ID	General Y/N	Section #	Page #	Req #	Description	Cosmetic Y/N	Reviewer Organization
1a Scope	Y	1.2	1-1		We agree with the health programs listed under the scope, but urge that they not be called "Exchange Health Services Programs" but rather "CalHEERS Health Services Program" given that DHCS continues to be responsible for administering Medi-Cal and MRMIB Healthy Families and AIM.		
1b		1.2	1-2		We agree with the core services listed here and are particularly pleased to see the inclusion of "Eligibility Transfer (i.e. pre-enrollment, pre-notification, and pre-population of applications)." A key to maximizing enrollment in the Exchange and Medi-Cal will be identifying existing limited-scope health programs or programs with populations with high overlap with Exchange and Medi-Cal eligibilty, e.g. people receiving FamilyPACT services or CalFresh benefits and parents of Healthy Families children to name a few. We urge that the required functionality be further spelled out and included in the RFP Business requirements. Specifically, CalHEERS should have the functionality to receive information from SAWS, MEDS, MAXe2 and other state program databases to, with the consent of the consumer, prepopulate an application for health coverage subsidy programs and process the application, asking for any missing needed information from the consumer.		
1c		1.2	1-2		In addition to pre-enrollment, we urge that the RFP include the capacity to accept information from county programs, including not only the LIHPs but programs such as Healthy San Francisco and CMSP so that individuals receiving county health services can, with their consent, be screened for eligibility and enrolled in the appropriate coverage, either Medi-Cal or the Exchange.		
1d		1.2	1-2		We also ask that the RFP provide for the ability to accept applications initiated through contact with other state agencies which interact with those highly likely to be uninsured, such as EDD for UI and SDI. As with horizontal integration with human services programs, we recognize that this capability may evolve over time and may not be fully operational 1/1/14. But it needs to be planned for. EDD, the courts (divorce, family law), even DMV are state agencies that have contact with individuals more likely to be uninsured than those who are not newly unemployed, divorced or moved.		
1e		1.2	1-2		We would urge that the "alternative approach" to case management - having the counties manage all Medi-Cal cases - MAGI and non-MAGI be clearly required in all bids. This approach has several advantages - keeping families cases together when there are MAGI and non-MAGI beneficiaries and keeping a family or person's benefits together when they have CalFresh and/or income support as well as Medi-Cal. In several places (noted elsewhere) there is a lack of clarity about whether the RFP seeks case management of both MAGI and non-MAGI Medi-Cal at the county level.		

1f		1.2	1-2		Top bullet point about integration of "other eligibility programs" should specify them and include at least SAWS.		
1g		4.3			The functional scope does not explicitly include processing of applications submitted by mail, phone and in person. These are all application venues requried by the ACA and while we recognize that counties and the Call Center may be the parties accpeting applications in this way functionality for inputting or accepting applications coming through these venues should be spelled out in the Solicitation.		
1h		4.2 Project Schedule	4-30		The schedule calls for CalHEERS to "be operational to enable early enrollment as early as July 1, 2013 but no later than October 1, 2013." We urge that the Solicitation consistently require, as it does on page 1-15, enrollment functionality which is installed, tested and fully operational by 7/1/13 to allow fixes to any glitches before enrollment starts in October 2013. We further urge concrete timelines for some of the "mandatory optional" functions. As stated below we don't believe the functionality for health application data used to start public benefits application has to be operational by 2014 but should be operational by 2016 to access the window of the federal allocation waiver.		
2a Governance		1.3.2	1-4		The Background section of the Solicitation states that the CalHEERS Steering Committee - made up of a rerpresentative from the 3 Project Sponsors, DHCS, the Exchange and MRMIB - has overall authority for the project. All three of these entities should rightly be integrally involved in the development and oversight of CalHEERS since it will enroll people into Medi-Cal and Healthy Families as well the Exchange. However, we recognize the need to provide accountability by holding responsible one overall agency. If the Exchange is this central agency responsible for oversight of CalHEERS, then there must be mechanisms to ensure that DHCS retains ultimate oversight of the Medi-Cal program and MRMIB over HFP. DHCS remains the sole state agency for Medicaid. DHCS must have veto power over decisions affecting Medi-Cal eligibility rules and other program components. Our concern arises out of practical experience including experience of the Single-Point of Entry (SPE) for Medi-Cal and HFP. MRMIB governs the SPE process and vendor contract though the joint children's application is also a Medi-Cal application. The joint application only screened for the Medi-Cal FPL programs - not the Medi-Cal programs for families and for disabled children. This harmed children with disabilities as well as families needing coverage This should not be repeated with CalHEERS. The role of DHCS in administering the Medi-Cal program and therefore having descisionmaking authority over the portions of CalHEERS administering Medi-Cal should be spelled out in an MOU made public. It should specify that DHCS has oversight over any MEDS interface or integration with CalHEERS. Also troubling, the roles of DHCS and MRMIB as project sponsors is frequently not reflected in the RFP where repeatedly statements are made about the Exchagne exercising oversight roles, without acknowledging the other project sponsors (examples below). This must be corrected to properly show the governance of CalHEERS.		

2b		4.5 Project Management Scope	4-46		The RFP requires the vendor to work with Exchange staff in managing the project. Since this is the Eligibility, Enrollment & Retention System for many eligible for Medi-Cal and Healthy Families as well as the Exchange, DHCS and MRMIB staff should have a role in project management. This should be made unambiguously clear to potential vendors.		
2c		4.5.2	4-47		The issue above of oversight being done by the Exchange instead of all three CalHEERS Sponsors is repeated numerous times and is quite troubling. For example, under Scope Management, after rightly noting that changes to the requirements will likely be made, the Solicitation refers to final decisions needed by CMS and the Exchange, again ignoring DHCS and MRMIB.		
2d	Y				Numerous places the RFP refers to "Exchange Health Services Programs" which is misleading at best and at worst, suggests that the Exchange will have management responsibilities over Medi-Cal and Healthy Families and AIM. For example, will the Exchange be negotiating Medi-Cal managed care contracts? No. DHCS will. While the ACA clearly requires state Exchanges to enroll eligible persons into MAGI Medicaid and CHIP, federal Medicaid law still requires a single state Medicaid agency and California law designates DHCS as that entity for Medi-Cal. The RFP could refer to Medi-Cal, HF and the Exchange as "health subsidy programs," "state affordability programs," or "CalHEERS programs" to acknowledge the non-subsidized coverage. The chosen term should be in the glossary but the RFP should not use "Exchange Health Services Programs" to refer to Medi-Cal and HF.		
2e		1.3.2	1-5		Table 2 lists the Project Sponsors. It should clarify into which health coverage programs the Exchange enrolls individuals. The description of DHCS should spell out that the Medi-Cal program will continue, with the implementation of the ACA, to determine eligibilty for Medi-Cal - both MAGI and non-MAGI.		
2f		1.3.2	1-7		We look forward to reviewing the CalHEERS organizational chart and think it will be helpful to clearly lay out DHCS's leadership role alongside the Exchange here.		
2g		1.4	1-7		The Business Need spells out the needs and vision for the Exchange and ignores that some 2 million additional Californians will be eligible for Medi-Cal and Medi-Cal eligiblity rules will be fundamentally changed and simplified.		
2h		2.22	2-25		The Solicitation vests final authority to award the contract solely with the Exchange. We would urge that DHCS and MRMIB have a role in making the contract award given that the system will enroll people into Medi-Cal and Healthy Families. We do not want to repeat the problems with SPE that harmed consumers.		
2i				PM 37	Exchange staff should be replaced with "CalHEERS staff."		
2j		1.3.2	1-6		The list of Program Partners rightly includes OSI, DMHC, CDI, CTA, CDSS, county welfare departments and the SAWS. We would urge that the Office of the Patient Advocate (OPA) be added to this list to reflect the expanded role of the OPA as serving as a central point for consumer assistance		

3 Interface and legacy systems	Y				Though it might not belong in the RFP for the CalHEERs vendor, there needs to be clarity about the plan to update MEDS interfaces with all IT systems as part of implementation of CalHEERS. We recommend that as an additional attachment, more detail about this vision be included. Also, we request that End-to-End transparency of the MEDS modernization and/or interfacing project, timeline, opportunities for stakeholder input, benchmarks and plan for reporting progress be shared by appropriate CalHEERS Sponsoring Partners.		
3 Interface and legacy systems		1.2	1-2		The Sponsors state in this section that they desire a baseline system that "integrates with MEDS and other eligiblity programs." First, the RFP should clarify what is meant by "integrates with MEDS." Does it mean full integration into the same IT project with same governance (Exchange or Partners?). Additionally, even though MEDS functionality is an Option to Buy, interfacing with MEDS should not be. Though interfaces are explained in 4.4.7 we think that they should be spelled out earlier in functionality and more clearly. Second, it is unclear what the RFP means by "integrating with other eligiblity programs" does it mean pulling other programs into the same IT project with the same governance (Exchange or Partners?).		
3 Interface and legacy systems		1.2	1-2		Table One Lists Integration with MEDS as an "Option to Buy." Since this is an Option to Buy, the RFP should list interface with MEDS as a requirement (in this same chart - not just in 4.4.7) and add all the information necessary to ensure that in the Attachment 3 - Requirements.		
3 Interface and legacy systems		1.2	1-2		We support the modernization of MEDS. We also recognize that this is a major IT project in its own right. It would require considerable policy development between the state and counties as well as a detailed and comprehensive list of its own requirements. The CalHEERS RFP contains a paragraph. This is not sufficient. If the Partners would also like the option to integrate and/or modernize MEDS, they should list that as a Mandory Option and Option to Buy, but not unless they also include comprehensive list of requirements and specs for how to achieve this important, but ambitious, goal.		
3 Interface and legacy systems		4.3.8	4-15		We share the desire of the Partners to modernize MEDS. We also think that a modernized MEDS would improve the functionality of CalHEERS. However, we are concerned with the lack of specificity of what this project would entail and the absense of a timeline for this endeavor. Additionally, MEDS is currently a project of DHCS, HHS and the counties and it is unclear how integrating MEDS into the HEERS IT project change or influence the governance of MEDS. Again, DHCS is the sole state agency for Medicaid: CalHEERS is not. The Exchange is not.		

