TexCare Partnership
Request for Proposals

For

Promotor(a)/Community Health Worker (CHW) Projects

In Harris County including Houston, Webb County including Laredo, Bexar County including San Antonio, El Paso County including El Paso and the four counties within the Lower Rio Grande Valley -- Cameron, Hidalgo, Willacy and Starr

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SECTION 1 MISSION

1.01 Mission Statement

The mission of the Health and Human Services Commission ("HHSC") in this procurement is to obtain proposals to demonstrate the efficacy of using the Promotor(a)/Community Health Worker (CHW) model in the Children's Health Insurance Program (CHIP) for Texas and the Texas Medicaid Program. The purpose of the Promotor(a)/CHW model in the CHIP/Medicaid Program is to contribute to the Healthy People 2010 goal of eliminating health disparities in Texas. HHSC will accomplish this mission by contracting for appropriate technical assistance for Harris County including Houston, Webb County including Laredo, Bexar County including San Antonio, El Paso County including El Paso and the four counties within the Lower Rio Grande Valley -- Cameron, Hildalgo, Willacy, and Starr Counties. The achievement of this goal will fulfill the intent of the 76th Texas Legislature per House Bill 1864.

1.02 Mission Objectives

This Request for Proposal ("RFP") is to invite Potential Contractors to submit proposals to demonstrate the efficacy of using the Promotor(a)/Community Health Worker (CHW) model through the TexCare Partnership, which offers children's health insurance options through Medicaid and CHIP. Eliminating health disparities by the year 2010 will require new knowledge about the determinants of disease and effective interventions for prevention and treatment. It will also require improved access for all to the resources that influence health. Improving access to quality health care and the delivery of preventive and treatment services will require working more closely with communities to identify culturally sensitive implementation strategies. The primary goal of this procurement is to obtain for the taxpayers of Harris, Webb, Bexar, El Paso, Cameron, Hildalgo, Willacy, and Starr Counties and members of the TexCare Partnership Promotor(a) or CHW services that achieve the following objectives:

1. Increase applications to TexCare Partnership;

2. Increase enrollment in CHIP and Medicaid;

3. Educate CHIP/Medicaid members on appropriate use of health care resources, including the use of any available Medicaid or CHIP managed care plan that provides coverage to beneficiaries and the effective use of a member's primary care provider;

4. Promote CHIP/Medicaid members' regular, appropriate use of preventive care services, particularly prenatal care services and services available under the Texas Health Steps Program (formerly known as the Texas Medicaid Early Periodic Screening, Diagnosis, and Treatment Program);

5. Encourage and assist CHIP/Medicaid members to develop a basic family preventive health plan;

6. Encourage and support CHIP/Medicaid members in keeping appointments for health care, following up on missed appointments, and complying with the instructions of health care providers; and,

7. Achieve the best value for the taxpayers of Texas.

Eligible contractors include community-based groups, health departments, public and private agencies, not-for-profit organizations, boards, and other health related organizations. **Medicaid and CHIP managed care organizations (MCOs) are not eligible for contract award.** Other organizations that are Medicaid/CHIP providers may apply but must demonstrate how member freedom of choice will be protected.

A Potential Contractor must demonstrate its ability to provide assistance that will enable HHSC to achieve these Mission Objectives and will be evaluated, in part, by the degree to which it shows how it will assist HHSC to achieve these objectives.

Potential Contractors may prepare and submit proposals as follows:

a. One proposal for all locations;
b. One proposal for multiple locations;
c. One proposal for a single location.

To be considered, the Potential Contractor's proposal must state which location(s) the proposal is intended to cover. If a proposal is submitted for multiple locations the Potential Contractor must indicate if the proposal may be considered for individual areas. If the Potential Contractor submits proposals for all locations but is willing to be considered for one or more locations within the five, then this must be clearly indicated. HHSC reserves the right to award one or more, or all, of the locations to a given proposer. The proposed locations are as follows:

Location 1:	Harris County including Houston
Location 2:	El Paso County including El Paso
Location 3:	Bexar County including San Antonio
Location 4:	Webb County including Laredo
Location 5:	Lower Rio Grande Valley including the following counties: Starr, Cameron, Hidalgo, and Willacy.

1.03 Sponsoring Agency

The Health and Human Services Commission was created in 1991 to oversee and coordinate the planning and delivery of health and human services programs in Texas. It is established pursuant to Chapter 531, Texas Government Code and is responsible for oversight of Texas health and human service agencies. HHSC is designated as the single State agency for purposes of administration of the Texas Title XIX Medical Assistance Program (Medicaid) and the administering agency for the State Children's Health Insurance Program.[1] The chief executive officer of the Commission is Don A. Gilbert, Commissioner of Health and Human Services.

1.04 Promotor(a)/Community Health Worker (CHW)

a. Background

The formal participation of CHWs in health and human services systems has been documented in the United States since the 1950s. The National Community Health Advisor Study estimates that there are currently at least 12,500 CHWs serving throughout the U.S. in CHW programs involving both volunteer and paid CHWs. CHWs work in clinics and reach out into homes, community centers, and the streets, addressing some of the most difficult health problems. They serve on the front lines of public health, where resources are limited and demands are great.

