**THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS**
**ACTION AGENDA SUMMARY**

**DEPT:** Health Services Agency **BOARD AGENDA #** *B-8

**Urgent** ☐ **Routine** ☒ **AGENDA DATE** September 9, 2008

**CEO Concurs with Recommendation YES** ☒ **NO** ☐ **4/5 Vote Required YES** ☐ **NO** ☒
**(Information Attached)**

SUBJECT:

Approval to Issue a Request for Proposals for the Purpose of Identifying and Assessing Interested and Capable Licensed Health Plans to Serve as the Local Initiative Medi-Cal Managed Care Health Plan for Stanislaus County

STAFF RECOMMENDATIONS:

1. Authorize the issuance of a Request for Proposals for the purpose of identifying and assessing interested and capable licensed health plans to serve as the Local Initiative Medi-Cal Managed Care Health Plan for Stanislaus County.

2. Direct the Managing Director of the Health Services Agency to make a recommendation to the Board of Supervisors subsequent to the assessment of the responses to the Request for Proposal.

FISCAL IMPACT:

There is no fiscal impact associated to authorizing the release of the Request for Proposals. The current contractual arrangement between the Health Services Agency and the Anthem Blue Cross, which serves as the Local Initiative Health Plan provides revenue to the Agency for certain administrative and outreach services. The funding rate is based on enrollment and as such the amount varies year to year. During the past three years, this amount has averaged approximately $750,000 annually. In addition to this revenue,

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BOARD ACTION AS FOLLOWS:

No. 2008-642

**On motion of Supervisor** Monteith **, Seconded by Supervisor** DeMartini
**and approved by the following vote,**
**Ayes: Supervisors:** O'Brien, Grover, Monteith, DeMartini and Chairman Mayfield
**Noes: Supervisors:** None
**Excused or Absent: Supervisors:** None
**Abstaining: Supervisor:** None

**1)** X **Approved as recommended**
**2)** _____ **Denied**
**3)** _____ **Approved as amended**
**4)** _____ **Other:**
**MOTION:**

Christine Ferraro

**ATTEST:** **CHRISTINE FERRARO TALLMAN, Clerk** **File No.**

**FISCAL IMPACT (Continued):**

the Health Services Agency receives fifteen percent (15%) of the profits earned from the Anthem Blue Cross profits on the Medi-Cal business in Stanislaus County. Since the beginning of this operation in 1997, the Health Services Agency has received a total of $3,124,869 in shared profits; however, no profits have been earned to allow for sharing since 2001.

**DISCUSSION:**

In 1993, the California Department of Health Services (DHCS) issued its strategic plan for expansion of managed care in the Medi-Cal program. This plan targeted thirteen (13) counties in which DHCS contracted with two licensed health maintenance organizations (HMOs) to take care of all Medi-Cal recipients within three primary aid categories. Of these two HMOs, one was to be an existing commercial plan while the Counties were given the option to develop the other plan called the Local Initiative.

Stanislaus County was one of the thirteen counties given the option to develop a Local Initiative.

In 1994, the Stanislaus County Board of Supervisors (BOS) began the process of authorizing the establishment of the Stanislaus County Local Initiative. With the State DHCS approval, the County decided to pursue a contract relationship rather than develop a County operated health plan. The County released a Request for Information (RFI) from interested health plans for the purpose of identifying an appropriate vendor to serve as the Local Initiative health plan for Stanislaus County and to develop a subcontract relationship with the Health Services Agency.

The following year, the RFI was developed and sent to interested health plans. In 1996, a consultant was retained to evaluate the proposals and make recommendations to the Board of Supervisors. The same year, the Board of Supervisors authorized the Stanislaus County Health Services Agency (the Agency) to enter into negotiations with Blue Cross of California (BCC) for consideration as its Local Initiative Health Plan Partner. In 1997, the BOS passed a resolution that designated BCC as the Local Initiative Health Plan Partner and conveyed that decision to DHCS. Under the state's Medi-Cal Managed Care program, the state negotiates, enters the contract with and provides the funding to the health plan, although the local Board of Supervisors retains the discretion to choose the health plan. DHCS finalized arrangements with Blue Cross and the Local Initiative Medi-Cal Managed Care Health Plan in Stanislaus County began operations in October of 1997.