3 Interface and legacy systems		4.3.1	4-4	BR 19, 195	Key Functionalities of Eligility & Enrollment include verifying in real-time whether an individual is already eligible and receiving benefits for subsidized healthcare via MEDS 'interface.' This is also listed as a requirement in Attachment 3 - Business Requirements 19. Additionally, the BR 195 list requirement to track outcomes of referrals to SAWS via MEDS. We request that the RFP add more detail about the MEDS interface (which is not discussed as a mandatory requirement until 4.4.7).		
3 Interface and legacy systems		4.4.3.2	4-26		We support RFP assertion that MEDS shall continue to serve as the centralized master data repository for the limited data set of application tracking (i.e., MEDS Application Tracking Database) and enrollment data it manages. We would like RFP to clarify details of interface and that the interface is a requirement of the system (unless integration is purchased).		
3 Interface and legacy systems		4.4.7	4-38		Interface with SAWS is confusing. RFP requires a two-way interface with SAWS and with MEDS, but there isn't clarity in the requirements about how this will work. The RFP should make it clear that county workers are able to use SAWS to determine eligiblity for SAWS programs and data can move from SAWS (either through MEDS interface or directly) into CalHEERS. People who come into a county office (or county call center) should not have their information entered into two different systems.		
3 Interface and legacy systems	Y				What will be the relationship between MEDS clearance verification systems and Federal Verification HUB? We recommend RFP acknowledges the need for a CalHEERS process that offers clients / application assisters / county workers / etc. a way to resolve discrepencies.		
3 Interface and legacy systems		4.4.7	4-37		Vendor is required to design a solution that integrates the CalHEERS functions and provides customers with a secure, comprehensive and unencumbered user experience when dealing with CalHEERS. We agree with this statement, but request that the RFP clarify that it will be the role of the vendor to ensure an IT architechture for ensuring this is true regardless of their point of entry into CalHEERS.		
4a Eligibility & Enrollment		4.3.1	4-1		Much of the functionality in the application submission and eligiblity and erollment processes are user-friendly features which we support, including enabling users to save work in the process, consent for pre-population of data and allowing self-attestation of eligibility information.		
4b		4.3.1	4-1	BR-38	The functionality for CalHEERS to determine eligibility for Exchange MAGI Medi-Cal, HF and AIM, included in the Business Requirements should also be included in the list of Functionalities/Services.		

4c		4.3.1	4-1		The list of functionalities includes a calculator to compare costs across plan options, but it does not include a calculator for determining eligibility under MAGI. Since MAGI eligibility for premium subsidies will be based on annual income and an applicant may only have information on current weekly or monthly income, there should be a calculator to easily compute annual income and compare to the current income levels for MAGI Medi-Cal, Healthy Families and advanced premium credits. This will be significant for applicants who have had a change in income levels since the MAGI reported from the federal data hub.		
4d		4.3.1	4-1		Eligibility determinations will be based on MAGI, which is going to be coming from the most recently filed federal tax return that is available in the federal data hub. Complicating eligibility determinations will be the fact that current incomes may have changed significantly since the time that the prior tax return was filed. One important functionality will be the opportunity for the applicant to indicate changes in income from the reported MAGI and either attest to or provide verification of current income, so an accurate determination of eligibility can be made. This should be made clear in the list of functionalities.		
4e		4.3.1	4-4	BR 24	We support linking the current provider application processes, e.g. Prenatal Gateway and CHDP Gateway, into CalHEERS. The requirements language should be strengthened to specify the functionality required - linking these provider application streams into CalHEERS.		
4f				UR 12	This requires the vendor to offer the widest variety of coverage options available based on the consumer's eligibility information. We agree that consumers should be evaluated for all programs, but vendor requirements should specify the "hierarchy" of health coverage programs. Under the law, someone who is eligible for no-cost Medi-Cal is not eligible for Healthy Families or premium subsidies in the Exchange. Accordingly, this requirement should be modified to reflect those steps. If this is not done, consumers will be harmed by being required to pay premiums when they were eligible for no-cost Medi-Cal. This would replicate the problems with SPE in which kids with disabilities and kids in working families were not appropriately screened for all Medi-Cal programs. It also violates federal law.		
4g		Appendix H	5		The section regarding “Existing Eligibility Systems” does not acknowledge that county welfare offices will receive in-person applications from individuals who are eligible for MAGI Medi-Cal. We recommend that the RFP clarify the counties’ role in the MAGI Medi-Cal eligibility determination process.		
4h		Appendix A	G-8		The definition of MAGI is confusing and differs from the federal definition found in Internal Revenue Code Sec. 36B(d)(2)(b), which states that Modified Adjusted Gross Income is Adjusted Gross Income plus exempt foreign interest, interest exempt from taxation and, now, Social Security income.		

4i	Y				There is insufficient guidance about how phone, mail and in-person applications will be handled. While the RFP rightly provides for consumers to be able to update information numerous ways and get assistance by phone and email, the RFP does not include functionality for the acceptance and processing of mail-in, phone and in-person applications. Functionality should also be included to allow a paper application to be scanned and subsequently be processed electronically.		
5 Account Management		1.4.1	page 1-8		Important to include the ability to "time out" the functions to ensure that only those who should be responsible for viewing the account have access to it.		
5a		1.4.1	page 1-8		We applaud the ability for a user to create an account and apply and manage the account. May need explicit provision allowing for pre-designated assisters to have access to the account as well.		
5b		1.4.1	page 1-8		We applaud the ability for a user to browse annonymously before providing personal information		
5c		4.3.1	page 4-1		We appreciate the ability of a user to bypass an application for subsidy coverage and go straight to QHP screening. It is unclear whether the ability also exists to jump back and forth throughout the application. If not clearly stated, we would support a system that allows a user to enter data in a non-consecutive format.		
5d		4.3.1	page 4-1		We applaud the system functions proposed to be able to enter information, save it at any point, restart, and exit without saving. Important, however, to include a "time-out" function, without losing data, for privacy and security purposes.		
5e		4.3.1	page 4-1		We appreciate that the proposed system will update and report both to the consumer and assister. We suggest adding language that requires the assister to be officially designated as an assister before the system grants access.		
5f		4.3.7	page 4-15		While the employee can update her/his own account, it is not clear whether it is a private account of the same account the employer can access. We believe that the system needs to be designed to provide for a SHOP employee to access the system through a separate personal account, in addition to the one for the employer. The account should be protected for use of the employee and only her/his designated assister. The account should also provide for individual access for all of an employee's covered dependents.		
5g		4.3.7	page 4-15		This provision should also include the requirement that the system should have the capacity to handle dependents and dependent coverage through the SHOP.		
5h		4.3.7	page 4-15		The ability to select premiums should envision capacity for individual employees and their dependents.		
5i		4.3.9	page 4-19		We appreciate the consideration that the system will have the capacity to prepopulate information.		
5j		4.3.9	page 4-19		We appreciate the consideration that the system will notify the consumer regarding her/his data saves, mandatory fields and expiration of incomplete applications.		

5k		4.3.9	page 4-19		We appreciate the consideration that the system will provide consumers and assisters the ability to navigate between multiple related input screens without losing information - and print screen capability.		
6 Exemptions		4.3	page 4-32		Business/Functional Scope: We support the treatment of exemptions as a core/functionality service of the Exchange. Laws that apply to CalHEERS should be consistent with federal ACA requirements governing the collection and use of health information by Exchanges (which limit the collection of personal information, and the use of that information, to what is strictly necessary to operate the Exchange - see Sections 1411(g)(1) and 1411(g)(2) of the ACA). The functionality must ensure the privacy of information is intact and not shared with any other entity or used for any other purpose.		
		4.3	page 4-35		Business/Functional Scope: While it makes sense for the Exemption category to be considered a sub-category of the Eligiblity and Enrollment Business Functions of the Exchange, because there are many categories of exemptions (i.e. for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold), the functionality of the system needs to address how that information will be collected if not part of the initial eligibility screen.		
		4.3.1	page 4-2		The Exemption – Key functionality which includes: ☐ Receiving and verifying individual exemption renewals. ☐ Processing individual application exemption requests (i.e., new and renewal) and notifying CMS - makes sense. See comment above on issues related to collecting exemption category information. This functionality must ensure the privacy of information is intact and not shared with any other entity or used for any other purposes.		
		4.6.3.1	page 4-58		CalHEERS Users: Eligibility workers (which may include County Workers, MRMIB workers and Exchange staff) will review and approve exemption applications following strict privacy protocols (see above).		
		4.8.6.1	page 4-72		Call Center: Should include a link to help regarding exemptions.		
			BR34		The provision that CalHEERS provides the functionality to process individual exemption requests sounds appropriate.		
			BR35		The CalHEERS shall provide the functionality to process, verify and track individual exemption request information. While we support this, the functionality clearly needs to address the many reasons that exemptions can be granted. Those include: financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold). Will the system be able to track all of these reasons or categories?		