Promotores(as) are a subset of a larger group of health workers known as CHWs. Some other names for these health workers are Lay Health Advocate, Promotor(a), Outreach Educator, Community Health Representative, and Peer Health Promoter.[2] In this Request for Proposal, the terms Promotor(a) and CHW are used interchangeably.

The roles and responsibilities of CHWs vary greatly. In practice these roles generally include:

- outreach worker,
- advocate,
- translator,
- educator,
- mentor,
- cultural mediator, and
- role model.[3]

CHWs perform one or more of the following functions:

- assess individual and community health needs;
- coordinate care and case management;
- educate institutions about community norms, needs, culture and strengths;
- educate individuals and families about prevention and access to care; and
- organize community activities.[4]

b. Promotores(as) in Texas

In Texas, Promotores(as) or community health workers (CHWs) often provide the vital link connecting underserved clients with essential health and human services. The uniqueness of their service lies in their ability to relate to clients through shared experiences drawn from living as neighbors in common communities. First-hand knowledge of the barriers, to delivery of health care in a community, gives CHWs a stake in eliminating those barriers.

The role of the Promotor(a) or CHW differs widely from community to community. The strength of this workforce is that it can be shaped to fit the needs identified by community members. For example, CHWs may:

- serve as interpreters or translators for clients during doctor visits,
- help clients identify benefits for which they are eligible and
- assist with completion of applications to receive benefits and services.
- As community leaders, they may empower their neighbors by organizing and motivating them to become actively involved in improving living conditions within their neighborhood.
- In the role of health educators, CHWs may inform their clients of ways to prevent illnesses and teach them how to manage chronic diseases.
- Experience has shown that CHWs are a valuable resource for informing and recruiting their neighbors to participate in social programs for which they qualify.

The Texas Administrative Code, Title 25, Rule §146.1, defines a Promotor(a) or Community Health Worker as:

A person who, with or without compensation: provides cultural mediation between communities and health and human service systems, informal counseling and social support, and culturally and linguistically appropriate health education; advocates for individual and community health needs; assures people get the health services they need; builds individual and community capacity; or provides referral and follow-up services.

Furthermore, the Texas Administrative Code, Title 25, Rules §146.4 and §146.8 set forth the minimum standards for Promotor(a)/CHW certification and the eight core skill and knowledge competencies for training community health workers or Promotores(as). Those eight core competencies include:

- communication skills,
- teaching skills,
- service coordination skills,
- capacity-building skills,
- advocacy skills,
- interpersonal skills,
- organizational skills and
- knowledge base.

In particular, Promotores(as)/CHWs have assisted public health providers in serving individuals and communities in the border region for decades. Promotores(as) have provided such services to health centers as:

- assisting in case conferences,
- client education,
- referrals to other health and social services, and
- volunteer coordination.

In border communities, Promotores(as) have:

- conducted needs assessments,
- distributed surveys to identify barriers to health care delivery, and
- made home visits for patient education and follow-up.

Because many Promotores(as) along the border speak both Spanish and English, they have helped families talk with health care providers. Information provided to the 76th Legislature identified approximately 30 Promotor(a) projects which operate along the Texas border region.

CHW studies in Texas and in other states, in addition to the National Community Health Advisor Study, have documented the success of the Promotor(a) or Community Health Worker model.[5,6,7,8] Findings have demonstrated the effectiveness of prevention efforts, the reduction of cultural and linguistic barriers to care, success in assisting individuals to navigate complex health and human service systems, and improvements in the quality and cost-effectiveness of care. The use of the Promotor(a)/CHW model shows promise in helping to eliminate health disparities by working more closely with communities in a culturally appropriate manner and by improving access to health care resources through educational efforts.

Information about Promotores(as)/Community Health Workers, the National Community Health Advisory Study, Texas Legislative Reports, House Bill 1864, Texas Board of Health Rules and other relevant documentation can be found on the Internet at: www.tdh.state.tx.us/ppdc/ppdc.htm.

1.05 Children's Health Insurance Program (CHIP)

a. Background and Origins of CHIP

A major provision of the Balanced Budget Act of 1997 established the State Children's Health Insurance Program (CHIP) (Title XXI of the Social Security Act). This program is a historic milestone in the financing of health care for children.[9] Not since the enactment of Medicaid has there been a greater investment in children's health care. Title XXI offers an unprecedented opportunity to expand insurance to a large percentage of uninsured children.

The number and proportion of American children lacking health insurance increased in 1996 to the highest levels ever recorded by the Census Bureau's Current Population Survey. In 1996, 15.1 percent (11.3 million) of children younger than age 19 were uninsured, up from 14 percent (10.3 million) who were uninsured in 1993 (AAP Division of Health Policy Research, Health Insurance Status of US Children Under Age 19, 1997). Nationwide, the increase in uninsured children is related to an enrollment decline in Medicaid rather than to a decrease in the number of children with employer-based insurance. As of 1996, 21.6 percent (16.2 million) of children younger than age 19 were enrolled in Medicaid, down from 23.5 percent (17.2 million) who were enrolled in 1993. As of 1996, 63.3 percent (47.4 million) of children younger than 19 years had private employer-based insurance, up from 62.5 percent (45.7 million) in 1993.

