File No. 160634 Committee Item No. 6
Board Item No. 20

COMMITTEE/BOARD OF SUPERVISORS

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Committee: Budget & Finance Committee **Date** June 17, 2016

Board of Supervisors Meeting **Date** 7/12/16

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Completed by: Linda Wong **Date** June 10, 2016
Completed by: Linda Wong **Date** 7/6/16

[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.

NOTE: **Unchanged Code text and uncodified text** are in plain Arial font.
Additions to Codes are in *single-underline italics Times New Roman font*.
Deletions to Codes are in ~~*strikethrough italics Times New Roman font*~~.
Board amendment additions are in double-underlined Arial font.
Board amendment deletions are in ~~strikethrough Arial font~~.
Asterisks (* * * *) indicate the omission of unchanged Code subsections or parts of tables.

Be it ordained by the People of the City and County of San Francisco:

Section 1. The Administrative Code is hereby amended by revising Section 21.44, and renumbering it as Section 21A.3, to read as follows:

SEC. ~~*21.44*~~ *21A.3*. DEPARTMENT OF PUBLIC HEALTH MANAGED CARE CONTRACTS.

(a) Findings.

(1) The federal government and state government continue to increase the proportion of safety net health care services provided under a managed care model, by, among other things, transitioning Seniors and Persons with Disabilities to Medi-Cal managed care, expanding Medi-Cal managed care eligibility to individuals below 138% ~~*percent*~~ of the federal poverty level, establishing pilot programs to transition those persons who are dually eligible for Medicare and Medicaid into managed care, and establishing state health

exchanges to provide federally-subsidized health insurance for persons with incomes up to 400% ~~percent~~ of the poverty level.

(2) The Department of Public Health's ("DPH") mission includes the provision of high-quality health care to all San Franciscans, including the uninsured and low-income individuals who access health care through federally- and state-subsidized programs. Historically, DPH has fulfilled its 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 ("SFHP"), authorized by California Welfare ~~&~~*and* Institutions Code § 14087.36~~,~~ and Administrative Code Chapter 69.

(3) Under the shift to a managed care-focused system for delivery of health care services, to participate as a provider in certain programs, DPH will need to be a contracted partner 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.

(4) Both the federal and state governments acknowledge through policy and legislative actions that county health care providers are expected to increase services to individuals newly eligible for insurance under the Affordable Care Act ("ACA") (see, 42 U.S.C.A. § 18091 and 26 U.S.C.A. § 5000A). In ~~2016~~2017, the federal government plans to reduce the Disproportionate Share Hospital program, which has been a source of funding for safety net providers, like DPH, for many years. Similarly, under AB 85 (June 27, 2013), the State of California ~~will~~ now recoups indigent health care realignment allocations, funds that formerly went to counties. In both cases, providers such as DPH are expected to replace those revenues by increasing enrollment of persons who are newly eligible for managed care insurance programs.

(5) Shortly after the passage of the ACA, DPH entered into a year-long Integrated Delivery System planning process, which concluded that to remain financially viable under ACA, DPH must transition from a "provider of last resort" to become a "provider of choice" to retain clients newly enrolled in insurance under the ACA.

(6) In February 2013, DPH and the Controller's Office jointly launched a Health Reform Readiness Assessment project and engaged Health Management Associates, a consulting firm specializing in healthcare. The Controller's summary report of that effort, on file with the Clerk of the Board of Supervisors in File No. 141097, concluded that in order to maintain excellence in patient care and financial health, DPH should focus on increasing "the number of insured and covered clients, by maximizing the current Medi-Cal expansion," and "contracts with health plans." The Health Reform Readiness Assessment also recommended that DPH increase the number of insured patients in its network by 30,000 over the next five years. The timely ability to enter into and modify managed care contracts is critical to achieving these goals.

(7) In July 2013, the City convened the 41-member Universal Healthcare Council ("UHC"), engaging a wide range of stakeholders to examine San Francisco's implementation of the ACA. The UHC Final Report 2013, on file with the Clerk of the Board of Supervisors in File No. 141097, adopted guiding principles, including: a commitment to "full implementation of the ACA in San Francisco;" "maximizing enrollment of San Franciscans into the new insurance opportunities created by the ACA;" and sharing responsibility among all sectors of society, including City government, to "reduc[e] the number of uninsured residents and ensur[e] access to care." To meet these expectations, DPH must be given the administrative tools to fully engage in implementation of the ACA.