			BR36		The CalHEERS shall provide the functionality to initiate an automated process for determining Individual Exemption if an individual has indicated an exemption condition based on the submission of a completed application. While we support this idea, more detail should be provided on how this will work, including all the categories of exemptions that need to be looked at.		
			BR37		The CalHEERS shall provide the functionality to notify CMS of verified exemption requests with monthly reports. These reports must be subject to the same privacy protections noted above.		
			BR84		We support adding a requirement to auto enroll in existing plan if still eligible and data is verified; to verify/add requirement to opt out of Exchange coverage; and to notify them of coverage requirements and exemption application.		
			BR86		We support the CalHEERS providing the functionality to process individual exemption renewal.		
			BR204		We support the CalHEERS tracking and reporting the number of exemptions from coverage and reason.		
7a Case Management		4.3.1	4-3		We support enabling authorized users to manage and update information online.		
7b		4.3: Table 10	4-32		The RFP requires bids to include centralized case management of MAGI Medi-Cal cases and may use an alternate approach of managing all Medi-Cal cases within the SAWS systems. We urge that bids be required to include both options with an analysis of the advantages and disadvantages from a consumer & family perspective. Given the large number of families who have at least one member in MAGI Medi-Cal and at least one in non-MAGI Medi-Cal and the high number of persons who have Medi-Cal and other public program administered by the county SAWS systems we urge that case maintanence of all Medi-Cal cases be done by the counties.		
7.5a Renewals		4.3.1	4-3		We support allowing the enrollee to choose the method by which she will be informed of the annual enrollment or renewal period but ask that she be able to select at least 2 methods, e.g. text and mail, to best ensure she receives the information.		
7.5b		4.3.1	4-3		The list of key renewal functionality includes "annual, periodic and ongoing (rolling) automatic redetermination" based on data matches. We agree that ex parte review of information for annual renewal should be included but oppose unlimited trolling of information. This is unnecessary, costly and could disrupt coverage.		
7.5c		4.3.1	4-3		The written notification/request should be pre-populated with information known about the beneficiary so she only has to add information not otherwise available in databases and change incorrect information.		
7.5d		4.3.1	4-3		Renewal functionality should ensure that consumers have adequate time to respond and change programs without a break in coverage. This goal is articulated in the vision and should similarly be represented in the renewal functionality requirements.		

7.5e		4.3.1	'4-3		Renewal functionality should ensure that consumers are not asked for information which has been established and does not change. For example, once a beneficiary has established her citizenship she may not be asked for that information again.		
10 Notices and Appeals		4.3.1 and 4.3.4	4-3, 4-7		Notices: Additional functionality requirements need to be added under Eligibility and Enrollment specifically related to notices of an action, and in particular notices of adverse actions, that impact any applicant (or recipient's) eligibility for any public benefit (Medi-Cal, CHIP, etc.), for Exchange eligibility, for APTC or CSR. While the Appeals section does specifically address written notice of an appeal decision, it doesn't go beyond that. The capability will need to account for cases requiring multiple notices or single notices with multiple parts, in some cases. Because all applications are Medicaid applications, functional capability must meet the federal Medicaid requirements to include specific action taken, the specific reasons for the action taken (factual basis) and specifically include the hearing or other appeal rights that the applicant has. In addition, the functionality must also include the ability to meet any additional functionality requirements/modifications that will certainly be necessary once the federal regulations governing the Exchange appeals and due process are published. The requirements, while not laid out clearly here, appear to be acknowledged in Business Requirements document (Attachment 3), Rows "BR 88 through BR 95. See below. The "notices" paragraph under the Reporting Section (4.3.7) is unclear as written and uncertain if intended to be related to procedural protections inherent to notice in the due process context. For example, the first bullet, "Notify individual of payment discrepancies," may solely be about late payment of premiums but not at all relate to entitlement to a premium tax credit subsidy. Yet if this notice is intended to terminate coverage for failure to pay, it has broader legal consequences. It is imperative that the functionality requirements distinguish informational notices that shall be sent out to applicants or enrollees from those notices of adverse determinations, which are a different and specific type of notice and have different legal implications and requirements.		
10a		4.3.1 and 4.3.4	4-3, 4-7		If the Exchange vendor will have a role in issuing notices related to external review of plan adverse claims determinations related to medical necessity determinations (e.g. independent medical review) or coverage (e.g. rescission), that functionality requirement must also be added to the notice requirements.		
10b		4.3.1 and 4.3.4	4-3, 4-7		The functionality must be added to require the vendor provide all notices in a manner or format that complies with all state and federal disability laws, including the ADA and Section 504 of the Rehabilitation Act, including any reasonable accommodations necessary.		

10c		4.3.1 and 4.3.4	4-3, 4-7		The functionality must be added to provide all notices in threshold languages (and multiple language tag lines) based on the preferred language of the consumer (BR 124). Threshold languages should at a minimum be determined by Medi-Cal Managed Care standards, and not the Dymally-Alatorre Bilingual Services Act, as indicated in the RFP.		
10d		4.3.1 and 4.3.4	4-3, 4-7		The functionality must be added to provide all notices by the preferred method of contact (i.e. online, email, mail, phone, etc) as chosen by the consumer.		
10e		4.3.1	4 - 3		APPEALS: It is unclear from the draft appeals section which entity is ultimately responsible to manage the appeals to the multiple programs that could be implicated by an eligibility determination (Medi-Cal, CHIP, AIM, HFP, Exchange, etc.). Will this vendor manage and oversee the entire Appeals process, including mandated timelines, hearing decisions, etc., or simply hand these appeals over the the agency that manages the program (DHCS, MRMIB, etc.). Appendix H, page 4, states that the Exchange staff will be responsible for "Review and processing of MAGI Medi-Cal, CHIP, APTC and CSR appeals." The appeals section requirements should explain how will that relationship will work and what protocols the vendor will need to carry out to effectively link with Exchange staff on Appeals.		
10f		4.3.1	4 - 3		There appears to be no clear process for how a consumer can appeal a problem with the QHP in the enrollment process or if a QHP does not adhere to Exchange quality standards. Is there no right to appeal such a decision or is this handled elsewhere in the RFP.		
10g		4.3.4	4 - 7		The HBEx needs to create a tracking system to collect data on the number of appeals against a QHP for not meeting established standards. This information should also be available in the reporting section.		
10h		Attachment 3		BR124	The Business Requirements (Attachment 3) should be amended to require that: (1) the appeals notice be made available in Medi-Cal threshold languages as selected under individual preferences (see BR 124), (2) that CalHEERS include functionality that will ensure applicant and recipients be notified of appropriate appeals process (Exchange Process, Medi-Cal Process, CHIP Process, etc.) by prominent placement on the web portal and with a notification via their 'preferred communication method' (see BR 18) each time there is an adverse action, (3) that a BR be added to state that "CalHEERS shall have the functionality to track and record QHP connected appeals and make this information available via monthly reports." These content should reflect what is in the narrative found under Eligibility and Enrollment 4.3.1; Appeals 4-3.		
10i		4.3.7	4-10, 4-11		SHOP: Appeals - see SHOP Comments		

12 Service/Consumer Assistance	Y	1.2	page 1-2		We strongly support translation of the web portal into Spanish and the "translation of Forms, Notifications, and IVR in all Threshold Languages" as referenced in the RFP. Forms and notification should be developed using plain language that reflects a fourth and sixth grade level, which is in accordance with recommendations of the National Institutes of Health. Threshold languages should at a minimum be determined by Medi-Cal Managed Care standards, and not the Dymally-Alatorre Bilingual Services Act, as indicated in the RFP. This is especially important since the portal has to be able to process any Medi-Cal application. We urge the state to translate the web portal into Chinese, the third most common language spoken in California. The web portal should be designed to allow for the capability to support other translations at a future date.		
12a	Y	1.3.3	page 1-7		The description of the stakeholder process only refers to the process between stakeholders and the Exchange (e.g. written and public comments and small group discussions). This should be expanded to include a process for stakeholder input into the design and testing of the IT system for current as well as future modifications. This process should be tied to vendor pay and identified as a metric required to meet the contract. We urge CalHEERS to require User Acceptance Testing (UAT). The purpose of a UAT is for users to test the system in a pseudo environment to verify that the system is performing to specifications. UAT provides CalHEERS and its Program Partners, as well as California consumers and a wide range of diverse stakeholders - employers, consumer advocates, employees, assisters, issuers - an opportunity to review and accept system components prior to release of the system for public use. It demonstrates that the software meets functional requirements and specifications and accommodates the needs of the variety of users who will interface with the system. UAT should be required throughout the life of the contract when enhancements or modifications to the system are made.		
12b	Y	1.4.1	page 1-7		This provision should be specific in the bullets to test for user accessibility with uninsured and other potential users representing a diverse set of demographics reflective of the population who will benefit from CalHEERs. See comment on section 1.3.3.		