Although the reasons for this decrease are not clear, it is likely that the strong economy has raised income levels of many families above some current state Medicaid eligibility thresholds, and welfare reform policies have unintentionally reduced the number of Medicaid recipients. Many families leaving the welfare roles are unaware that their children continue to be Medicaid-eligible.

Despite this increase, most children without health insurance have an employed parent, who either is not offered health benefits by their employer, cannot afford to pay the premium contributions, or simply choose not to buy health insurance. Individual states vary with respect to changes in numbers of uninsured children based on state economic conditions, state Medicaid eligibility levels, outreach and enrollment activities, welfare reform policies, and the availability of other state health insurance programs.

b. Implementation of CHIP in Texas

Texas has one of the highest percentages of uninsured children in the U.S. Phase I of the Texas response to the Children's Health Insurance Program was a Medicaid expansion for teens ages 15-18 at or below 100 percent of the federal poverty level (FPL) that became effective July 1, 1998. Phase II of the Texas response (henceforth referred to in this RFP as "CHIP") is a state-designed program targeted to newborns through 18 years of age at or below 200 percent FPL who are not otherwise eligible for Medicaid.

c. Eligibility for CHIP in Texas

Eligibility for CHIP coverage is determined according to:

- income,
- family size,
- insurance status,
- citizenship status, and
- residency in Texas.

There is no assets test.

Some type of cost-sharing applies to most eligible families, including:

- annual enrollment fees and co-pays for families below 150 percent FPL, and
- monthly premiums and co-pays for families above 150 percent FPL.

To discourage families from dropping private insurance in favor of CHIP coverage (a practice sometimes described as "crowdout"), the state does not accept children into the program unless the children are uninsured for a minimum of 90 days. There are some good cause exceptions to this policy.[10]

CHIP eligibility is continuous for a 12-month period. During the 10th month of coverage, CHIP families begin the renewal process, which consists of confirming prior application information or submitting updated information. As the CHIP program in Texas matures, maintenance of coverage through successful renewal will be as critical a program goal as attracting new enrollees. More to the point, renewal will be the foundation for a long-term period of strong enrollment in Texas.

To date, enrollment in CHIP has been available on a continuous basis. HHSC has the statutory authority to specify open enrollment periods. Also, because CHIP is not an entitlement, HHSC has authority to establish waiting lists if budgetary considerations necessitate them.

Information about the contracted community-based organizations, the TexCare Partnership outreach campaign, the TexCare Partnership outreach efficacy study, or any aspect of the CHIP implementation can be found on the Internet at:

www.hhsc.state.tx.us or
www.texcarepartnership.com

d. Legal Authority

The Texas Phase II amendment to the Texas CHIP plan is the state's response to the federal CHIP, Title XXI of the Social Security Act, as created by the Balanced Budget Act of 1997. The Texas CHIP statutory authority is articulated in SB 445 as adopted by the 76th Legislature and signed by the governor. The fiscal authority for CHIP in Texas for fiscal years 2002-2003 will be contained in the General Appropriations Act as adopted by the 77th Legislature.

The U.S. Health Care Financing Administration (HCFA) approved the Texas Phase II amendment to the Texas CHIP plan in September 1999.

1.06 Medicaid

a. History

Congress established the Medicaid program under Title XIX of the Social Security Act of 1965. This is the same legislation that created Medicare. Texas began participating in the Medicaid program in September 1967.

Title XIX of the Social Security Act created the Medicaid program to provide medical assistance for low-income persons. Medicaid is a federal/state-matching program, in which both the federal and state governments must contribute a specified percentage of total medical expenditures.

Medicaid was intended to provide access to health care for low income Americans. However, the expense of the program and the number of Americans served has grown beyond original expectations.

b. Medicaid's Expansion

Over a period of three decades, Congress transformed Medicaid from a narrowly defined program available only to persons eligible for cash assistance, into a large program with complex eligibility rules.

In state fiscal year (SFY) 1997, Texas Medicaid covered nearly 2.5 million people. During the late 1980s and early 1990s, Congress expanded Medicaid eligibility to include a greater number of elderly, people with disabilities, children and pregnant women. As a result of these statutory changes, the Texas Medicaid population tripled in just a decade, adding more than one million people between 1990 and 1995.

c. Eligibility Under the Expanded Program

Federal laws passed in the late 1980's mandated coverage for groups of people ineligible for TANF or SSI and resulted in major expansions of the Medicaid-eligible population. The Medicaid program has also expanded the services it covers. The following program expansions resulted from federal mandates:

- Significantly increased payments to hospitals that serve large numbers of poor uninsured or Medicaid recipients, these payments, known as disproportionate share hospital payments ("DSH" or "Dispro") slowed or mitigated local property tax increases in Texas' large urban areas and slowed the rate of rural hospital closures;
- Coverage of prenatal and delivery services for certain pregnant women and their infants who have no other insurance;
- Expansion of services to many children in low-income families who do not receive cash assistance (TANF);
- Expansion of Medicaid to fill gaps in Medicare services to poor persons who are elderly or disabled; and,
- Coverage of the full array of federally-allowable Medicaid services as medically necessary and appropriate for all children on Medicaid.

