder required to verify the uninsured status for a period of 90 days prior to application or is there a requirement that the applicant family show the applicant to have been uninsured for this period of time? Will the information be accepted as a self-attestation?

Answer: Uninsured status will be self-declared with no verification required. However, to protect program integrity, HHSC may require the contractor to conduct random verification. This will be an issue subject to contract negotiation. . As noted at the outset of this document, this answer is subject to federal guidance that may result in changes to the implementation and administration of CHIP.

7. Would a waiting list be developed for the open enrollment period, since an application may

be submitted at any time (as stated in several places throughout this RFP)?

In the interim periods, while waiting for the CHIP open enrollment period, would applicants who did not qualify for Medicaid be referred to THKC for potential interim coverage?

Will it be the bidder's responsibility to track potential enrollees in between enrollment periods and notify them when the period is open for new enrollments? Will applications be held and submitted for processing during this time period?

Answer: During any closed enrollment period, generic applications would continue to be processed and eligibility determination notices sent. CHIP-eligible children would be put on a waiting list. At a pre-determined time prior to the start of an open enrollment period, enrollment materials would be sent to the families of the children on the waiting list. Regarding the question of whether CHIP-eligible children will be referred to THKC during the closed enrollment period: this question will be resolved during the process by which HHSC determines whether to have open and closed enrollment periods following the initial statutorily-required year of continuous enrollment.

8. Can applications also be accepted via fax and the Internet?

Answer: Faxed applications will not be accepted if an original signature is required by the federal government. Digital signature standards currently are under development by a number of state agencies and may impact the answer to this question. Pending that development and federal guidance, we are deferring an answer to this question at this time. Internet applications will be processed only if a cost-effective, secure, and reliable data entry methodology is proposed (see Section VI(E)(2)(b) of the RFP).

9. How will providers do the enrollment? Will they have applications in their office that they ask patients to complete who appear to quality for some type of assistance program? What if the provider does not participate in the CHIP program? How would applicants seeking health care get this information?

Answer: HHSC anticipates that providers will participate in outreach by publicizing the program and facilitating the application process through such activities as distributing generic applications, distributing novelty items with the toll-free number, and helping families complete the application. This latter facilitation activity relates to the eligibility determination process as distinct from the plan enrollment process. In this latter regard, providers will not be allowed to facilitate or participate in the process during which families enroll in a health plan and choose a PCP for their children.

10. What types of community based organizations will be doing enrollment? Is this face-to-face enrollment, or just assistance with completing an application already provided by another source?

Will community-based organizations be able to receive applications and enroll children in the CHIP program?

Answer: HHSC expects a wide range of community-based organizations (CBOs) and coalitions of CBOs to participate in outreach, either through contracts or voluntary partnerships. CBOs will be involved in publicizing the program, distributing applications and brochures, helping families complete applications, and educating families about the importance of health insurance for their children. To avoid a conflict with Insurance Code guidelines prohibiting non-licensed individuals from conducting activities normally reserved for insurance agents, they will not be allowed to facilitate or participate in the process of enrolling children in specific health plans.

11. Will community based organizations and providers be paid an enrollment fee for assisting potential eligibles with the application process? What is their incentive for involvement to support the enrollment/application process?

Answer: No enrollment fee or direct per-person financial incentive will be paid by HHSC. The incentive of CBOs who enter into an outreach contract with HHSC will be meeting contractual performance measures. The incentive of CBOs who participate in voluntary partnerships will be promoting a program they view as very positive for uninsured children in Texas.

12. Children not eligible for Medicaid or CHIP will be referred to the THKC. Who is responsible for these referrals? The bidder will do the initial screening and forward Medicaid eligibles to the TDHS for processing. If these applicants are rejected, does the state then forward these applicants to the THKC for potential coverage? Are the Medicaid denied applications referred back to the bidder for then forwarding to the THKC?

Answer: The administrative services contractor is responsible for referring to THKC children who are ineligible for Medicaid and CHIP. Children who are referred to Medicaid and are denied coverage because of income or assets will be automatically deemed eligible for CHIP based on denial codes that will be electronically sent to the contractor by the Department of Human Services.

13. If THKC does not provide coverage, is there accountability on the part of the bidder to track the ultimate outcome for each and every applicant? Will THKC provide its own reporting to the Agency? For cases that the bidder refers to THKC, are these cases to be marked as closed by the CHIP TPA bidder?

Answer: The contractor's only responsibility relative to a THKC referral is to make the referral in a timely and reliable manner. Once a referral occurs, the case is considered closed for the purposes of the CHIP system. . However, it may be necessary for purposes of program evaluation to match the contractor's data files on CHIP applications referred to THKC with THKC enrollment files.

14. By what date is HCFA expected to approve the Texas Phase II CHIP plan? If revisions are required, will the RFP be amended and/or timelines adjusted accordingly?

Answer: The Phase II state plan amendment was submitted to the federal government June 23. Federal requirements state that HCFA must approve a state's CHIP plan or plan amendment within 90 days of submittal. However, the clock stops running during any question and answer period that may ensue between HCFA and a state. If revisions are required by HCFA, and those revisions materially affect the responsibilities of the eventual administrative services contractor, HHSC will provide timely notification to all proposers and will make any adjustments to timelines and RFP requirements and conditions that it determines are appropriate.