12c	Y	1.4.1	page 1-7		Future Vision: 1) We support translation of the web portal into Spanish with the ability to be translated into threshold languages. We believe the web portal should also be translated into Chinese, which is spoken by close to one million Californians. 2) Threshold languages for the purposes of this RFP should be defined as Medi-Cal Managed Care threshold languages not based on the Dymally-Alatorre Bilingual Services Act. This is an especially important distinction since the portal has to be able to process or refer Medi-Cal eligible individuals to the appropriate Assisters 3) Aspects of the web portal content (e.g. Forms, Education Materials, QHP Information and the languages they provide, and Links to Assisters) should be required to be presented in threshold languages in addition to Spanish and English by 2014. 4) A message announcing the general availability of language assistance services and the right to oral interpretation with an 800 number should be provided on the home page and other relevant pages in a minimum of 15 different languages. Currently, several government agencies at the federal and state level provide information about the availability of language assistance generally on every notice or correspondence sent to enrollees. For example, the Social Security Administration, through its Multilanguage Gateway, translates many of its documents into 15 languages and CMS recently announced plans to translate Medicare forms, including notices, into 15 languages in addition to Spanish. 5) The cost of providing translation in threshold languages should be weighed against the cost of NOT having the full translations/functionality availability - i.e., the ongoing/recurring costs of telephonic interpretation vs. the one-time costs of programming.		
12d	Y		page 1-8		We support the existence of a feedback loop for persons with disabilities regarding ease of accessibility. A feedback loop should be programmed for all users, including Limited English Proficient (LEP) individuals. The feedback mechanism could include a written comment/complaint function as well as a stakeholder focus groups for the design and testing of the IT functions including future modifications. In addition, we should assure that the site is comprehensible to those with low literacy levels. The RFP should make clear that written documents are required to be in language that reflects a fourth and sixth grade level, which is in accordance with recommendations of the National Institutes of Health.		
12e	N		page 1-8		We commend the specific provisions in this section that relate to the development of a "no-wrong door" service system.		

12f	N	4.3.1	page 4-1 thru 4-3		We support the RFP requirement that the IT system support online calculation of gross and net premiums of selected plans and notifying individuals of penalties and/or liabilities. 1) We ask that this functionality also allow for online reporting by individuals when they have a change in income or family size outside of regular enrollment and renewal periods. 2) We also ask that the system enable real-time adjustments to eligibility based on reported changes in income or family size, especially for Exchange subsidies which expose individuals to tax penalties. 3) The system should have the ability to calculate projected income based on employment changes (e.g. part-time/full-time) or changes in family size when individuals report a change. 4) The IT system should have the capacity to accept data from EDD re: income/employment of individuals: not expect this to be operational by 2016 but similar to horizontal integration with public programs the IT system should have the capacity to add this later.		
12g	N	4.3.5	page 4-8		The term "Assister" may include Navigator, Broker, Agent, County Worker, and MRMIB worker. We note that the term "Assister" does not refer to Exchange staff. The system must have functionality to allow state employees to assist people in applying for and enrolling in health coverage. In addition, the list of Assisters should include language to ensure that the system provides functionality for any other individual or entity, as identified under policies to be developed, who has sufficient training to assist people in applying for and obtaining coverage. (See also comments on Appendix A: glossary).		
12h	N	4.3.5	page 4-8		We support the RFP requirement that customer correspondence and IVR be provided in English, Spanish and other threshold languages. However the thresholds should be based on Medi-Cal Managed Care threshold languages not on thresholds identified in the Dymally-Alatorre Bilingual Services Act. We applaud the provision in BR123 (see comments below) to allow CalHEERS to record individual preferences (e.g. desired language for written and spoken communication, communication methods (mail, email, telephone, IVR, etc.). We assume that this information is being captured to allow individuals to receive future communications in their primary language. If so, this should be clearly stated as part of the functionality of the RFP. This functionality should apply to employers as well. We believe this provision will greatly increase access to health coverage and information for Limited-English-Proficient consumers.		
12i	N	4.3.5	page 4-8		Online Help should be able to connect with jurisdictionally-appropriate state agencies and regulators, such as Office of the Patient Advocate, DHCS, MRMIB, DMHC, and CDI. Consumers who enroll via the Exchange website will return when questions or problems arise with their coverage and should be directed to the proper authority or regulator.		
12j	N	4.3.6	page 4-9		We support reporting and tracking functions to track high-use/low-use by program and demographic to target outreach. This will be especially important given the diversity of the uninsured and those newly eligible for coverage.		

12k	N		page 4-9		We strongly support functionalities to "create and deliver via email, letter, text or voice mail, multi-lingual mass notices to targeted groups for purposes of outreach, increased awareness, enrollment and participation." This functionality should include at a minimum, Medi-Cal Managed Care threshold languages. This type of targeted outreach and enrollment in other languages will help to ensure the Exchange reaches California's diverse communities.		
12l	N		page 4-9		We applaud the reporting and tracking functionality that will allow the Exchange to "Track the source of possible outreach efforts (e.g. TV, radio, online, etc.)". This should include a functionality to track the use of ethnic media as well.		
12m	N		page 4-9		We applaud the funcationality provision with respect to generating consumer surveys "via online, email, letter, or phone" to "compile and analyze responses of Exchange consumers for the purpose of assessing customer service or other related matters." The survey should be translated into Spanish and English as well as other threshold languages and designed to identify and measure effectiveness in enrolling and reaching out to diverse communities.		
12n	N	4.3.7	page 4-14		The term "Assister" may include Navigator, Broker, Agent, County Worker, and MRMIB worker. We note that the term "Assister" does not refer to Exchange staff. The system must have functionality to allow state employees to assist people in applying for and enrolling in health coverage. In addition, the list of Assisters should include language to ensure that the system provides functionality for any other individual or entity, as identified under policies to be developed, who has sufficient training to assist people in applying for and obtaining coverage. (See also comments on Appendix A: glossary).		
12o	N		page 4-14		We support the RFP requirement that customer correspondence and IVR be provided in English, Spanish and other threshold languages however the thresholds should be based on Medi-Cal Managed Care threshold languages not on thresholds identified in the Dymally-Alatorre Bilingual Services Act. To ensure consistency in the information provided to a LEP individual, we recommend that once a LEP individual/employer makes a request for materials in a non-English language, the Exchange should provide all subsequent notices to that person in the non-English language requested as set forth in BR123.		
12p	N		page 4-14		Online Help should be able to connect with jurisdictionally-appropriate state agencies and regulators, such as Office of the Patient Advocate, DHCS, MRMIB, DMHC, and CDI. Consumers who enroll via the Exchange website will return when questions or problems arise with their coverage and should be directed to the proper authority or regulator.		
12q	N		page 4-14		A message announcing the general availability of language assistance services and the right to oral interpretation with an 800 number should be provided on the Web Portal Online Help page and other relevant pages in a minimum of 15 different languages by 2014.		

12r	N	4.3.9	page 4-18		We applaud the inclusion of strong language with respect to disability access. We commend the mention of health literacy and language access however we would like to see this provision strengthened by including references to federal and state law. Specifically ACA Title V Subtitle A, definition of health literacy; Section 1557 of the Patient Protection and Affordable Care Act (ACA) and Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) which expressly prohibit discrimination on the basis of race, color, or national origin under any program or activity receiving Federal financial assistance from the Department of Health and Human Services. Section 1557 and Title VI of the Civil Rights Act require the provision of oral language assistance in any language to all LEP applicants and enrollees. Exchanges are subject to both Title VI of the Civil Rights Act of 1964 (since they will receive federal funds) and Section 1557 of the ACA (since they will receive federal funds and are an entity created under Title I of the ACA).		
12s	N		page 4-19		We support providing web portal content in English and Spanish with regards to: ☐ Website text, instructions, and navigation guidance ☐ Education Materials ☐ Online Assistance ☐ Online Chat ☐ Web-Videos ☐ Frequently Asked Questions (FAQs) ☐ Guided Self Help Tools ☐ QHP Information ☐ Forms ☐ Information and links to other health benefit programs. Aspects of the web portal content (e.g. Forms, Education Materials, QHP Information and the languages they provide, and Links to applicaton Assisters) should be required to be presented in threshold languages in addition to Spanish and English by 2014.		
12t	N		page 4-19		We support the key functionalities under Ease of Use. However the system must include a time-out function for those accessing the Exchange at a public site such as a library etc. to protect consumer information.		