Source: Texas Medicaid in Perspective, Third Edition, February 1999.

1.07 Texas Health Steps

The Texas Health Steps program, formerly known as the Texas Medicaid Early and Periodic Screening, Diagnosis, and Treatment program (hereafter referred to as THSteps) is a federally mandated preventive health care program administered by the Texas Department of Health.

a. Background

The purpose of THSteps preventive health care is to ensure that Medicaid enrolled children have the opportunity to stay healthy through the receipt of periodic medical and dental check ups and necessary treatment.

A major THSteps program function is to influence the eligible population of approximately 1.6 million recipients to seek medical and dental check ups. The THSteps program goal is for 80 percent of program participants statewide to participate in check ups. Numerous outreach strategies are employed:

1. Letters mailed from the TDH Central office to members statewide.

   Letters are classified as follows:

   a) New and Re-certified: Newly enrolled or re-certified Medicaid clients receive an informing letter advising them of program participation benefits;

   b) Periodic Due: Clients receive a letter when they are due a medical or dental check up;

   c) Overdue: Clients receive a letter when they are overdue a medical or dental check up;

   d) Ten Month Old: Clients receive a letter when a child turns ten months of age. The letter advises the parents about the importance of the child receiving dental check ups beginning at one year of age and the continued need for medical check ups; and,

   e) Newly Pregnant: Women who are newly diagnosed as pregnant receive a letter informing them of the benefits of preventive care.

b. Regional Outreach Activities

TDH regional and contract staff conduct a variety of outreach:

1. Telephone Calls: Clients are contacted over the phone using various lists such as new and re-certified client listing, periodic due, and overdue lists;

2. Face-to-face Encounters: Home visits are conducted for clients who either request this service or who have been determined to be historically non-participant;

3. Group Presentations: Presentations are conducted at group events held at various locations such as Women, Infant and Children (WIC) centers and Department of Human Services (DHS) offices; and,

4. DHS Informing: During Medicaid eligibility determination, clients are informed about THSteps services by the DHS staff.

1.08 Summary

This RFP is being published to invite Potential Contractors to provide assistance to HHSC and other state agency staff in the demonstration of the efficacy of the Promotor(a)/Community Health Worker model in the TexCare Partnership in selected counties of Texas.

This RFP is an invitation to Contractors to join us in our Mission. HHSC seeks accurate, complete and innovative responses to this request. Our evaluation of potential partners for this Mission will be based on how Contractors demonstrate their willingness to be accountable for results, and their responsiveness to the needs and reasonable requests of HHSC.

SECTION 2 PROCUREMENT STRATEGY AND APPROACH

2.01 Statutory Basis: "Best Value"

Section 2155.144, Government Code, obligates HHSC to purchase goods and services on the basis of "best value." HHSC rules define "best value" as the optimum combination of economy and quality that is the result of fair, efficient, and practical procurement decision-making and which achieves health and human services procurement objectives.[11]

a. Statutory Best Value Factors

Best value is achieved by examining factors, applicable to the RFP, other than price in making a contract award. Among the factors HHSC is authorized by statute to examine are the following:

1. Any installation costs;
2. The delivery terms;
3. The quality and reliability of the vendor's goods or services;
4. The extent to which the goods or services meet the agency's needs;
5. Indicators of probable vendor performance under the contract such as past vendor performance, the vendor's financial resources and ability to perform, the vendor's experience and responsibility, and the vendor's ability to provide reliable maintenance agreements;
6. The impact on the ability of the agency to comply with laws and rules relating to historically underutilized businesses or relating to the procurement of goods and services from persons with disabilities;
7. The total long-term cost to the agency of acquiring the vendor's goods or services;
8. The cost of any employee training associated with the acquisition;
9. The effect of an acquisition on agency productivity;
10. The acquisition price;
11. The extent to which the goods or services meet the needs of the client(s) for whom the goods or services are being purchased; and,
12. Any other factor relevant to determining the best value for the agency in the context of a particular acquisition that is sufficiently described in a solicitation instrument.[12]

b. Best Value Factors for this Procurement

HHSC will evaluate proposals submitted in response to this RFP, on the basis of the following best value factors. These best value factors include the following and are listed in relative order of importance:

1. Contractor experience with operating and managing a community-based comprehensive outreach, health education and outreach program using a Promotor(a)/CHW model;

2. Contractor plans, methods and curricula for training Project Staff and Promotores(as)/CHWs based on state-identified CHW core competencies listed above;

3. Contractor strategies for achieving mission objectives and performance goals including a work plan for the planning and implementation processes with reasonable timelines;

4. Contractor's understanding and identification of members to be served;

5. Quality of external relationships and level of involvement;

6. Qualifications of project staff;

7. Contractor's demonstrated ability to assure quality;

8. Proposed cost; and,

9. Other administrative assurances such as hours of operation, employee immunization policy, use of marketing materials, record retention, and reporting requirements.

c. Basic Philosophy: Contracting for Results

HHSC's fundamental commitment is to contract for results. A successful result is defined as the generation of discrete, defined, measurable, and beneficial outcomes that support the State's Mission and Mission Objectives, satisfy the requirements of the resulting contract and focus globally on eliminating health disparities. To this end, the State will rely on the Contractor's representations of its expertise and will regard all communications of its knowledge, experience, willingness, and readiness as inducements to the award of the contract.