15. What kind of "good cause" exceptions will be made to eligibility determination? Will these exceptions be expected to be programmed into the system or will they be manual overrides?

Answer: As of the date of this document, the specific criteria constituting "good cause" exceptions had not been finalized by HHSC. Until they are identified, it is not possible to specify whether the criteria will be automated or be executed through manual overrides. Once this policy is determined (and other policies that will affect the CHIP administrative system's business rules), the system's underlying business rules must be appropriately modified.

16. Regarding the coalitions of community-based organizations, please specify whether the Agency expects that bidders will include outreach services and/or subcontracts with community-based organizations.

Answer: Responders to the administrative services RFP should not include outreach services in their proposals, either directly or through subcontracts with CBOs.

17. If possible, please provide the Bills referenced in the RFP, or provide information about how they may be accessed through the Internet or other sources.

Answer: Senate Bill 445, 76th Legislature, can be accessed at the Texas Legislative Council website: http://www.capitol.state.tx.us/.

18. Please provide a copy of the Texas Phase II CHIP plan that is pending.

Answer: The Phase II state plan amendment is available on the HHSC website: http://www.hhsc.state.tx.us/ipisi/Phase2.html .

Section IV: Proposal Screening and Evaluation

1. Can the State specify the scale (i.e., percent of total available points) of "additional consideration" to be provided bidders that have implemented a CHIP in another State?

Answer: HHSC has determined that the state's interests are better served by publishing the evaluation criteria in relative order of importance, without specifying the weight attached to specific evaluation criteria.

2. Will the same "additional consideration" be provided to bidders that have implemented comparable programs in other States, e.g., programs for the uninsured?

Answer: As noted in Section IV of the RFP, "proposers will receive additional consideration if they have implemented a system for a state-designed children's health insurance program in another state, whether or not the program is funded with Title XXI dollars." In practical terms, this means administrative services in regard to a state-designed CHIP program will be given the same level of "additional consideration" as a non-CHIP state-designed health insurance program for children.

Section V: Administrative Information

1. May the contractor include suggested financial incentives in its proposal?

Answer: Yes. Any such incentives should be tied to measurable, verifiable results. Any recommended incentives are strictly subject to the approval of HHSC. HHSC is not obligated to consider any proposed incentives.

2. What reports and inspections provision will be required to ensure compliance with federal purchasing laws?

Answer: This provision in the RFP is a safeguard to ensure that the procurement complies with federal requirements designed to promote "open and free competition." Because federal regulations that govern CHIP do not require special reporting to ensure compliance with federal purchasing laws, the primary intent of this RFP provision is to ensure consistency with the intent of applicable purchasing laws. The administrative services contract may contain specific reporting requirements for purposes of complying with optional state or federal law.

Section VI: Proposal Content

1. The RFP states, "All pages of the proposal, including any attached documents, must be consecutively numbered." Does this requirement include appendices such as manuals,

marketing pieces from existing programs, and printed and bound documentation, or does it pertain to the technical approach and costing information volume only? Please elaborate as to exactly which materials must be consecutively paginated.

Answer: The main body of the proposal must be consecutively numbered. The cost proposal (submitted in a sealed envelope) must be consecutively numbered as a separate document.

2. Please specify if the Agency would like sections tabbed so that they are easily identified.

Answer: That approach is preferable though it is not mandatory.

Section VI(E)(1): Operational Issues

1. Can some system components reside outside the mileage limit, e.g., dental claims processing, telephone system components, and computer system components?

Answer: Some of the infrastructure components may reside outside the mileage limit so long as this does not negatively affect (as determined by the state): the ability of the Austin-area state agency staff (or the management contractor's staff, if management of the administrative services contract is outsourced) to do their jobs reliably and efficiently; and the primary storage of all data related to the Texas CHIP Phase II contract within the mileage limit. Off-site back-up storage may be outside the mileage limit.

2. Can the State define or explain the following phrase: "right of remuneration" in the context of the "joint licensing agreement" scenario?

Answer: This questions pertains to the following scenario under Section VI(E)(1)(c): "HHSC and proposer develop a joint licensing agreement, with both parties having proprietary access to the system modifications and right of remuneration after the contract with the proposer terminates." Within this statement, "right of remuneration" means the State and the proposer will reach a financial settlement of their respective rights and obligations regarding the developed system in accordance with applicable federal and state laws and regulations.

3. The proposer is required to describe proportions of the infrastructure that will be devoted to CHIP and each of the other programs. What role will the contractor have working with other programs?

Answer: The questions pertain to the following statement under Section VI(E)(1)(i): "If any portion of the program infrastructure will be shared with other programs, the proposer must specify what percentage of capacity will be devoted to the Texas CHIP program and what percentage will be devoted to each of the other programs." In this

context, "other programs" means any other contracts or obligations the proposer has with other entities or states (including programs within Texas such as Medicaid or the Texas Healthy Kids Corporation) to provide comparable services.