12u	N		4-19-4-20		We support the key functionalities related to format. To ensure cultural and linguistic access there should be a feedback loop and stakeholder engagement in the design and testing process for current and future modifications. Please see comments above for 1.3.3. Additionally, Exchange terminology (as well as color, symbols, and forms etc.) should be culturally and linguistically appropriate and in language that reflects a fourth and sixth grade level, which is in accordance with recommendations of the National Institutes of Health. The Exchange should create an approved translation handbook to ensure consistency of translated terminology used with different materials and across the various platforms: phone, mail, internet and in-person.		
12v	N	4.4.3.6	page 4-32		We support the general functionalities of the presentation layer to the end user including the development of a mobile application which will greatly increase access to the Exchange for California's diverse communities. We strongly believe that translations of lists of navigators, agents, or brokers (including interactive maps and directions) and related web portal content should be required to be translated in threshold languages by 2014 in addition to Spanish and English.		
			page 4-32		As drafted, the RFP requires the vendor to evaluate UX2014 and other simlar interfaces, choose what elements to adopt, and inform the Exchange of its approach and how it will deliver a first-class user experience. We appreciate the focus on the first-class user experience and urge that the solicitation spell out, by way of example, elements that comprise such so the vendor uses the right criteria, including: design appeal, as demonstrated by focus group and/or usability testing by diverse audiences; ease of use; consumer decision aids; a default pathway that allows speedy plan selection; reliable, vetted plan information so that it is trusted; strong consumer privacy standards; and commitment to continuous improvement. We agree that UX2014 should be evaluated, as well as any similar interfaces, but urge that the CalHEERS Steering Committee, rather than the vendor, have the final say on what the front-end interface is. Federal HHS will issue an electronic application and it and other options should be evaluated, but CalHEERS should maintain ultimate decisionmaking authority over this key decision. If the state uses an application that differs from the federal one, it must be approved, requiring state agency involvement. This is critical as state agencies develop the paper and phone applications as well. Finally, unlike the draft language, which gives only the Exchange consultation authority over the interface, the authority should be shared by all 3 CalHEERS Steering Committee partners since the online application will equally be an application for Medi-Cal, Healthy Families and the Exchange.		

12w	N	4.4.3.7	page 4-33		We agree that the system must send appropriate notices in multiple languages to support the core services of the Exchange. Notices must be translated at a minimum into Medi-Cal Managed Care threshold languages. We would like to know where the list of languages in BR221 was generated from in order to make sure they are the most relevant languages for translation.		
12x	N	4.8.6.1	page 4-72		1) This appears to have been written prior to the decision to pull out the Service Center discussion into a separate process. 2) The draft RFP is unclear whether it seeks a bid for the vendor operate a call center or whether the RFP requests the IT necessary to support a call center. Health Access suggests that the IT RFP should be plainly limited to the IT to support the call center and that consistent with Exchange Board Action on 12/20/11 the RFP should be modified so that it is plainly limited to IT to support a call center.		
12y	N	4.8.6.1	page 4-72		Must be able to connect with existing state agencies and offices (DHCS, OPA) that provide assistance functions to beneficiaries, as Exchange products will have significant crossover. There should be a link to assistance for help with exemption requests.		
12z	N	4.8.6.2	page 4-73		A translated message should be provided on the outside of the envelope of outgoing mail with an 800 number to call for language assistance.		
12aa	N			BR123	We strongly applaud the inclusion of a provision to allow CalHEERS to record individual preferences (e.g. desired language for written and spoken communication, communication methods (mail, email, telephone, IVR, etc.). We assume this information will be used to ensure that future communications are in an individual's spoken language. We think it would be helpful to state that clearly in the RFP so vendors can develop the appropriate functionality to enable this to happen. We believe this provision will greatly increase access to health coverage and information for Limited-English-Proficient consumers.		
12bb	N			BR221	We applaud translation of the web portal into Spanish and translation of the toll number threshold languages. Threshold languages should at a minimum be determined by Medi-Cal Managed Care standards, and not the Dymally-Alatorre Bilingual Services Act, as indicated in the RFP. We would like to know where this list of languages in BR221 was generated from (Spanish, Arabic, Armenian, Cambodian, Chinese, Farsi, Hmong, Korean, Russian, Tagalog and Vietnamese) in order to make sure they are the most relevant languages for translation. We think it is also important for consumer assistance functionality to include a message on the web portal home page and other relevant pages in at least 15 different languages notifying consumers of their right to oral interpretation in any language along with a toll free number for consumer assistance.		

13 Call Center/IVR	Y				We are glad to see IVR development under same contract (or subcontract) as the CalHEERS, but would like more detail. IVR is just as important a public face as the online portal. RFPs for IVRs are usually quite lengthy. IVRs can be very stifling to access if they are done poorly. We would like more detail about the IVR Specifications and Business Requirements, Timelines, Integration with Call Center and Plan to Include Stakeholder input.		
13 Call Center/IVR	Y				It isn't clear: Is IVR for CalHEERS or for Exchange? It says IVR will "interface" with CalHEERS. That suggests that only for Exchange? Please make it clear in the RFP.		
13 Call Center/IVR	Y				RFP says "IVR should be threshold languages" (p. 8) and "IVR Should be Dymally-Alatore" (pg. 49) and "IVR should be English and Spanish" (pg 55)		
13 Call Center/IVR	Y				Draft IVR plan (including how it will interact with call center) must be made available for advocate and call center staff review and comment and that the final plan be maintained and updated public ally.		
13 Call Center/IVR	Y				Business requirements (on attachment three) pertaining to the IVR should be added. Currently, the only mention of the IVR is that there should be an interface to CalHEERS.		
13 Call Center/IVR	Y				Will the IVR be used for outbound calling, texting, etc as part of the outreach & enrollment campaign or to remind customers of upcoming deadlines? If so, this should be mentioned in the RFP as a necessary component of the IVR either as optional mandatory and or optional buy-in.		
13 Call Center/IVR	Y				RFP should ask for vendors to detail the types of IVR reports they will make available and how these will be made available to call center management and CalHEERS Sponsoring Partners (i.e. language selected, service selected, drop offs/disconnects, etc.).		
13 Call Center/IVR	Y				RFP should identify key functions of IVR (how many lines, outbound calls, caller ID, connections to other state or county agencies, identification of local county office or application assister by zip look-up, cloud / web based system for easy changes to recording, configuration, etc. by authorized call center staff.		
Assister Interface 14a		4.3.2	page 4-5		We applaud inclusion of the system to be able to track application and enrollments via assisters.		
14b					We appreciate the requirement that the system include a function to be able to calculate assister fees.		

14c				BR-139, BR 197, BR 198 and BR 199	We appreciate the functionalities required in the system to track applications by Assisters, as well as the system's ability to identify applications by Assister and the follow-up required to determine the number of individuals enrolled or not enrolled by Assister, which would allow for oversight by the Exchange to ensure Assisters are achieving the goals associated with the Assister role.		
14d		4.3.2 and 4.3.7 (SHOP)	page 4-5 and 4-12		We appreciate the functionality built into the system to issue, track and reconcile Assister fees.		
14e		4.3.5	page 4-8		The list of Assisters should include language to ensure that the system provides functionality for any other individual or entity, as identified under policies to be developed, who has sufficient training to assist people in applying for and obtaining coverage. (See also comments on Appendix A: glossary). Also we are concerned that the system does not appear to have a function that would allow the applicant to officially "designate" an Assister via the web portal, in-person, or by mail.		
14g		4.3.5 and 4.3.7 (SHOP)	page 4-8 and page 4-14		We appreciate the system will be designed for one Assister to have a single sign-on for multiple cases.		
14h		4.3.5	page 4-9		We are concerned about Assister management placeholder. This is an important issue for consumers. We would like to be able to comment on a draft when it is ready. Important is to design a system that provides a method for authorizing Assisters, that has the capacity for consumers to designate their official Assister representative and prevents an Assister from acting on behalf of a user without designation authority.		
14i		4.3.7	page 4-12		It is unclear whether the vision is that some Assisters will manage accounts for small businesses. If so, would there be different system requirements that had to be developed for those that manage accounts?		
14j		4.3.7	page 4-14		The list of Assisters should include language to ensure that the system provides functionality for any other individual or entity, as identified under policies to be developed, who has sufficient training to assist people in applying for and obtaining coverage. (See also comments on Appendix A: glossary). Also we are concerned that the system does not appear to have a function that would allow the applicant to officially "designate" an assister via the web portal, in-person, or by mail.		
14k		4.6.3.1	page 4-58		In Table 14, we are assuming that there will be a training program for Assisters. The IT system should be designed with the capacity to support the training system, when the decision has been made whether to do so. This would be a function that would provide an infrastructure to support a training module/s on the substance necessary to become an Assister.		