2.02 Strategic Elements

a. Contract Term

The contract(s), if any, resulting from this RFP will begin on or about September 1, 2001 and will continue for a three-year period. The contract(s) may be contingent upon funding being available for the term of the contract(s).

No more than $1,000,000.00 may be available per year to fund the projects. The specific dollar amount to be awarded to each successful proposer will depend upon the merit and scope of the proposed project. Continued funding in future years will be based upon availability of funds and documented progress of the project during the prior budget period. Funding may vary and is subject to change for each budget period. The maximum RFP award for one project is $250,000.00 per year.

Depending upon the merits of the proposal, a lesser or greater amount may be awarded for each location but not exceeding $250,000.00. The total amount of funds awarded will not exceed $1,000,000 per year. Within this maximum amount, HHSC will determine the amount that is actually spent and the expenditure of funds on any aspect of the contract is subject to prior HHSC approval.

2.03 Remedies

Remedies will be standard remedies included as part of the contract. Examples of remedies may include, but are not limited to:

1. Written corrective action plans;
2. Additional reporting;
3. Withholding of payment; and,
4. Termination.

2.04 External Factors

Potential Contractors should be aware that external factors may affect the scope of this project.

a. Budgetary and Other Resource Constraints

Any contract resulting from this procurement is subject to the availability of state and federal funds. HHSC certifies that, as of the issuance of the RFP, budgeted funds are available to reasonably fulfill the requirements of the RFP.

b. Use of Contract Funds

Funds are awarded for a specifically-defined purpose and may not be used for any other project. Funds may not be used to supplant local or state funds or the following:

1. Advertising costs for anything other than the recruitment of staff, procurement of scarce items, or disposal of scrap or surplus items;
2. Bad debts;
3. Bidding or proposal costs;
4. Capital expenditures;
5. Contingencies;
6. Contributions and donations by contractor;
7. Entertainment costs (including but not limited to meals, beverages, gratuities);
8. Excess facility costs;
9. Fines and penalties;
10. Interest costs and investment consultation costs;
11. Fund-raising costs;
12. Losses on other grants or contracts;
13. Organization or reorganization costs;
14. Public information service, except as specified in the contract; and,
15. Publication costs.

2.05 Legal and Regulatory Constraints

Potential Contractors should be aware that state and federal law generally limit the ability of HHSC to delegate certain decisions to a contractor. Specifically, the functions that may not be delegated to a contractor include the following:

1. Policy making authority and

2. Final decision-making authority regarding acceptance of contracted services.

Other functions may be delegated to the Contractor by HHSC.

SECTION 3 PROJECT SCOPE

3.01 General Scope

HHSC seeks proposals to demonstrate the efficacy of using the Promotor(a)/CHW model in outreach and enrollment in CHIP and Medicaid; increasing access to services available through CHIP and Medicaid; educating CHIP and Medicaid members on the appropriate utilization of services; and, encouraging the use of preventive services in CHIP and Medicaid. The primary goal of this procurement will be principally accomplished through the Selected Contractor(s) performance of the following tasks:

1. Provision of appropriate services to a significant number of CHIP and Medicaid members;

2. Recruitment, hiring, training, retention, and management of Promotores(as)/CHWs;

3. Development and effective implementation of a workplan and timeline;

4. Reaching agreed upon TexCare Partnership program milestones;

5. Support of and involvement with other community based organizations conducting outreach; and,

6. Evaluation of the effectiveness of Promotores(as)/CHWs.

3.02 Results

The Selected Contractor(s) will be responsible for achieving the following results:

a. Operating Hours

Operations are to be conducted at least six (6) days per week and at a minimum during the hours of 8:00 a.m. - 7:00 p.m. Monday - Friday, and Saturday 9:00 a.m. - 1:00 p.m., excluding federal holidays.

b. Employee Immunization Requirements

The selected contractor(s) must ensure that employees comply with the following immunization requirements:

MMR:	Two (2) doses or evidence of immunity to measles, mumps, and rubella.
Varicella:	Two (2) doses, reliable history of disease, or evidence of immunity to chickenpox.
Influenza:	One (1) dose annually.