4. Is HHSC looking for one person each to fulfill the functions of toll-free call center; information systems; processing of applications and enrollment information (including necessary electronic interfaces); financial functions; and reporting? Will HHSC allow one person to fulfill more than a single function?

Answer: A person may assume management or technical responsibility over more than a single function, assuming the person is qualified in each of the operational areas. In this event a proposer should explain why this approach would work and why it would be beneficial to the State.

5. Is HHSC looking for managers or staff who will actually be performing the work?

Answer: The question is unclear. However, to reiterate the intent behind Sections VI(E)(1)(d) and (e), HHSC expects the successful contractor to recruit highly qualified management and technical staff to oversee the critical functional areas of the contract. Non-management and non-technical operational staff must be appropriately trained.

6. If the contractor is a wholly owned subsidiary of a corporation, is the AGENCY requesting financial statements from the subsidiary, from the parent corporation or both the parent and the subsidiary?

Answer: HHSC requests financial statements from both the parent and subsidiary corporations.

7. Under qualifications and capacity, please clarify whether the 67% applies to those staff who will implement and set up the program, or those individuals who will manage and staff the program once it becomes operational.

Answer: The 67% requirement has been deleted from the RFP.

<u>Section VI(E)(2): Business Rules</u>

<u>Call Center</u>

1. How will the bidder be notified regarding special mailings or media campaigns that may cause new questions or increased phone volume? Staffing needs to be adjusted to accommodate for these periods while continuing to ensure that call center performance standards are maintained.

Answer: It is HHSC's intent to closely coordinate the overall outreach effort (including the marketing campaign and the CBO contracts) with management of the administrative services contractor.

2. What other languages is the bidder expected to provide translation services for? Is the use of an external vendor (such as AT&T Translation Services) acceptable?

Answer: The use of an external vendor is acceptable. It is not possible at this time to identify translation requirements for languages other than Spanish. That determination will occur on an ongoing basis according to experience with monolingual non-English and non-Spanish speaking applicants.

3. Will the Agency require the capability to monitor active calls on the hotline? If so, will the Agency be expected to perform this monitoring function on the contractor's business premises?

Answer: Monitoring active calls is not a specific RFP deliverable. However, the RFP does require that customer service representatives treat callers with dignity, courtesy, and a respect for their privacy and HHSC expects proposers to have a reliable management strategy for complying with this requirement.

4. Will HHSC require that the application be created over the phone through contractor's call center staff? How will the staff receive documentation and a signed application?

Answer: Call center staff must be capable of entering application data into the automated system during a phone call with an applicant family. Once this process concludes, the application must be printed and mailed to the family for its review, signature by the adult making application, and return with any necessary verifications.

5. What criteria will be used to determine whether the 5% penalty for failure to meet performance objectives will be assessed?

Answer: The quantitative performance criteria are specified in Section VI(E)(2)(a).

<u>Web Site</u>

1. Who will define, identify, and/or approve the health related links for the CHIP web site? Does the bidder have the responsibility and authority to select links, in addition to any required by the Agency?

Answer: Some of the links will be identified by HHSC and the contractor will be encouraged to recommend other links to information on health care and related services or programs for children and families. All links must be approved by HHSC.

2. Is a signature on the application a required field? If all other information is correct and complete, is an applicant not enrolled unless the application is signed? Must it be an original signature, or is a fax or electronic signature acceptable?

Answer: Each application must have an original signature; faxes or electronic signatures are may not be acceptable subject to federal guidance (see response to question 8 on page 4). Enrollment may not occur until a child is deemed eligible for CHIP, and that eligibility determination may not be made without an original signature, again subject to federal guidance.

3. If the premium is paid and all other information is complete, would enrollment be denied if the application is unsigned?

Answer: Yes.

4. If on-line applications are developed, is on-line field validity editing a requirement?

Answer: Yes.

Applications

1. Will the contractor be responsible for printing the application form?

Answer: The only time the contractor will be responsible for printing an application form is in response to a telephone application. The contractor will not be responsible for printing blank application forms for general distribution. HHSC will provide those forms to the contractor at no charge.

2. Will the contractor be responsible for distributing the application form?

Answer: The contractor will be responsible for mailing application forms upon written or telephone request.

3. How will community based organizations be identified? Is it the bidder's responsibility to locate and form liaisons with these groups? Will the Agency provide a statewide listing of involved community organizations? If there are several in a region, what method is the bidder to use to identify to which agency the notice of follow-up copy is to be sent?

Answer: CBOs will be identified through contracts with HHSC and through local voluntary partnerships. The administrative services contractor will not have a responsibility to locate these groups, although HHSC will expect the contractor to work collaboratively with CBOs at its direction. HHSC will specify the zip code-based list of

contracted or volunteer CBOs from which the contractor would select for purposes of follow-up notification.

4. The contractor is to develop and maintain a web site for CHIP, while HHSC is going to provide the application. What is the scope of the application to be provided by the HHSC?

Answer: Please consult Section VI(E)(2)(c) for a list of the application's data elements.

5. The RFP requires that applications be stored for four years from the "last active date of the document." Please clarify whether this means the "last active day of the case."