14l		4.7.2	page 4-66		The table listing Training materials needs to include language to ensure that the system provides functionality for any other individual or entity, as identified under policies to be developed, who has sufficient training to assist people in applying for and obtaining coverage. (See also comments on Appendix A: glossary).		
14m		Appendix A: Glossary			The list of Assisters should include language to ensure that the system provides functionality for any other individual or entity, as identified under policies to be developed, who has sufficient training to assist people in applying for and obtaining coverage. (See also comments on Appendix A: glossary).Also we are concerned that the system does not appear to have a function that would allow the applicant to officially "designate" an assister via the web portal, in-person, or by mail.		
14n	Y	General			When registering and tracking certified Assisters, the system should have a mechanism for linking information to complaints about Assisters.		
14o	Y	GENERAL			We believe the system should have functions to support a state reporting system in the event that an Assister is found to be committing fraud or is barred from an Exchange for deceptive activities. We hope that Exchanges will oversee their Assister programs carefully enough that this problem will not arise, but in the event that unscrupulous individuals become Assisters, the system needs the capacity to track and monitor		
14p	Y	GENERAL			The system should be able to categorize Assisters based on language capacity, not just region, etc.		
14q	Y	General			Need mechanism for consumer to designate Assister as the representative to avoid fraud. The specific individual needs to designate the specific Assister and the system needs to be designed with that function enabled and required.		
14r				BR 179 and BR 180	We applaud the inclusion of a function that would track individuals viewing a person's personally identifiable information and/or personal health information and allow an applicant to view his/her record to see who viewed the record, what items were viewed, and a time stamp to indicate when the record was viewed.		
16a Data Verification		4.3.1	'4-2		In addition to the fields listed for verification (citizenship, tribal affiliation, incarceration), income should be specified because the use of verification will be particularly important for income.		
16b		4.3.1	'4-2		In addition to notifying the customer of the application status and any outstanding items, a key function will be to inform the customer of the ability to correct and the process for correcting any incorrect or outdated information pulled during the verification process.		
17 QHP Functionality	y	4.3.3.	p.4-6		Monitor compliance: Include capture of complaint information and resolution details for Medi-Cal managed care plans and HFP plans as well as QHPs		
17a							

17b	y	4.3.3	p.4-6		Rate review: Key functionality must include not only rates based on issuer provided information for both indiviudals and employers but also information from CDI/DMHC on results of mandatory rate review (e.g. rate reduced by 3%, rate approved, etc.). System should have capacity to reflect other information about rates: for example, CDI/DMHC may provide other info such as issuer refused to comply with request to provide data to regulators.		
17c		4.3.1	p4-1	BR 50-BR 58, BR65-66	We support the provision of information on costs and benefits of plans; also the calculator.		
17d				BR 50-BR 58, BR65-BR66	Comparison of plans: In addition, consumers should have the opportunity to compare if changes in circumstance, such as job loss/gain or divorce. (e.g. if I am unemployed for four months and then go back to work at old salary, what is the impact?)		
17e				BR59-BR64, BR67-BR69	We support the plan comparison information. Be sure to provide capacity to update/redesign (e.g. langauge access added to HEDIS by OPA)		
18 SHOP	Y	4.3.7			The development of the SHOP requirements in the RFP are a good start in developing language for how employers and employees will access the SHOP. The individual calculator for both the employer and employees, the website assistant tools and real time notification of eligibility are all good steps in helping the consumer make an educated decision on which QHP to enroll into. However, some areas of the SHOP development are unclear in how the employer and/or employee will access the necessary information.		
18a	N	4.3.7	4 - 10		Application: The functionality for the application process needs to make clear that one seamless application needs to be made for both the employer and the employee. Further, under the application it lists that an employer will update the employee roster with information regarding demographic, health habits, and family data. This information should be confidentially and voluntarily reported by the employee and not the employer in order to protect the employee's rights to privacy regarding their health status and demographic information that would not otherwise be available to the employer. No employer should be able to access the information an employee provides when enrolling into a QHP. An employer should not have access to the employee's confidential information.		

18a.1	Y	4.3.7	4 - 10		Enrollment of employees should be separate from enrollment in the individual exchange because the requirements for eligibility are different. For example, some individuals who would be ineligible for enrollment in the individual exchange may be employees of small businesses.		
18a.2	Y	4.3.7			We endorse the definition of both employers and employees as consumers for purposes of SHOP (in the "consumer assistance" section). In accordance with that concept, a SHOP employee should have the ability to access information and manage his/her SHOP coverage through their employee account. This account could be established in a manner that preserves privacy and confidentiality with respect to their employer, including with respect to the issues raised in the comment above.		
18b	Y	4.3.7			Language Access: In California, language access can be an issue for employers and business owners as well as employees. We support the development of the web portal into English and Spanish. We strongly encourage the web portal to also be translated into Chinese, the third most spoken language in California, while also creating a system that can be easily translated into other threshold languages at a later time. We also encourage that the website and all notifications for small businesses be accessible in the top 15 threshold languages. We urge the state to consider translating portions of the web portal and other forms and documents (e.g. welcome, FAQs, Forms, links to consumer assistance and other health programs) into other languages as well. Tag lines with an 800 number for consumer assistance including oral interpretation in any language should be provided on the home page and other relevant pages in a minimum of 15 different languages. Further, the RFP recommends the use of the threshold languages identified in the Dymally-Alatorre Bilingual Services Act; this act does not adequately cover the number of threshold languages in the State and would leave too many small business owners and their employees without adequate access to they SHOP. Therefore, we recommend using the Medi-Cal Managed Care standards for language access to best serve the limited English proficient employers and employees accessing the SHOP.		
18c	Y	4.3.7			Testing of the system and stakeholder engagement: Similar to the individual Exchange, it is important to include time for the testing of the system with stakeholders. The RFP should include a section informing the process by incorporating the need to build in stakeholder engagement to the work plan. We also recommend a testing of the SHOP before it is fully launched on 1/1/2014. Further, we recommend that the timeline for testing adhere to the same timeline as the individual Exchange with the idea that the launch will occur 7/2013 to allow for early enrollment. Must test with a diverse group of stakeholders reflective of the population who will utilize the SHOP.		
18d	Y	4.3.7			The application should ask the employee to identify when they have a dependent who is potentially in need of coverage in the Exchange Health Services Programs and, where that is the case, whether they authorize sharing information with the EHSP for purposes of facilitating application/enrollment.		

18e	N	Attachment 3		SR 38	Federal law does not require the checking of employee SSNs with the Federal Data Hub. We strongly oppose the development of an IT system that allows for this function. It unnecessarily duplicates the role of employers.		
18e.1	N	Attachment 3		SR63, SR65, SR 68	RFP assumes policy decision that employers will be able to limit choice of plans available to employees. We oppose this policy. We recognize that employers will set employer share of premium but we support employee choice of plans, including ability to pay more to get more comprehensive coverage. This is a policy decision, not a IT requirement.		
18e.2	N	4.3.7	4 - 10		Appeals: Employees must have a mechanism that supports them in being able to communicate with the system when their employer is not diligently maintaining coverage/protecting their interests. The employee account should support this function.		
18f	N	4.3.7	4 - 10		Enrollment: The development of the individual applicant calculator should mirror the calculator in the individual market with the exception that the SHOP calculator should allow for the employee to include the portion of the premium their employer will make. Further, the calculator should have the functionality to determine premium cost and out of pocket cost based on the number of dependents an employee would like to also cover under their employer's plan. If the employer does not cover dependents, then the calculator should aid the employee in determining their premium and out of pocket costs to also cover the dependent through the individual Exchange.		
18 g		4.3.7	4 - 11		Disenrollment: Should include ability to provide notification to an employee when their employer is taking steps to discontinue SHOP or disenroll the employee and/or their dependents. This notification should provide the employee with an ability to learn about their options and provide a link to other coverage options (Exchange/EHSP)		
18h		4.3.7	4 -12		Small Business Premium Payment Financial Transactions: While the overall process for payment by employers looks good, it is unclear as to the process employees will go through to pay their portion, if any, of the premium. We would recommend that the same system being established for the employer, also be established for the employee through the employee's private account.		
18i		4.3.7	4 - 12		Notices: To ensure consistency in the information provided to a LEP individual, we recommend that once a LEP individual makes a request for materials in a non-English language, the SHOP should provide all subsequent notices to the claimant in the non-English language.		
18j		4.3.7	4 - 13		Reports: We applaud the effort to collect data on the SHOP and generate reports to evaluate and understand enrollment trends, cost, assisters, etc. We recommend that in addition to reports being generated for the HBEx and policymakers, that all data and reports be public information. We recommend that CalHEERS have the functionality to generate reports based on appeals and complaints of a QHP issued by an employer or employee.		

18k		4.3.7	4 - 14		Consumer Assistance: We applaud the effort to create consumer assistance functionality that is "user-friendly, web-based, self-service and provide online assistance to all customer user types via a range of web browsers and various mobile applications." We also support the functionality to provide real-time guidance, navigation, and help for customers. A robust consumer assistance platform is imperative for the SHOP to work. The term Assister should be expanded to include any other individual or entity as provided under the policies to be developed who has sufficient training to assist individuals in enrolling in coverage. Last, the web portal needs to share information for consumer assisters with tag lines in at least 15 languages to help employers and employees identify an assister for help.		
18l		4.3.7	4 - 15		Small Business/Employer Tools: While the employee can update her/his own account, it is not clear whether it is a private account of the same account the employer can access. We believe that the system needs to be designed to provide for a SHOP employee to access the system through a separate personal account, in addition to the one for the employer. The account should be protected for use of the employee and only her/his designated assister. The account should also provide for individual access for all of an employee's covered dependents.		
19 Financial Management Capacity		4.3.2	'4-5		We support tracking applications and enrollments for which assisters were involved in order to ensure that assisters receive accurate payments for services rendered. We also agree with the need to ensure that CalHEERS can (1) collect and aggregate premiums, (2) electronically collect fees from plans to support the Exchange and (3) electronically provide data needed for reinsurance and risk adjustment calculations.		
Human Services Integration 20a	Y	1.4.1	1-7		We applaud the Sponsors' inclusion of "expanded integration" with human services programs as part of the future vision for CalHEERS. However, we recommend several changes, described below, to help make this vision more concrete and ensure that integration occurs in a timely manner.		
Human Services Integration 20b	N	4.3.1	4-4		With respect to the first sub-bullet under "Other Non-Health Services Programs" (notifying applicants they may be eligible for other programs and directing them to appropropriate links), we recommend that this function be considered a Core Functionality Service, with delivery required by January 1, 2014, rather than a Mandatory Optional Functionality Service. With respect to the second sub-bullet in this section (collecting and sending application data to another system to "complete the application process"), we recommend that this bullet be revised as follows: "Collecting and sending the basic application data to the system of record for that program to CONTINUE the application process AND TRACK THE RESULT OF THAT PROCESS, WITH THIS FUNCTIONALITY TO BE DELIVERED ON OR BEFORE DECEMBER 31, 2015.		