Anthem Blue Cross (Blue Cross of California) has been Stanislaus County's Local Initiative Medi-Cal Managed Care health plan since 1997. The County has not sought alternatives since the 1997 launch.

When the Health Services Agency clinic division Strategic Plan was adopted by the Board of Supervisors in September of 2005, one of the activities approved was to explore Medi-Cal Managed Care alternatives. In terms of timing, the Agency sought initiatives which could stabilize the financial condition of the clinic system before embarking upon a strategy for Medi-Cal Managed Care, as the role and interest of the Agency could differ depending upon the resulting composition and structure of the clinic system. The Agency sought and received the Federally Qualified Health Center Look-Alike designation effective in September of 2007, and began implementing various other cost saving or revenue enhancing initiatives.

The Agency has developed and would like to issue a Request for Proposals (RFP), in accordance with the 2005 Strategic Plan as a matter of due diligence, and to explore marketplace opportunities which may offer new, unique and/or improved services in our community.

For several months the Agency has been working with the State Department of Health Care Services regarding the Local Initiative arrangements. Through these communications, the Agency learned that as part of an industry routine to renegotiate reimbursement rates, Blue Cross has issued a termination notice to the State Department of Health Care Services, of their contract as the Local Initiative of Stanislaus County. This has happened before and the State and Blue Cross have reached agreement such that the termination notice was essentially transparent to the community. According to the State, the current termination notice would take effect October 31, 2008 if a successful renegotiation is not achieved.

Regardless of the outcome of those negotiations, the County Board of Supervisors continues to have the authority to determine which health plan has been selected to negotiate with the State. The State Department of Health Care Services has assured the Agency of their support to implement changes if the Board of Supervisors decides to direct a change.

The purpose of this RFP is to assess interest and intent as well as to evaluate the experience, capabilities, and philosophy of Health Maintenance Organizations (HMOs) that may be interested to participate in a business relationship with the Stanislaus County Health Services Agency and to serve as the Local Initiative in Stanislaus County. The Agency is seeking a partnership with a Knox-Keene licensed health plan that combines the strengths and expertise of a Local Initiative with managed care experience and knowledge in order to best serve Medi-Cal recipients in Stanislaus County. On the basis of information provided in response to this request, the Agency

will select up to three (3) plans to interview. A plan would then be selected upon staff recommendation and Board of Supervisor approval, with which the Agency would enter into negotiations. A review of the selected plan's infrastructure, policies, systems, commitment and finances will be conducted.

It is the objective of the Agency to develop a competitive, cost effective, and locally directed plan that provides quality health care in a culturally and linguistically diverse setting with services geographically proximal to its members.

In order to assure that the criteria developed for the RFP effectively included matters of importance to both providers and Medi-Cal beneficiaries, a community stakeholder meeting was held on June 17, 2008. Approximately 35 participants attended and provided their input. Participants included representatives from each of the hospitals, physicians and managers from the County clinics and Golden Valley Health Centers, representatives from the Community Services Agency and Behavioral Health and Recovery Resources, an Independent Practice Association (of community physicians), Public Health nurses and the Public Health Officer, and a Community Health Center Board member who is a Medi-Cal beneficiary. A long list of items of importance to these participants was created and incorporated into the attached RFP.

Once proposals are received and evaluated, staff would return to the Board of Supervisors with a recommendation, and would then report that outcome to the State Department of Health Care Services. If the recommendation is to make a change, the State Department of Health Care Services would then initiate their readiness review and negotiate a contract with the new health plan. That process is estimated to take a minimum of six months.

The Agency briefed the Health Executive Committee of the Board of Supervisors of this initiative at its meetings of December 4, 2007 and May 6, 2008.