Answer: It means from the "last active day of the case."

6. Please clarify the term "non-fraud claims."

Answer: "Non-fraud" refers to case where an error is the result of misunderstanding, client error, or agency error with no intent to defraud.

7. What are the data retention requirements for situations involving fraud, quality control sanctions, or non-fraud claims?

Answer: For cases with a pending fraud referral, records must be kept until a final disposition is received after which the four-year storage requirement begins. For cases subject to quality control sanction (in the event the federal government imposes quality control requirements), records must be kept until the sanction period is resolved after which the four-year storage requirement begins.

<u>Screening, Eligibility and Referrals</u>

1. Define the term "children with special health care needs." This is used throughout the RFP and affects potential available primary care providers, reporting, and other administrative requirements of the contractor. Who will identify children who fall into this category? Will the application contain the information for the bidder to make a determination?

Answer: A child with complex special health care needs must:

- **Range in age from birth up to age 19 years;**
- **Have a serious ongoing illness, a complex chronic condition, or a disability that has lasted or is anticipated to last at least twelve continuous months or more;**
- **Have an illness, condition or disability that results (or without treatment would be expected to result) in limitation of function, activities, or social roles in comparison with accepted pediatric age-related milestones in the general areas of physical, cognitive, emotional, and/or social growth and/or development;**

- **Require regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel; and**
- **Have a need for health and/or health-related services at a level significantly above the usual for the child's age.**

The generic application will include a health status question, the sole purpose of which will be to preliminarily identify children with complex special health care needs (CCSHCNs). Following enrollment in a health plan, a physician will make a final confirmation of a child's CCSHCN status. Health plans must convey all CCSHCN confirmations back to the administrative services contractor. The contractor must track both positive responses to the health status question and subsequent CCSHCN confirmations.

2. If citizenship is self-declared, why is the bidder responsible for connecting with the Alien Status Verification Index? (see page 28 – Electronic Interfaces).

Answer: This is a federal requirement. The Personal Responsibility and Work Opportunity Act of 1996 requires verification of immigration status for federal public benefits programs, including CHIP. States must verify with INS the immigration status of qualified aliens. ASVI provides this verification.

3. RFP identifies that separate tracking is needed for Legal Aliens enrolled in CHIP. However the reports defined in Appendix XX do not specify any reporting for this group. Are the reporting requirements to be "mirrored" between Legal Aliens and US Citizens for duplicate reporting formats unique to each group?

Answer: Yes.

4. Based on the requirement that the contractor is to forward electronically all applications that appear to be Medicaid eligible to the DHS, the assumption is being made that ALL applications must be data entered by the contractor before any eligibility review and determination is made. Please confirm that this is the Agency expectation.

Answer: The assumption is correct.

5. What percentage of applications does the Agency expect would be received electronically, via the Internet or other means available?

Answer: This information is not known. As stated earlier, the availability of the application process via the Internet will be determined based on the responses received.

6. If DHS denies an application for Medicaid eligibility, they will send an electronic code to the contractor. Will the DHS also return the paper application that is required to be sent to them immediately following submission of the electronic application data?

Answer: Yes. The returned paper application will be the original or a photocopy, depending on the process that is negotiated with the Department of Human Services.

7. Will the contractor have electronic interface with the Texas Employee Retirement System to determine applicants who may be eligible for enhanced premium subsidy? This is not listed on the electronic interfaces on pages 28-30. Will this be a self-attestation question?

Answer: There will be an electronic interface with ERS, but it will not be for lookup purposes to determine whether specific applicants are state employees eligible for an enhanced premium subsidy. Rather, the purpose of the interface will be to transmit data associated with children of state employees from the administrative services contractor to ERS. State employees will be identified during the application process by matching an applicant's employer with a database of all ERS-participating entities. The database of ERS-participating entities will be provided to the contractor by HHSC or its designee.

8. How often will the contractor be required to review changes in eligibility or premium due to children's ages? Is this a period review of all active applications, or an annual review at anniversary of each enrollee?

Answer: Based on a child's date of a birth, the CHIP system must be capable of automatically recognizing when a child's eligibility status changes because of a birthday. This must be an ongoing (as opposed to periodic) function of the system.

9. Is income for the year assumed to be that which is reported at enrollment? If so, how are adjustments made if this amount changes?

Answer: Income reported at enrollment carries through the 12 months of continuous eligibility unless a family voluntarily reports a change in income to the administrative services contractor.

10. If income drops to qualification levels, will families be transferred to Medicaid?

Answer: Children remain in CHIP for the 12=month period of continuous eligibility unless the family voluntarily reports the drop in income to initiate a transfer to Medicaid. In that case, CHIP coverage ends if the child is determined to be eligible for Medicaid.

11. How is percentage of income and percentage of federal poverty level (FPL) to be calculated for those families with irregular earnings?

Answer: FPL will be based on the family's income, adjusted to a monthly level, as it is reported on the application. Twelve months of continuous eligibility are unaffected by occasional changes in income during that period unless they are voluntarily reported by the family.

12. What does HHSC view as adequate proof of immigration status? Will a photocopy of the applicant's green card or a birth certificate suffice?