Human Services Integration 20c	N	4.6.1.3.1	4-56		This section does not appear to directly address the issue of "pre-enrollment," despite the fact that the "Eligibility Transfer" row in Table 10 (p. 4-34) indicates that pre-enrollment will be described in Section 4.6.1.3.1. We recommend that this section include a description of pre-enrollment, including both what it means and how it is intended to work.		
Human Services Integration 20d	N	Appendix A	G-11		The glossary does not include a definition of "pre-enrollment." We recommend that such a definition be added.		
Human Services Integration 20e	N			BR 46	We recommend that the following requirement be inserted after the current BR46: "The CalHEERS shall provide the functionality to collect and send basic application data for other non-health services programs to the system of record in order to continue the application process and track the result of that process, with this functionality to be delivered on or before December 31, 2015."		
21 Monitoring, Reporting, Evaluation	Y	GENERAL			Importance of referencing privacy and security standards, including time-out function to protect publicly located data screens. We would recommend in each of these sections incorporating a reference to 4.4.8 and		
21a	Y	GENERAL			Accolades for anticipating all the different types of reporting for individual and SHOP populations - 4.3.4 and 4.3.7		
21b	Y	GENERAL			Public reporting of data collection, in aggregate, including demographic data (page 4-6) is laudable and should be explicitly made available on the website of CalHEERS and/or Program Sponsors.		
21c	Y	GENERAL			Reporting function should exist to ensure that data is collected and publicly reported on the number of people applying for individual exemptions, the number granted and the number denied.		
21d	Y	GENERAL			Reporting requirements for the SHOP exchange should be designed to track dependents of employees. While the decision whether or not to cover dependents has not been made, the system should be designed to support the function when/if that decision is made. We would strongly support SHOP employers offering SHOP coverage to dependents.		

21e	Y	General			We urge CalHEERS to require User Acceptance Testing (UAT). The purpose of a UAT is for users to test the system in a pseudo environment to verify that the system is performing to specifications. UAT provides CalHEERS and its Program Partners, as well as California consumers and a wide range of diverse stakeholders - employers, consumer advocates, employees, assisters, issuers - an opportunity to review and accept system components prior to release of the system for public use. It demonstrates that the software meets functional requirements and specifications and accommodates the needs of the variety of users who will interface with the system. UAT should be required throughout the life of the contract when enhancements or modifications to the system are made.		
21f		1.3.3	page 1-7		The description of the stakeholder process only refers to the process between stakeholders and the Exchange (e.g. written and public comments and small group discussions). This should be expanded to include a process for stakeholder input into the design and testing of the IT system. This process should be tied to vendor pay and identified as a metric required to meet the contract.		
21g		1.4.1	page 1-7		This provision should be specific in the bullets to test for user accessibility with uninsured and other potential users representing a diverse set of demographics reflective of the population who will benefit from CalHEERs. See comment on section 1.3.3.		
21h			page 1-8		We support the existence of a feedback loop for persons with disabilities regarding ease of accessibility. A feedback loop should be programmed for all users, including Limited English Proficient (LEP) individuals. The feedback mechanism could include a written comment/complaint function as well as a stakeholder focus groups for the design and testing of the IT functions including future modifications. In addition, we should assure that the site is comprehensible to those with low health literacy.		
21i		4.3.1	page 4-2		We applaud the collection of voluntarily provided data on race, ethnicity, sex, primary language and disability status. We believe the collection of this data is a requirement under Section 4302 of the Affordable Care Act and will be necessary for the Exchange to accurately measure health disparities. The collection of demographic data however, should be limited to only that which is minimally necessary and protected by privacy and security measures. It is important to ensure that access to the data does not, in itself, result in adverse selection. Health status information is not minimally necessary information and should not be collected directly from the consumer as part of the enrollment process, as this provision suggests. A statement should be included explaining that any data collected will be used to improve the quality of care.		

			page 4-2		The process for collecting race/ethnicity data should be consistent with the current U.S. Census methodology. In general, this means that the ethnicity data should be collected first (Hispanic, non-Hispanic) with race collected subsequently (Black, White). We know that race ethnicity data collected in the opposite order during previous Census counts resulted in massive undercounts of groups who are ethnically identified. The system should allow an assessment of LEP status at the same time as it collects race/ethnicity data. If someone triggers an indicator that they are LEP the system should be designed to trigger access to an information resource where people are provided with access to language services as afforded under law or translation services that suffice.		
			page 4-2		The process for collecting race/ethnicity data should be consistent with the current U.S. Census methodology. In general, this means that the ethnicity data should be collected first (Hispanic, non-Hispanic) with race collected subsequently (Black, White). We know that race ethnicity data collected in the opposite order during previous Census results in massive undercounts of groups who are ethnically identified.		
21j		4.3.2	page 4-4		Need privacy and security protections referenced here. Information should be proteced by privacy and security provisoin of 4.3.8 and should limit access to small group of users (role-based security).		
21k			page 4-4		Reference privacy and security of personal information in section 4.4.8 and general comment above		
21l			page 4-4		Reference privacy and security of personal information in section 4.4.8 and general comment above		
21m		4.3.3	page 4-6		Reference privacy and security of personal information in section 4.4.8 and general comment above		
21n		4.3.4	page 4-6		Monthly reports on HBEX enrollees, including unique individual identifier, plan, type of coverage, rating criteria, demographic data, effective dates - importance of making this information easily accessible to the public on the website of CalHEERS. This same should be collected for enrollees in the SHOP Exchange and should be referenced in 4.3.7.		
21o		4.3.7 (SHOP)	page 4-7		Reports on ER applications received, those enrolled and timeframe from application to enrollment should include the ability to collect data about dependents. While the decision whether or not to cover dependents has not been made, the system should be designed to support the function when/if that decision is made. We would strongly support SHOP employers offering SHOP coverage to dependents.		
21p					This provision should include the ability to collect data about dependents. While the decision whether or not to cover dependents has not been made, the system should be designed to support the function when/if that decision is made. We would strongly support SHOP employers offering SHOP coverage to dependents.		
21q		4.3.6	page 4-9		We applaud the inclusion of tracking high-use/low-use by program and demographic to target outreach.		

21r		4.3.7	page 4-13		Data should be collected on the employer, if any, of adults enrolled. This should be collected in order to monitor for compliance with the employer responsibility requirements, as well as affordability of employment-based coverage. Additionally, this provision should include the ability to collect data about dependents. While the decision whether or not to cover dependents has not been made, the system should be designed to support the function when/if that decision is made. We would strongly support SHOP employers offering SHOP coverage to dependents.		
21s			page 4-14		The system should have the ability to track by employer the lack of affordability of premiums. Additionally, this provision should include the ability to collect data about dependent coverage. While the decision whether or not to cover dependents has not been made, the system should be designed to support the function when/if that decision is made. We would strongly support SHOP employers offering SHOP coverage to dependents.		
21t		4.4.10	page 4-44		Performance requirements are quite weak and leave too much discretion with the vendor. On our review, there was nothing in Attachment 3 identifying performance metrics. At a minimum vendor deliverables should be tied to stakeholder input in the design and testing, including future modifications.		
21u		4.4.12	page 4-45		Reports and reporting - good list of coverage metrics, affordability and comprehensiveness, access to care, consumer experience, consumer feedback, assister support, technology platform and security - while we strongly applaud these metrics and appreciate them being included as reporting measures from the vendor, we are confused about where the data would come from and how collection would be implemented.		
21v			page 4-45		Strong role-based security measures should be in place in order to ensure real-time monitoring protects privacy, including a time-out function.		
21w		4.5.6	page 4-48		The quality management methodology should require more specifity to ensure the user satisfaction incorporates a diverse set of stakeholders and a robust process.		
21x		4.6.1.3	page 4-55		More standards should be included here that require stakeholder engagement for development and testing. The process should be tied to vendor pay and identified as a metric required to meet the contract.		
21y		4.7.2	pages 4-62 thru 4-63		More standards should be included here that require stakeholder engagement for development and testing. The process should be tied to vendor pay and identified as a metric required to meet the contract.		
21z		4.7.2	pages 4-64 - 4-66		More standards should be included here that require stakeholder engagement for development and testing. The process should be tied to vendor pay and identified as a metric required to meet the contract.		
21aa		6.2	page 6-16		The evaluation team should be exapnded to include a person with contract evaluation experience and a person with a strong consumer focus.		