**POLICY ISSUE:**

Approval of this recommendation is consistent with the Board of Supervisors' priorities of *A healthy community*, *Effective partnerships* and *Efficient delivery of public services*, by allowing the Health Services Agency to assess the market for opportunities regarding Medi-Cal Managed Care health plans.

**STAFFING IMPACT:**

There is no staffing impact associated with this report.

DRAFT

# REQUEST FOR PROPOSAL

## STANISLAUS COUNTY HEALTH SERVICES AGENCY
## Medi-Cal Managed Care Initiative

## I. PURPOSE

The purpose of this Request for Proposal (RFP) is to evaluate the experience, capabilities, and philosophy of Health Care Service Plans (HCSPs) who may be interested in participating in a business arrangement with Stanislaus County Health Services Agency (HSA) Medi-Cal Managed Care to serve as the Local Initiative in Stanislaus County. HSA is seeking a partnership with a Knox-Keene licensed health care service plan that combines the strengths and expertise of a Local Initiative with managed care experience and knowledge in order to best serve Medi-Cal recipients in Stanislaus County. A review of the selected plan's systems and finances will be conducted and a business plan will be jointly developed.

It is the objective of HSA to develop a competitive, cost effective, and locally directed plan that provides quality health care in a culturally and linguistically diverse setting with services geographically proximal to its members.

## II. DESCRIPTION OF NEED; DEVELOPMENT OF A NEW LOCAL INITIATIVE

Anthem Blue Cross Partnership Plan has been Stanislaus County's Local Initiative Medi-Cal Managed Care health plan since 1997. HSA is developing and issuing a new RFP for the following reasons:

- Exploring managed care alternatives was an initiative in HSA's September, 2005 three-year strategic plan;
- Periodically providing an opportunity to other health plans to submit applicable proposals is a fundamental aspect of due diligence by a public entity;
- Exploring opportunities in the marketplace that may exist could offer a new focus on Stanislaus County's community needs.

## III. BACKGROUND

In 1993, the California Department of Health Services (CDHS) issued its strategic plan for expansion of managed care in the Medi-Cal program. This plan targeted thirteen (13) counties in which CDHS contracted with two licensed Health Care Service Plans (HCSPs) to take care of all Medi-Cal recipients within three primary aid categories. Of these two HCSPs, one was to be an existing commercial plan while the Counties were

given the option to develop the other plan called the Local Initiative. Stanislaus County was one of the thirteen counties given the option to develop a local initiative.

### A. DEVELOPMENT CHRONOLOGY OF MAINSTREAM PLAN

In 1996, CDHS designated Omni Health Care as the Mainstream Plan for Stanislaus County. It began operations in 1997 and terminated its contract with CDHS as the Stanislaus County Mainstream Plan in 1999. In September, 2003 HealthNet was named Stanislaus County's Mainstream Plan and began its operations in August, 2005.

### B. DEVELOPMENT CHRONOLOGY OF THE LOCAL INITIATIVE

In 1994, the Stanislaus County Board of Supervisors (BOS) began the process of authorizing the establishment of the Stanislaus County Local Initiative. With CDHS' approval, the County decided to pursue a contract relationship rather than develop a County operated health plan. The County released a Request for Information (RFI) from interested health plans for the purpose of entering into business arrangements with Stanislaus County to implement the Local Initiative on a subcontracting basis.

The following year, the RFI was developed and sent to interested health plans. In 1996, a consultant was retained to evaluate the proposals and make recommendations to the BOS. The same year, the BOS approved Stanislaus County Health Services Agency (HSA) to enter into negotiations with Blue Cross of California (BCC) for consideration as its Local Initiative Health Plan Partner. In 1997, the BOS passed a resolution that designated BCC as the Local Initiative Health Plan Partner. Following that, CDHS sent written confirmation that BCC was granted a conditional start date to begin Medi-Cal Managed Care operations in Stanislaus County and in October, 1997 BCC initiated operations as the Stanislaus County Local Initiative.