Answer: A photocopy will be acceptable; however, verification with ASVI will still be necessary.

13. How should the applicant's income be stated in the required document (on monthly, bi-weekly, or weekly basis)?

Answer: The generic application is designed to give families the option of reporting income according to the periodicity with which they are paid, regardless of whether that is weekly, bi-weekly, monthly, or twice a month. The CHIP system must be capable of translating the data as it is reported into monthly income data.

14. What does HHSC consider acceptable income disregards?

    Eligibility screening describes that net income must be verified, along with any claimed "income disregards." How does this process vary from the "assets test" that the RFP states is not to be performed or required?

Answer: Applicants are allowed the following deductions, which are separate and distinct from the assets categories used to screen children for Medicaid (vehicles, cash on hand, land, etc.):

- **The total amount of any child support/alimony paid by a household member to someone outside the household**
- **Work-related expense ($90 per employed household member)**
- **Dependent care cost ($200/month for each child under age 2, $175/month for each child age 2 and up)**
- **A deduction of $50 from any child support received by a member of the household (if mother receives $200 child support, $50 is subtracted leaving a net income of $150 from child support)**

15. What is "an alternative action", other than deeming the children eligible for CHIP II?

Answer: If a child is not enrolled in Medicaid for a reason other than income or assets (failure to keep a DHS appointment or provide necessary Medicaid verifications, for example), it would not be appropriate to deem the child eligible for CHIP. In those cases, alternative actions would be necessary (no further action on the case or referral to THKC would be two possibilities).

16. Please provide the regulations governing eligibility for the CHIP in Texas, or provide a reference indicating where bidders can obtain the regulations.

Answer: The legislative eligibility requirements are contained in SB 445, 76th Legislature. The eligibility criteria are also enumerated in the Title XXI state plan amendment. . Those requirements also will be reflected in rules to be promulgated by HHSC.

Enrollment, Re-enrollment, and Disenrollment

1. Who will be responsible for assignment of the new enrollee's PCP? Is this the responsibility of the health plan, the enrollee (i.e. mandatory field to be completed on the application), or is there a default process to be initiated by the bidder if an applicant is determined eligible, has selected a health plan, and all other criteria have been met? Please expand on this issue.

Answer: This question is addressed in Section VI(E)(2)(e) as follows: "Families must choose a health plan, a PCP, and an alternate PCP. To facilitate the PCP selection process, on a weekly basis health plans will electronically transmit provider data to the selected contractor. When the contractor is notified that a particular PCP is no longer available, enrollment materials must be updated accordingly. This updating process must occur at least once a month. If a family selects a PCP who is no longer available, the alternate PCP selection will be transmitted to the health plan." If a family fails to select a PCP at the time of enrollment, the child(ren) will be defaulted to a PCP by the selected health plan.

2. Please clarify the point at which a child is considered enrolled and eligible for services. Does the premium have to be received before the enrollment record is sent to the designated health plan? Is the enrollment record sent as soon as application is complete and approved, and contractor continues to follow-up for premium?

Answer: The premium must be received before the enrollment record is sent to the selected health plan. The other issues are addressed in Section VI(E)(2)(e).

3. How will applicants obtain the information needed to select health plans and primary care providers?

Answer: As described in Section VI(E)(2)(e), the administrative services contractor must design, produce, and update -- subject to HHSC approval -- enrollment materials intended to help CHIP-eligible families select a health plan and PCP.

4. Is the 12 months of continuous coverage applicable to eligibles who are on a monthly premium payment status? Or is this only for enrollees who pay one annual enrollment premium?

Answer: The 12 months of continuous coverage is unrelated to a family's cost-sharing responsibilities.

5. Why is the Agency not sending reminders to families whose 12-month continuous enrollment insurance coverage is about to expire?

Answer: The process for reminding families to re-enroll is the principal responsibility of the administrative services contractor, with support provided by health plans and CBOs.

6. How will Open Enrollment periods work with the annual expiration date of the first year of coverage? Will open enrollment apply to new applicants only?

Answer: HHSC will determine at a later date whether open enrollment dates will apply after the first year of operation during which continuous open enrollment is required by state statute.

7. Are the two instances identified (death and moving out of state) the only instances where disenrollment would be retroactive?

Answer: Disenrollment is retroactive in the following cases:

- **"Aging-out" when a child turns nineteen**
- **Failure to re-enroll at the conclusion of the 12-month eligibility period**
- **Change in health insurance status (i.e., a child enrolls in an employer-sponsored health plan)**
- **Failure to meet monthly cost-sharing obligation**
- **Death of a child (disenrollment is retroactive to end of the month following the date of the child's death, except that retroactivity is limited to a maximum of four months)**
- **The child permanently moves out of the state (effective the last day in the month in which the move occurred)**

8. What are HHSC's expectations regarding enrollment materials for the visually impaired?

Answer: All visually-impaired applicants must have access to appropriate enrollment materials. Proposers must describe how they intend to meet this requirement.

9. What about Medicaid eligibility found during the monthly data match run by the State? Will there be a data match with the TIERS and the THKC coverage files?