21ab		6.3.2	page 6-17		Consider adding in the proposal review an interview of a state agency, business or other organization that did not award a contract to the vendor/applicant to learn more about why another entity may have chosen not to contract with the vendor in the past.		
21ac		6.3.2	page 6-17		Applicants should not be evaluated strictly on a "past performance" basis, but rather the evaluation should also evaluate what other vendor contracts are currently in place or up for consideration.		
21ad		6.3.2	page 6-17		We would recommend a tiered interview process that would allow the evaluation team to have a second interview of the top finalists before the vendor choices are presented to the Exchange Board for selection. The knowledge of senior contracting staff, including their accessibility and ability to communicate, can be a critical determinate to success.		
21ae		6.4	page 6-18		The evaluation should be broadened to look at experience not only for state and governmental entities, but also for the business and non-governmental sector.		
21af		6.4	page 6-18		We applaud the inclusion of evaluation of sub-contractors as a critical element in choosing a vendor.		
21ag		6.4	page 6-18		Under project management and staffing, there should be explict mention of the details of reporting Requirements and accountability to CalHEERS and Project Sponsors, if the vendor is selected. This may be assumed, but we believe it should be explicitly stated here.		
21ah		6.4	page 6-18		In order to ensure that low cost does not drive the decision, given the complexity and importance of this contract, we would favor a pass/fail or equivalent scoring on cost - in other words, if three bidders come in around the same cost, they should be rated as "good value" or "met cost targets." If a bidder comes in at a considerably lower cost than all others, the evaluation team should be extra careful in the evaluation of their alleged proficiencies in the submission under the business/technical components of the proposal.		
22 Privacy and Confidentiality Protections	Y	General			Privacy and security protections should be spelled out to include a "timed out" function that will ensure that secured information isn't left on a computer screen in a public place once the authorized user has stopped using the system.		
22a	Y	General			A set of "Consumer and Patient Principles," endorsed by Consumers Union and 23 diverse, consumer-oriented groups including Health Access California, cover elecronic health information exchange in California. They can be found here: http://www.consumersunion.org/pdf/HIE-Principles-6-10.pdf. We recommend that the security and privacy principles in this solicitation incorporate those principles by reference.		

22b	Y	General			It is critical that CalHEERS be governed by a comprehensive security and privacy policy and technology framework that protects consumers and Program Sponsors. The solicitation, however, places the responsibility for developing such a framework on the vendor. The responsibility for developing a strong privacy and security framework should be vested with CalHEERS and not left to the vendor. While the vendor may play a role in helping CalHEERS understand the technical capabilities that are available to support particular policy proposals, the ultimate responsibility for making those choices rests with CalHEERS or the state agency Program Sponsors.		
22c	Y	General			Existing privacy and security laws do not fully cover the Exchange or certain functions anticipated by the solicitation. Those laws were designed to address particular data flows in the health care system and are an incomplete or poor fit for the data flows required for CalHEERS.Thus, reliance on existing laws is insufficient. In addition, laws that apply to CalHEERS should be consistent with federal ACA requirements governing the collection and use of health information by Exchanges (which limit the collection of personal information, and the use of that information, to what is strictly necessary to operate the Exchange - see Sections 1411(g)(1) and 1411(g)(2) of the ACA). It is critical that Program Sponsors, through a public process, develop a set of privacy and security policies/best practices to govern CalHEERS that support CalHEERS' core functions, fill gaps in applicable law, and build public trust in CalHEERS' operations. The vendor should not design the policies, but rather implement the policies and best practices as part of the contract. The solicitation needs to expressly acknowledge that CalHEERS and its Program Sponsors will develop policies and best practices, not the vendor. The vendor will participate in that process and ensure CalHEERS complies with those policies and best practices as in effect from time to time. A phased approach on such development by CalHEERS may be necessary here given that these requirements will not be developed by Dec. 30, 2011.		
22d		4.3.1	page 4-1		Need to state up front in the eligibility and enrollment section that the vendor will adhere to the CalHEERS privacy and security provisions articulated in 4.4.8		
22e		4.3.7	page 4-10		Need to state up front in the eligibility and enrollment section that the vendor will adhere to the CalHEERS privacy and security provisions articulated in 4.4.8		

22f		4.4	page 4-20		It is critical that the Exchange, DHCS, and MRMIB, through a public process, develop a set of privacy and security policies and best practices to govern CalHEERS that support CalHEERS' core functions, fill any gaps in applicable law, and build public trust in CalHEERS' operations. The vendor should then be required to support these policies and best practices as part of the contract. As noted above, the solicitation now gives the Vendor the responsibility for developing the privacy and security "framework" and relies too heavily on ensuring compliance with existing law. The solicitation needs to expressly acknowledge that the Program Sponsors will be developing further policies and best practices for CalHEERS and the vendor will be required to participate in that process and ensure CalHEERS complies with those policies and best practices as in effect from time to time.		
22g		4.4.8	page 4-38		The solicitation should be clear that the vendor will be required to develop functionalities to support privacy and security policies developed by the Program Sponsors. Requiring express adherence (vendor "shall ensure") to the policies listed on pages 4-39 to 4-40 may be premature, particularly for those laws that do not necessarily apply to the CalHEERS by their terms (such as HIPAA and HITECH). The solicitation should leave discretion to CalHEERS and Program Sponsors to make determinations on applicable law (where there is authority for discretionary judgment).		
22h		4.4.8	page 4-39		Add language that requires the vendor to build the system to be adaptable to new technology and security threats.		
22i		4.4.8	page 4-43		We strongly agree with the need to develop policies, best practices and "protections" for CalHEERS based on the identified privacy principles. However, the responsibility for developing the framework should not rest with the vendor. The solicitation needs to be clarified so that the ultimate responsibility for developing appropriate policies, practices and protections is with CalHEERS and/or the Program Sponsors and that the job of the vendor is to assist in this process and to ensure that CalHEERS is designed to comply with the requirements.		
22j		4.4.8	page 4-44		The solicitation notes that the vendor takes the lead role and is responsible for ensuring business associate agreements are in place in order to exchange PII and PHI, "following DHCS policies, best practices, and HIPAA regulations." The section further notes that DHCS functions as Subject Matter Expertise support on this requirement. We agree that a state agency should be in the position of determining when business associate agreements need to be executed and with whom, and the substance of what those agreements should cover. The role of the vendor should be to execute these determinations. The solicitation needs to be made more clear on this point. This should also be a model for revising the solicitation to reflect our comments above about the respective roles of state agencies and the vendor.		

23 System Requirements		1.1.1 Solicitation Objectives 1.4.1 Future Vision	1.1, 1.9		We applaud the requirements that the system be open source, that the vendor be required to proactively monitor other states' developments (though this should be broader than just exchange developments; should include Medicaid and CHIP as well), and that the vendor leverage other states' efforts.		
23b			4-18		We support the requirement that CalHEERS be accessible from smart mobile device applications.		
24c		4.4, 4.5.9	4-22, 4-49		We strongly support the requirement that the CalHEERS IT architecture be sufficiently flexible and agile to respond quickly to changes. This is critical given that there are sure to be changes in the rules and system requirements.		
24 d		4.4.3.3	4-29		We support the requirement of a centralized business rules repository to store the eligibility and enrollment rules in a format readable by people, not just computers. We request that the RFP require that this repository be made publicly available - posted on the CalHEERS website.		
24 e		4.4.3.6 Presentation Layer	4-32		We support the general functionalities of the presentation layer to the end user including the development of a mobile application which will greatly increase access to the Exchange for California's diverse communities. We strongly believe that translations of lists of navigators, agents, or brokers (including interactive maps and directions) and related web portal content should be required to be translated in threshold languages by 2014 in addition to Spanish and English.		

24f		4.4.3.6 Presentation Layer	4-32		As drafted, the RFP requires the vendor to evaluate UX2014 and other simlar interfaces, choose what elements to adopt, and inform the Exchange of its approach and how it will deliver a first-class user experience. We appreciate the focus on the first-class user experience and urge that the solicitation spell out, by way of example, elements that comprise such so the vendor uses the right criteria, including: design appeal, as demonstrated by focus group and/or usability testing by diverse audiences; ease of use; consumer decision aids; a default pathway that allows speedy plan selection; reliable, vetted plan information so that it is trusted; strong consumer privacy standards; and commitment to continuous improvement. We agree that UX2014 should be evaluated, as well as any similar interfaces, but urge that the CalHEERS Steering Committee, rather than the vendor, have the final say on what the front-end interface is. Federal HHS will issue an electronic application and it and other options should be evaluated, but CalHEERS should maintain ultimate decisionmaking authority over this key decision. If the state uses an application that differs from the federal one, it must be approved, requiring state agency involvement. This is critical as state agencies develop the paper and phone applications as well. Finally, unlike the draft language, which gives only the Exchange consultation authority over the interface, the authority should be shared by all 3 CalHEERS Steering Committee partners since the online application will equally be an application for Medi-Cal, Healthy Families and the Exchange.		
24g		4.3.1	4-1		Functionality requires a calculator to compare costs across plan options, which we support, but there should also be a calculator screening tool to allow people to enter basic information and see what program or level of subsidy they are eligible for.		
25 Facility		4.6.1.1.1	'4-54		We support the requirement that the development and implementation facility be located within 30 miles from the State Capitol and that the data center and service center be located within California.		