## IV. CRITERIA

Health Care Service Plan or Plan must meet all current California State Department of Health Care Services and Department of Managed Health Care requirements, including the following:

A. Plan Information: Size, financial and market stability, and available resources of plan;
B. Prior managed care experience including managing risk, managing various reimbursement models;
C. Prior Medi-Cal experience preferably in a similar size market and demographics;
D. Demonstrated commitment to a continuous quality improvement program and outcomes tracking;
E. Willingness to accept significant input from HSA within State and Federal requirements, and other stakeholders into the structure and function of quality assurance and improvement programs, member and provider services programs, public relations and marketing;

F. Current relationship with community providers and health care consumers;
G. Capability to share data with HSA and other stakeholders;
H. Willingness to be flexible and responsive to change;
I. Willingness to partner with non-traditional providers such a community based organizations;
J. Willingness to enter into an agreement with HSA wherein plan will compensate HSA for administrative or other defined services performed by HSA for the plan.
K. Willingness by plan to establish a local office to provide health education classes, member and provider services, outreach, and location for quarterly meetings with community partners;
L. Willingness to abide by HSA's "Guiding Principles" (See Stanislaus County Health Services Agency's Guiding Principles, Attachment I).
M. Willingness to enter into Managed Care contract with DHCS, and comply with all contractual requirements set forth in that contract, as well as comply with all applicable Federal and State laws and regulations.

## V. PROPOSAL TO INCLUDE

### A. General Information:

1. Enrollment in Stanislaus County and in Northern California, by County as of January, 2008
    a) Total
        - Commercial
        - Medi-Cal
        - Medicare, Medicare Risk
        - Worker's Comp
2. National Committee for Quality Assurance (NCQA) Accreditation Status. Utilization Review Accreditation Committee (URAC) Status.
3. A summary of plan's most recent DHCS Annual Audit-if plan currently serves Medi-Cal population to include any major or severe deficiencies and the corrective action plans taken. If not, a summary of findings or copy of the plan's most recent Department of Managed Health Care audit or survey report.
4. A description of the business advantages and disadvantages to your Plan serving as Stanislaus County's Local Initiative.
5. A description of the manner in which HEDIS studies are performed.
6. A description of enhanced benefits or services offered to beneficiaries.
7. A summary that describes if and how plan would subsidize a "Healthy Kids" program.
8. List an example or examples of innovative case management or UM that improved appropriate access to care, improved health outcomes, supported providers and reduced cost.

9. A description of how Plan proposes to collaborate on projects with HSA and how HSA's participation on such projects would be funded.
10. A description of Plan's revenue/profit sharing arrangements with HSA.

**B. Describe plan's qualifications in the following areas:**

1. Experience with target populations especially with culturally and linguistically diverse populations.
2. Familiarity with Medi-Cal providers and services; participation in other Medi-Cal networks; involvement in community and/or public health initiatives.
3. Data sharing capability.
4. Contracting records with local hospitals.
5. Financial performance in community and other areas.

**C. Demonstrate plan's experience and familiarity with the following services/issues. Focus should be on health plan's approach to these functions as well as any unique or outstanding features of your plan.**

**Please submit appropriate documentation for each item in each of the following categories:**

**1. Member Services**

a. Policies and procedures regarding member orientation including plan service guide that are appropriate for the varied literacy levels of Medi-Cal beneficiaries and availability in the languages of the non-English populations served by plan.
b. Policies and procedures that address member's rights and responsibilities.
c. Policies and procedures regarding member/patient education.
d. Policies and procedures for member selection of primary care physician.
e. Policies and procedures for notifying members for denial, deferral, or modification of requests for prior authorization.
f. Policies and procedures regarding annual surveys that assess members' satisfaction with plan and coverage and how the results will be shared with providers.
g. Policies and procedures regarding member outreach

**2. Quality Improvement System (QIS)**

a. A flow chart and/or organization chart identifying all components of the QIS and who is involved and responsible for each activity (Regional and Local Offices).
b. Procedures outlining how providers will be kept informed of the written QIS, its activities and outcomes.

c. Written description of the QIS.
d. Policies and procedures for performance of Primary Care Provider site reviews.
e. Policies and procedure regarding sharing of HEDIS Studies outcomes and improvement strategies.
f. Policies and procedures for credentialing and re-credentialing of providers. Include how large provider groups can obtain delegated status for credentialing. Include timeframes for credentialing providers especially if other providers are closed to new patients or plan lacks providers in specific specialty areas, i.e. pediatric specialty providers.
g. Address MOUs with Public Health for the STD, TB, CCS, Immunization, WIC, Family Planning and CHDP programs.