TB test: Upon employment, annually thereafter, and four to six weeks after suspicion of exposure.

c. Program Marketing and Training Materials

Marketing materials, developed by selected contractor(s), must be approved by the Director of Outreach in the TDH CHIP Bureau. Use of the THSteps name or logo must also be approved by the TDH THSteps program contact. Any alteration to existing marketing materials by the selected contractor(s) will require approval by TDH and/or HHSC. All training and creative materials become the property of HHSC and will conveyed to HHSC upon request. Failure to adhere to this requirement may void a portion of HHSC's payment.

d. Training

HHSC and TDH staff will provide an initial orientation to selected contractor staff within 30 days following the date of RFP award. All staff must be trained, have equipment in place and be prepared to begin service delivery on October 1, 2001. Selected contractor(s) are responsible for conducting on-going training activities and adherence to training standards and the core competencies as identified for Promotores(as)/CHWs in the Texas Administrative Code, Title 25, Part 1, Chapter 146. Selected contractor(s) will identify a specific person within the organization as the official trainer. Following the initial orientation, selected contractor(s) are responsible for training or retraining staff and/or providing continuing education. The following skill and knowledge-based training is required for all Promotores(as)/CHWs and project outreach staff:

1. TexCare Partnership application process;
2. CHIP enrollment process, eligibility criteria, and medical and dental benefits package;
3. Medicaid eligibility and application;
4. Texas Health Steps eligibility and services;
5. Texas Health Steps outreach and informing, including core competencies for CHWs;
6. Training about services for adolescents;
7. Managed care;
8. Take Time for Teeth;
9. Services available through DHS;
10. Case management; and,
11. Medical Transportation Program services.

e. Staff

Selected contractor(s) must appoint and maintain a Project Director for the contract possessing sufficient resource control authority to meet all RFP requirements.

Selected contractor(s) must complete a criminal background investigation for all staff who may be required to conduct home visits. Staff with a history of violent criminal behavior, sexual assault, domestic violence, or child molestation will not be allowed to conduct home visits, have unescorted access to clients, or access to client files. While HHSC recognizes that staffing changes are inevitable, a sufficient level of expertise must be maintained throughout the contract to ensure quality and continuity. Accordingly, the selected contractor(s) must provide HHSC with notice of contract staffing changes within two weeks of change. Notification should include the rationale for the change and any appropriate assurances that the contract's quality and continuity will not be materially affected. On request, the selected contractor(s) must also provide HHSC a copy of the replacement staff's summary of work experience, skill level and roles and responsibilities assigned under the contract.

f. Staff Salaries and Benefits (note: this requirement has been eliminated effective 7/20/01)

Selected contractor(s) must reimburse Promotores(as)/CHWs at a rate no less than $11 per hour and provide health insurance benefits at least equal to those available through CHIP.

g. Meetings

Selected contractor(s) will meet as necessary with the HHSC contract monitor.

h. Reports

Selected contractor(s) will be required to submit a monthly activity report, and program evaluation and financial reports (format to be specified by HHSC) on a specified report schedule.

i. Quality Assurance

Each month, selected contractor(s) will conduct a quality assurance evaluation of outreach activities. This evaluation will be based on a statistically valid sample of members contacted during the previous month and will assess, at a minimum:

1. Member recall of information presented during the outreach encounter;
2. The member's opinion of the value/quality of the information presented;
3. Staff assessment of member recall of services presented; and,
4. Action taken as a result of the outreach encounter.

Results of the quality assurance evaluation will be provided to the HHSC contract monitor by the 10th working day of the following month.

j. Performance Monitoring

HHSC reserves the right to conduct a review of the selected contractor(s) records and to conduct an on-site review at any time to ensure compliance with RFP requirements. HHSC may monitor selected contractor(s) performance under this RFP by telephone contact, records review, customer service satisfaction surveys, and other means. Regular contract program monitoring will be conducted on at least a quarterly basis.

k. Record Retention

The selected contractor(s) must maintain detailed records evidencing the administrative costs and expenses incurred pursuant to the provision of services under the RFP, and complaints, for the purpose of audit and evaluation by HHSC and other state or federal personnel. All records must be maintained and available for review by authorized staff during the entire term of the contract and for a period of three (3) years thereafter, unless an audit is in process. When an audit is in process or audit findings are unresolved, records must be kept until the issues are fully resolved.

l. Computer/Automation Requirements

The selected contractor(s) must maintain sufficient hardware and software to maintain tracking and reporting systems for employee records and training; client contacts; outreach activities and outcomes; financial budgets and expenditures; and other Quality Assurance record-keeping required. Computer forms will be provided by HHSC for many of these tracking and reporting requirements.

m. Member Outreach and Informing Activities

Information provided to members about all services must be relevant to the members' needs, appropriate to their cognitive skills and accessible to clients with limited English proficiency. Information must also be interesting and presented in a manner that is sensitive to the members' cultural backgrounds. Information must be presented in a positive and timely way that encourages members to understand and use services fully. Informing techniques/methods must be low literacy, bilingual and culturally relevant.

Outreach methods must be adapted to meet the needs of targeted populations. Outreach activities must be coordinated with other agencies and groups, which provide outreach within a community or geographic area. This may include: churches, public health providers, family planning providers, managed care providers, Volunteers in Service To America (VISTA), case management providers, et al. Finally, information must be presented in a manner that is convenient to clients.

