FILE NO. 160634

LEGISLATIVE DIGEST

[Administrative Code - Department of Public Health Managed Care Contracts]

Ordinance amending the Administrative Code to extend the authorization of the Director of Health to enter into managed care contracts for the provision of services to individuals covered under federal and state programs including subsidized health coverage for low income populations.

Existing Law

In 2014, under Charter Section 9.118, the Board delegated authority to the Director of Health to enter into managed care contracts where the City is reimbursed, in excess of one million dollars, for health care services provided at Department of Public Health (DPH) facilities, by insurance companies and other health care providers.

The rates of reimbursement are equal to or higher than either:

(1) Fee for Service: the California Department Health Care Services (DHCS) published Medi-Cal fee for service rates, or

(2) Capitated Rates: the average of per-member-per month rates for Medi-Cal managed care for Aid Codes Family and Medi-Cal Expansion, or successor provisions, set by DHCS as authorized by federal and state law.

The term of these contracts was limited to December 31, 2017. By January 1, 2016, the Controller, in coordination with DPH was to conduct an analysis of the health care services payment rates to ensure that these rates were within a reasonable range of the industry standard or that of comparable health systems, and to identify opportunities to improve contract terms.

The Director of Health will provide quarterly reports until 2017 to the Health Commission regarding the contracts approved under this ordinance and the aggregate amount of reimbursement and revenue generated, and an annual report to the Mayor and the Board of Supervisors, indentifying the contracts approved and the aggregate amount of reimbursement

Amendments to Current Law

After conducting their review, the Contoller and DPH propose the following amendments:

- Extend the life of the ordinance, authorizing the end date of contracts to be no later than December 31, 2020
- Remove the hyperlink references to now outdated/defunct Medi-Cal tables

- Based on the Contoller's and DPH's experience comparing rates, add more accurate language regarding the process and means of comparison, allowing for some flexibility as the industry methods for rate setting evolve due to market forces
- Revise the reporting dates by the Controller (from January to February) and Director of Health (July to September) to allow better coordination with the availability of the necessary data, through 2021

Background Information

The federal and state governments continue to increase the proportion of safety net health care services provided under a managed care model. The DPH mission includes providing high-quality health care to all San Franciscans, including the uninsured and low-income individuals who access health care through federal and state-subsidized programs. Historically, DPH fulfilled this mission by providing services through a fee-for-service structure or in partnership with the San Francisco Health Authority, also known as the San Francisco Health Plan, a separate governmental entity.

Under the shift to a managed care-focused system for the delivery of health care services, in order to participate as a provider in certain programs, DPH needs to contract with insurers. Otherwise, current and prospective DPH clients will not have the option of selecting DPH as a provider. If DPH cannot offer itself as a contracted provider, continuity of care will be disrupted for those who have long histories with DPH health care providers, and DPH will lose revenue due to reduced patient care.

As the federal and state governments reduce previous forms of health care reimbursement to counties, counties must replace those revenues by the increasing enrollment of persons newly eligible for managed care insurance programs.

To participate in the new health care markets, DPH needs flexibility to enter into and modify managed care contractual arrangements. Most insurers operate with an annual open enrollment period. Time between these open enrollment periods is limited and health care contracts are often negotiated and executed in a relatively short time period. DPH must be able to meet the timelines expected in the industry in order to retain patients and revenue.

n:\legana\as2016\1600704\01102247.docx