**3. Utilization Management**

a. Written description of UM program that describes appropriate processes to be used to review and approve the provision of medical services.
b. Policies and procedures for prior authorization, concurrent review, and retrospective review.
c. List of services/procedures requiring prior authorization and the utilization review criteria.
d. Policies and procedures for the utilization review appeals process for providers and members.
e. Policies and procedures that specify timeframes for medical referrals and authorizations to include turn around time for plan to make necessary approval of referrals and authorizations
f. Policies and procedures to detect both under –and over-utilization of health care services.
g. Written description of how providers can easily access the plan's Utilization Management Department especially in urgent situations
h. Demonstrate evidence that Plan will direct Members to right level of care.
i. Demonstrate evidence that Plan has experience with chronic and preventive care.
j. Coordination of member care and services with CCS.

**4. Provider Network**

a. Submit proposed provider network showing the ability to serve eligible beneficiaries in the county pursuant to the contract.
b. Plan standards applied which demonstrates an adequate ratio of physicians and/or midlevels to members.
c. Policies and procedures regarding physician supervision of non-physician medical practitioners.

d. Proposed list of physicians by type (primary and specialists) within the organization's network in Stanislaus County.
e. Submit an analysis demonstrating the ability of the plan's provider network to meet the ethnic, cultural, and linguistic needs of the Members.
f. Plan on how to assist primary care providers with referrals to specialty providers that are not part of the plan's provider network.
g. Submit list of contracted hospitals including those out-of-area for specialty and tertiary care.

**5. Provider Relations**

a. Policies and procedures for provider grievances.
b. Written description of how organization will communicate the provider grievance process to providers.
c. Protocols for payment and communication with providers.
d. Submit a copy of the provider manual.
e. Process of provider/staff training.

**6. Provider Compensation**

a. Policies and procedures regarding payments to Primary Care Providers and Clinics.
b. Description of any physician incentive plans.
c. Policies and procedures for processing and payment of claims.
d. Policies and procedures for the reimbursement of midlevels i.e. physician assistants, nurse practitioners, certified nurse midwives
e. Policies and procedures for the reimbursement to HSA's Public Health Department for the provision of such services as immunization, STD, HIV counseling and testing, and other public health services.

**7. Access and Availability**

a. Policies and procedures that include standards for:
    1. Appointment scheduling
    2. Routine specialty referral
    3. First prenatal visit
    4. Waiting times
    5. Urgent Care
    6. After-hours calls
    7. Unusual specialty services
b. Policies and procedures regarding 24hr./day access without prior authorization, follow-up, and coordination of emergency services.
c. Policies and procedures regarding access to midlevels when the primary care physicians are fully booked.

d. Policies and procedures for providing cultural competency, sensitivity or diversity training for staff and providers.
e. Policies and procedures for the provision of 24-hour interpreter services at all provider/clinic sites.
f. Policies and procedures regarding transportation assistance for Members.
g. Policies and procedures regarding member access to specialty care providers.

**8. Case Management**

a. Policies and procedures for a disease/case management program. Include policies and procedures for identification and referral of members eligible to participate in this program and Provider assistance with recalcitrant patients.
b. Procedures for monitoring the coordination of care provided to members.

9. **Enrollment and Disenrollments**

a. Policies and procedures for how organization will update and maintain accurate information on its providers
b. Policies and procedures for how organization will share enrollment data from DHCS.
c. Policies and procedures relating to Member disenrollment including HSA initiated disenrollment.