In the Request for Proposal application, applicants must address the proposed approach to accomplishing this task, including:

- an outline,
- a work plan for the planning process with tentative dates for implementation,
- the level of involvement in the development of a plan by HHSC and TDH and other outside entities,
- the techniques to be used to prepare the plan,
- training methods and curricula to be used for instructing CHWs on core competency areas, and
- the strategies for assuring the quality and timeliness of the plan.

Potential contractor(s) must describe how the following objectives will be achieved and measured:

1. Increase applications to TexCare Partnership;

2. Increase enrollment in CHIP and Medicaid;

3. Educate CHIP/Medicaid beneficiaries on appropriate use of health care resources, including the use of any available Medicaid or CHIP managed care plan that provides coverage to beneficiaries and the effective use of a beneficiary's primary care provider;

4. Promote regular use of preventive care services by beneficiaries of the programs, particularly prenatal care services and services available under the Texas Health Steps and under CHIP;

5. Encourage beneficiaries of the programs to develop a basic family preventive health plan;

6. Encourage and support beneficiaries of the programs in keeping appointments for health care, following up on missed appointments, and complying with the directives of health care providers; and,

7. Achieve the best value for the taxpayers of Texas.

n. External Relationships or Partnerships

All Potential Contractors are urged to discuss their interests and ideas for developing projects early in the planning stage with state, regional, contracted community-based organizations and local planning agencies and/or health departments. Community support should be assured by providing opportunities for public and private participation in the planning and development phases of these projects. Potential external relationships or partnerships can include:

1. Regional TDH THSteps staff;

2. Department of Human Services (DHS) Eligibility Services Staff. DHS eligibility services staff determines client eligibility for Medicaid and are located in numerous office sites throughout the State;

3. TDH Medical Transportation Program. Within each region of TDH is a Medical Transportation Program. The Medical Transportation Program is responsible for the non-emergency transportation to THSteps/Medicaid services for eligible recipients, if the recipients have no other means of transportation;

4. THSteps/Medicaid/CHIP Providers. The selected applicant may schedule visits for THSteps/Medicaid/CHIP clients with THSteps/Medicaid/CHIP providers;

5. Other Outreach Contractors. Outreach units are required to coordinate with other organizations that serve Medicaid/THSteps/CHIP clients. These may include TexCare Partnership CBO outreach contractors, Monarch Management Company, DHS, other THSteps outreach contractors, public health providers, family planning providers, managed care providers, targeted case management providers, Medicaid managed care enrollment broker, and medical/dental providers;

6. Women, Infants, and Children (WIC). The Omnibus Budget Reconciliation Act (OBRA) of 1989 requires states to make specific efforts to coordinate with the special supplemental Food Program for WIC. THSteps (EPSDT) must give timely information about WIC and referrals to all Medicaid recipients who are pregnant, postpartum, breastfeeding, or are children under the age of five years;

7. Maternal and Child Health (MCH) and Other Programs. THSteps (EPSDT) must coordinate with Title V MCH programs and other programs that administer health services;

8. Head Start. THSteps (EPSDT) should coordinate with Head Start Programs. The two programs share the same goals and about half of Head Start families are also on Medicaid;

9. Housing and Other Programs. THSteps (EPSDT) programs should coordinate with housing programs, which often offer a physical site and focus from which services can be provided and coordinated. In addition, programs should coordinate with other federally funded social service programs (family planning services, and child care);

10. State or Local Education Agencies. THSteps/CHIP programs should coordinate with state or local education agencies;

11. School-based Health Clinics and School Health Staff. Because school personnel have contact with children and parents during the course of the year, schools can inform families about CHIP, Medicaid and THSteps; and,

12. Migrant Council. The migrant population is a targeted population for THSteps, each school district utilizes the services of an individual who is responsible for identifying students of migrant families and assisting them in accessing services.

3.03 Acceptance and Approval

Payment for Services and Deliverables is strictly conditioned on HHSC's approval and acceptance of the Service or Deliverable. HHSC may not honor an invoice or billing for Services or Deliverables that have not been accepted by HHSC's Project Manager or his designee.

3.04 HHSC Project Manager

The HHSC staff person assigned project management responsibilities for this project is

Jason Cooke
Texas Project Director
Children's Health Insurance Program

The organization(s) awarded the contract is responsible for coordinating all work through or with the HHSC Project Manager or his designee.

SECTION 4 RESPONSE REQUIREMENTS

4.01 Proposal Submission Dates, Time and Location

Responses to this RFP are due **August 1, 2001** at 5:00 PM Central Standard Time.

4.02 Proposal Format

This RFP contains the requirements that all Potential Contractor(s) must meet to be considered for funding. Failure to comply with these requirements may result in disqualification of the Potential Contractor without further consideration. Each Potential Contractor is solely responsible for the preparation and submission of an application in accordance with instructions contained in this RFP.

The proposal format and attached forms are to be completed in their entirety. While there is no page limitation to the proposal, Potential Contractors, where possible, are encouraged to provide brief yet substantive responses to all sections of the application.