Answer: DHS Medicaid will determine if a child is enrolled in both systems. If a child is found to be in both systems, electronic notification will be sent to the CHIP system which, in turn, will generate a disenrollment notice to be mailed to the child's family. TIERS is the proposed new eligibility system for DHS.

10. Will the CHIP application require social security numbers for data matches with the Medicaid system?

Answer: The generic application will require social security numbers for all children for whom health insurance is being sought. SSNs provide an additional method to match referrals of clients between CHIP and Medicaid and their use will improve the accuracy of data matches to ensure that clients are not simultaneously enrolled in both programs.

Cost-Sharing

1. Clarification is needed regarding the requirement to use any type of administrative cost allocation method as this may be viewed by the bidders as the State wanting a cost plus contract for administration.

Answer: Clarification of a proposer's cost allocation method is in the RFP so that HHSC understands how the proposer arrived at its budget.

2. Why is there different terminology for annual payment (enrollment fee) and monthly payment (monthly premium)? Is there significance to this?

Answer: Families between 100% and 150% are not required to pay monthly premiums for CHIP coverage. Their only cost-sharing obligations are nominal co-pays for certain services and a $15 annual enrollment fee. Families above 150% FPL must pay monthly premiums, but their initial premium is due at the time of enrollment (which makes it appear to be an "enrollment fee").

3. Would payment be sent to the State Comptroller by EFT?

Answer: Yes.

4. In the event of a retroactive increase in premium, would an enrollee also be terminated if the balance was not paid within 20 days?

Answer: HHSC does not anticipate retroactive premium increases in the context of the enrollee's premium cost-sharing obligation.

5. Is the health plan at risk for health coverage each month? If the premiums for the current month are due on the first day of the month, and the enrollee has until the 20th day of the month to pay – what if the enrollee does not pay and is cancelled at the end of the month? Does the health plan still receive payment for that month of coverage? Is the termination/ cancellation retroactive back to the prior month?

Answer: These questions are based on the premiums payable methodology outlined in the draft RFP posted for public comment in June. The final version of the RFP addresses these issues in Sections VI(E)(2)(f) and (g).

6. If a family's gross income changes during the calendar year, how does this affect the maximum 5% per year calculation for capping premium and copay requirements?

Answer: A change in gross income is germane to the 5% limit only if the family voluntarily reports the change in income to the administrative services contractor.

7. If an enrollee notifies the contractor that the 5% cap has been met (with a combination of premium and co-pays) is the contractor responsible for verification/ validation of this?

   Is the enrollee's statement that they have reached the 5% cap adequate for purposes of turning off premium monthly billing for the rest of the calendar year?

Answer: For verification purposes, families will track their expenses using a simplified form developed by the administrative services contractor. At this time, it is HHSC's intent that submittal of this form will be the only verification a family must provide and the contractor will have no additional validation requirement. Once the contractor determines that a family's 5% cap has been met, the monthly premium obligation ceases for the rest of the calendar year.

The question of verification may be subject to revision prior to program implementation. For instance, federal guidance and/or compelling programmatic reasons may lead HHSC to require families to submit receipts. In view of that possibility, proposers are invited to describe the impact of a more substantial verification requirement in their response to the cost-sharing section.

8. Does the 5% gross income cap on "CHIP-related expenditures" include the monthly premium?

Answer: Yes.

9. Could the premium payments ever be retroactively reinstated if the information was determined not to be correct? Would this be considered fraud?

Answer: Retroactive reinstatement of the premium obligation would be appropriate if it is later discovered that a family has not, in fact, met the 5% cost sharing cap. A determination of fraud, abuse, or at least enrollee family error would have to be made on an individual basis.

10. How will contractor be able to track the co-pay amounts to know when to trigger a notice to the Comptroller's office for premium overpay refund?

Answer: All co-pay tracking is the responsibility of the family.

11. Does the 5% gross income cap on "CHIP-related expenditures" include co-insurance as well as co-payments?

Answer: Based on comments received in regard to the draft health plan RFP, HHSC has decided to drop the co-insurance requirement in favor of deductibles for families between 186% and 200% FPL.

12. Is the contractor required to maintain a bank account to deposit Client Cost-Sharing funds into? Will the contractor be required to invest Client Cost-Sharing funds and pay interest to the HHSC? Can these funds be commingled with any other HHSC funds held by the contractor?

    Does the bank where the premium funds are held need to be a Texas bank?

Answer: HHSC declines to answer this question at this time, pending consultation with the Comptroller's office.

13. Is the contractor expected at act as a collection agency to collect these fees? If so, what level of collection effort is required?

Answer: No.

<u>On-Line Access and Reports</u>

1. Will the contractor be responsible for the cost of hardware/ software/ line charges to establish on-line access for Agency personnel?

Answer: HHSC interprets this question to be in reference to Agency modems, phone lines, telecommunications software, browsers, etc. The contractor will not be responsible for these costs associated with Agency's on-line access. However, the contractor as part of its overall fee structure must provide any specialized software that must be installed on Agency computers to gain access to CHIP system data and reports.

2. Will this access be provided at the contractor's site or at an Agency designated location?

Answer: On-line access implies a remote connection via the Internet or modem.

3. Will the Agency accept read-only access to the data?

Answer: Read-only access is appropriate for on-line viewing of the data, since the State does not intend to reserve the right to directly edit the data. However, the State does reserve the right to download data for internal analysis on its own systems.

Electronic Interfaces

1. The bidder will be required to interface with several different state agencies, health plans, and other vendors. Is it assumed that system compatibility with the HHS architecture standards will ensure compatibility with the other state agency systems? Are all state agencies linked together via the same system? What about Texas Healthy Kids Corporation?

Answer: Compatibility with HHS standards will be important but that, in and of itself, may not assure compatibility with specific software or hardware configurations. It will be the contractor's responsibility to make any necessary modifications to its system to ensure compatibility with DHS and THKC systems. Interfaces with health plans will be the product of consultation between the contractor and the health plans selected by HHSC through competitive procurement.

2. With DHS Medicaid data match interface, which agency takes the lead in handling the issue if duplicate enrollment is Medicaid and CHIP is identified?

Answer: DHS Medicaid will determine if a child is enrolled in both systems. If a child is found to be in both systems, electronic notification will be sent to the CHIP system which will, in turn, generate and mail a disenrollment notice to the child's family.

3. Can the CIDC and the Medicaid data match be combined into a single file sent to a single entity (i.e. NHIC?)

Answer: There will be an ongoing process of daily data transfers between the CHIP system and the DHS Medicaid eligibility system. These transfers will perform additional functions as well as the data match to identify dual enrollments. During CHIP system development, options can be discussed to further streamline the process.

4. Will the selected contractor have any interface or relationship with the State's Medicaid enrollment broker? Please specify any type of relationship.

Answer: No.

Data Recovery and Back-Up

1. What facilities and services are available at San Angelo State University? Will they furnish the facilities and the administrator provide all hardware, software and personnel?

The West Texas Disaster Recovery Operations Center (WTDROC) is a full service data center offering a variety of technical services, including network management, back-up, and disaster recovery. It is a 30,000 square foot computer center with full N+1 disaster

recovery facilities. Facilities, hardware, software, and personnel are available under contract with Northrup Grumman Technical Services Inc. (NGTSI).

2. How should the contractor determine whether the DROC is cost effective? Will the HHSC give that information to the contractor?

   Is the DROC at San Angelo State University free for use by the contractor? If not, how should it be priced?

Answer: WTDROC services are not free. Any proposer wishing to cost out the WTDROC services should request a cost proposal from NGTSI by contacting Mr. Bob Tyner at 512-444-9683.

Section VI(E)(3): Work Plan and Budget

1. Is budget information to be presented as part of the technical approach or be bound separately?

Answer: The budget information should be included as part of the overall proposal.

2. The agency is requiring the submission of two annual budgets outlining the contractor's anticipated start-up and recurring costs. Would the State allow flexibility in presenting cost detail and line items?

Answer: At this time, HHSC is not requiring the submission of budget information in a specific format. However, the presentation of the budget data should be sufficiently detailed to give HHSC a clear picture of the financial resources that will be devoted to each of the nine basic cost categories. For instance, within the "computer hardware, telecommunications equipment, and related electronic infrastructure" category, HHSC expects to see detailed, line-by-line information about the types of equipment that will be purchased and their respective costs. A single annual cost for this category would be considered non-responsive.

3. The nine cost categories are not mutually exclusive. Will the agency provide the bidders with operational definitions of the categories?

Answer: HHSC recognizes that it is possible for some costs to overlap multiple categories. The preferred approach in these situations would be to allocate the cost proportionally to the various categories. If that is not possible, the overlapping costs should be clearly identified with an explanation of why a cost allocation is not used. A possible example of a situation where the cost allocation approach might not be appropriate is hardware for the website, which could be itemized under the website category or the hardware category. In

a situation like that, a proposer should simply decide where to list the cost and make a notation in the other category as a cross-reference.

The following is a brief operational definition of each category.

---System development, modification, and testing: All costs related to new systems development, modification of existing systems to meet the unique needs of the Texas program, and relating testing and de-bugging (these will generally be start-up costs, although occasional development and testing may occur in the future to fine-tune the system or respond to state or federal policy changes)
---System implementation and maintenance: All costs related to deployment of the software across the contractor's enterprise (generally a start-up cost) and ongoing maintenance and support of the system including back-ups, training, data recovery, and hardware configuration (recurring costs)
---Web site development and maintenance: All costs related to the initial development of the web site (start-up cost) and ongoing maintenance of the website, including periodic hardware upgrades, software upgrades, and content changes (recurring costs)
---Any applicable software licensing fees: Any costs associated with commercial software licenses (could be a start-up or recurring cost, depending on the framework of the licensing agreements)
---Computer hardware, telecommunications equipment, and related electronic infrastructure: Costs associated with the purchase and maintenance of CPUs, monitors, printers, back-up devices, storage devices, networking equipment, modems, phones, cables, routers, voice mail systems, fax machines, copying machines, and other related equipment (initial purchases will be start-up costs, leasing and maintenance agreements and ongoing replacement and upgrade purchases will be recurring costs)
---Furniture or other non-electronic equipment or supplies: This is a "catch-all" category that includes items like office supplies (paper, copy toner), furniture like tables, chairs, and file cabinets, and other routine operating expenses (includes start-up costs and recurring costs)
---Staff (permanent and temporary): Apportioned salaries and fringe benefits for all permanent and temporary staff assigned on a full-time or partial-time basis to the Texas project (recurring cost)
---Leased space and related utilities (except for hotline costs): Recurring costs related to leased space and utilities (telephone costs that are not apportioned to the call center should be included in this category)
---Telecommunication fees: Recurring telephone costs apportioned to the call center