Any proposer must submit the original proposal and five copies of the original proposal.

4.03 Required Signature

The original proposal must be signed in ink. The officer or agent of the Potential Contractor who signs the proposal must be authorized to negotiate on behalf of the Potential Contractor and to commit the Potential Contractor to the terms and conditions of the contract resulting from this procurement.

4.04 Official Single Point-of-Contact

For purposes of addressing questions concerning this RFP, the sole contact will be:

Donna C. Nichols, MSEd, CHES
Public Health Promotion, Suite M-631
Texas Department of Health
1100 West 49th Street
Austin, Texas, 78756
512-458-7405
FAX: 512-458-7476
e-mail: donna.nichols@tdh.state.tx.us

Upon issuance of this RFP, other employees and representatives of the Health and Human Services Commission (HHSC) or the Texas Department of Health (TDH) will not answer questions or otherwise discuss the contents of the RFP with any potential applicants or their representatives.

Failure to observe this restriction may result in disqualification of any subsequent proposal. This restriction does not preclude discussions between affected parties for the purpose of conducting business unrelated to this RFP.

HHSC is the sole point of contact with regard to all procurement and contractual matters relating to the services described herein. The Children's Health Insurance Program or the Medicaid Program of the Texas Health and Human Services Commission is the only office authorized to clarify, modify, amend, alter, or withdraw the project requirements, terms, and conditions of this Request for Proposal and any contract awarded as a result of this Request for Proposal. All communications concerning this Request for Proposal must be addressed in writing to:

Donna C. Nichols, MSEd, CHES
Public Health Promotion, Suite M-631
Texas Department of Health
1100 West 49th Street
Austin, Texas, 78756
512-458-7405
FAX: 512-458-7476
e-mail: donna.nichols@tdh.state.tx.us

The physical address for overnight and personal deliveries is:

Donna Nichols
Public Health Promotion (Suite M-631)
Texas Department of Health
1100 W. 49th Street
Austin, Texas 78756

Written inquiries concerning this RFP must be received no later than 5:00 P.M. C.D.T. on July 13, 2001.

4.05 Proposal Delivery Methods

The State will only accept methods of delivery that establish proof of delivery of responses. The State will not accept delivery of proposals by fax. **All responses, regardless of method of delivery, must be received by the State's designated point of contact no later than 5:00PM, Central Standard Time, August 1, 2001.**

There is no penalty for submitting responses in advance of this deadline. However, any modifications or corrections to the original response the Potential Contractor chooses to incorporate must be received prior to submission deadline.

4.06 Proposers' Conference

A proposers' conference will be held on July 13, 2001 at 1:30 p.m. CDT in the public hearing room at the Texas Department of Health, Riata Crossing, Bldg 3, 12555 Riata Vista Circle, Austin, TX 78727. The proposer's conference is not required however, potential proposers are encouraged to attend.

4.07 Questions Regarding the RFP

Written questions will be accepted. Any explanation desired by proposers regarding the meaning or interpretation of the RFP provisions must be submitted in writing to Donna C. Nichols at the address provided in Section 4.04. The final date HHSC will accept requests for explanations is July 13, 2001 at 5:00 p.m. CDT. Responses to inquiries will be posted to the HHSC website no later than July 20, 2001 at 5:00 p.m. CDT.

If a Potential Contractor discovers any ambiguity, conflict, discrepancy, omission or other error in this request for Proposal prior to proposal due date, the Potential Contractor must notify the State's designated point of contact immediately in writing.

All questions must be submitted within the time frame specified. Clarifications issued as a result of the inquiry process will not constitute a basis for any extension or delays in the proposal submission deadline.

Footnotes

1. TEX GOV'T CODE ANN. §531.021(a) (Vernon 2000 Supp.); TEX. HEALTH & SAF. CODE ANN. §§62.051, 63.003 (Vernon 2000 Supp.).

2. University of Arizona. Weaving the Future: The Final Report of the National Community Health Advisor Study, June 1998.

3. Ibid.

4. Ibid.

5. Ibid.

6. Impact of community health workers on access, use of services, and patient knowledge and behavior. [Evaluation bulletin # 1] (Bethesda, MD: Health Resources and Services Administration, Bureau of Primary Health Care), 1998.

7. Williams D. La Promotora: Linking disenfranchised residents along the border to the U.S. health system. Health Affairs, Vol 20(3) (May/June 2001).

8. Zuvekas A, Nolan L, Tumaylle C, Griffin L. Impact of community health workers on access, use of services, and patient knowledge and behavior. Journal of Ambulatory Care Management, Vol. 22(4): 33-44 (October 1999).

9. TEX. HEALTH & SAF. CODE ANN. §§62.051 (Vernon 2000 Supp.); 42 U.S.C. §1397aa, *et seq.*

10. *See* TEX. HEALTH & SAF. CODE ANN. §62. (a), (d)(1); (b), (c) (Vernon 2000 Supp.); TEX. 1T.A.C. §370.46(a); (c), (d)

11. 1 T.A.C. §391.31(2).

12. 1 T.A.C. §391.121