4. Are the two annual budgets covering the first two years defined by contract year or as one budget for start-up costs and one budget for recurring costs?

Answer: The budgets are defined by contract year.

5. Would the State prefer that the budgets be presented by State Fiscal Year or by contract year?

Answer: Contract year.

6. Please specify the actual start-up date. What kind of financial penalties will be invoked if the contractor misses the anticipated start-up date?

Answer: The call center and the business process related to application processing, eligibility determination, and enrollment must start on or before April 2, 2000. The actual date will be a negotiated contract deliverable, subject to liquidated damages in the event of failure to deliver. Insurance coverage begins statewide on May 1, 2000. The financial penalties will be negotiated.

7. Please clarify the term "recurring costs." Does it mean costs attributable to systems maintenance and operations?

Answer: "Recurring costs" are costs that are anticipated to be ongoing and predictable, such as salaries, utilities, training, telecommunication fees, or leases. By means of comparison, non-recurring costs would include initial software development and testing, and investments in hardware.

8. Please specify the format for the Cost Proposal section.

Answer: At this time, HHSC is not requiring the submission of cost data in a specific format.

9. Is this contract subject to the Federal Acquisition Regulations? If so, which ones?

Answer: The CHIP procurements are not generally subject to the Federal Acquisition Regulation (FAR). Certain provisions of the FAR, however, govern the extent to which costs are allowed for commercial organizations and certain nonprofit organizations.

10. Is this contract subject to an HHSC or third party audit? If so, what would be the scope of the audit? Who would conduct the audit?

Answer: All CHIP contracts are subject to audit by HHSC or its designee or the State Auditor (under Government Code Section 2155.144). In addition, nonprofit organizations that receive a contract from HHSC for CHIP-related services are required under 45 C.F.R. 74.26 to obtain a single audit in compliance with the Single Audit Act Amendments of 1986. As provided in 45 C.F.R. 74.26, a commercial organization that receives a contract from HHSC for CHIP-related services is required to obtain a financial-related audit in compliance with Government Auditing Standards or an audit that meets the requirements of OMB A-133.

11. The document requests budget information for the first two years. Is the time of the budget information supposed to be for two years, or for the full term of the contract (three years)?

Answer: Two years.

Section VI(F): Fees

1. How will implementation/start-up costs be reimbursed? Should they be included in the monthly fees, or will they be reimbursed separately? If they are to be submitted separately, in what format should they be presented with the cost proposal?

Answer: The monthly fees should be considered all-inclusive. No implementation or start-up costs will be reimbursed separately.

2. "All fees will apply to the three year term of the contract…" Would the State accept different rates for each of the three "base" contract years?

Answer: The fees must apply to each of the three "base" contract years. Different rates per year will not be accepted.

3. Is HHSC open to various pricing techniques (fixed price, price per member per month, implementation price)? Does the HHSC prefer a specific pricing technique? If so, which one and why?

Answer: The cost methodology is clearly stated in Section VI(F) of the RFP. No other pricing approach should be proposed.

4. Is the application fee payable for applications entered into the system but that are missing information from the applicant?

Answer: Yes.

5. Would the contractor receive both an Enrollment fee for a newly enrolled family and a monthly maintenance fee for newly enrolled children in the same month?

Answer: The relationship between enrollment and the beginning of insurance coverage is described in Section VI(E)(2)(e): "Twelve months of continuous coverage begins on the first day of the month following enrollment unless enrollment occurs after the cut-off date, in which case coverage begins on the first day of the next month." The enrollment fee would be payable for the month in which enrollment occurs; the initial monthly maintenance fee would be payable for the month in which coverage begins.

Section VI(G): Other Required Forms

1. Will bidders who propose subcontracts with HUBs receive additional evaluation points?

Answer: State law requires state agencies to make a good faith effort to encourage the participation of HUBs in state contracts, including subcontracts. Prospective contractors are required to demonstrate good faith effort in the solicitation of HUBs on contracts where it is anticipated that subcontracts will be let. HHSC will evaluate the participation of HUBs in accordance with applicable law and precedent.

2. Regarding HUBs – does the Agency require that a certain percentage of the contract be allocated to HUB vendors? If so, please specify the amount.

Answer: General Service Commission rules (1 T.A.C. Section 111.13) establish an annual HUB utilization goal of 33 percent for all services contracts that are not construction, building construction, special construction trades, or professional services contracts. CHIP services procurements fall into this category.