(8) The ACA requires the creation of state health exchanges to provide options for insurance coverage, including for the formerly uninsured. To meet this mandate, the State of

California established Covered California, which provides a marketplace where individuals can purchase health insurance. Health insurers providing coverage under Covered California must offer health plans compliant with federal and state regulations under the ACA and subsequent legislation.

(9) Covered California provides the key means for individuals to comply with the individual mandate in the ACA. Through Healthy San Francisco and other programs, DPH has historically provided health care for a large number of individuals, who are now required to have health insurance under the ACA's individual mandate. For many of these individuals, obtaining insurance through Covered California is the only affordable way to comply.

(10) The only way to become a health care provider to individuals insured under Covered California is to enter into contractual arrangements with one or more of the state-authorized insurance providers. *Prior to the ACA*, DPH ~~currently~~ serve*sd* approximately *1*5,000 individuals who ~~will be~~ *could be* eligible for Covered California subsidized insurance ~~in 2015~~. If those individuals choose to enroll in insurance under Covered California, they will no longer be able to receive primary care, preventative care, specialty care, and other services from DPH and will be forced to move to another provider, unless DPH enters into contracts with those insurance companies.

(11) To participate in the new health care markets, DPH ~~will~~ need*s* 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. *Additionally, the submission of claims can take up to 12 months, then it takes three (3) to six (6) months to aggregate and analyze the data in order to enter into meaningful contract negotiations.* Under ~~current~~ *standard* City procedures for approving such contracts, DPH will struggle to meet timelines expected in the industry, which could limit its ability to retain patients and revenue.

(b) Acting under Charter Section 9.118, the Board of Supervisors authorizes the Director of Health to enter into contracts anticipated to generate over $1 million in reimbursements or revenue to the City to provide health care services at DPH facilities, including, but not limited to, primary care, specialty services, hospital services, and behavioral health services. These contracts may include fee-for-service arrangements, fully capitated arrangements where DPH receives fixed monthly payments per individual and is financially responsible for managing health care costs of its patients, or a hybrid of the two. The term of any such contracts shall terminate no later than December 31, ~~2017~~2020 and shall be subject to the review and approval of the Controller for consistency with the terms of this Section ~~21.44~~21A.3. The DPH annual budget shall show the revenues from the contracts as capitation rates or patient fees (collectively, "Rates of Reimbursement").

(c) Rates of Reimbursement for health services in contracts entered into under this Section ~~21.14~~ 21A.3~~,~~ shall be equal to or higher than either (1) Fee for Service: the California Department Health Care Services (DHCS) published Medi-Cal fee for service rates, *selected and adjusted as needed to align with the pending contract specifications* ~~*which are updated monthly and posted at http://files.medi-cal.ca.gov/pubsdoco/rates/rateshome.asp*~~; 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 ~~*and posted at http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDFinancialReports.aspx*~~. For the purposes of determining whether the Capitation Rates in contracts are equal to, or exceed the minima specified in this Section ~~21.44~~21A.3, *in addition to the gross capitation rates specified by DHCS,* the Controller shall consider net payments the City will receive for health services provided by DPH after removing *benefit carve outs, capitation splits, and/or* administrative fees and other amounts that state law allows the San Francisco Health Authority or other provider to

withhold, *as applicable. For either Fee for Service or Capitated Rate contracts, the Controller has the option of utilizing other relevant comparison rates or benchmarks which may be obtained via outside healthcare expertise, or through additional research by the Office of the Controller.*

(d) No later than ~~*January 1, 2016*~~ *February 1 of each year*, the Controller, in ~~*coordination*~~ *consultation* with DPH, shall *report on the review of reimbursement rates it has conducted for* ~~*conduct an analysis of*~~ *the preceding year*. *The Controller shall also periodically, in consultation with DPH, review* ~~*health care services*~~ payment rates ~~*to ensure that the rates in the DPH contracts are within a reasonable range of the*~~ *relative to available* industry standard*s* ~~*or that of comparable health systems,*~~ and identify opportunities to improve *future* contract terms.

(e) The Director of Health shall provide quarterly reports between September 1, 2015 and December 1, 20~~17~~*20* to the Health Commission of the contracts approved under this Section ~~*21.44*~~*21A.3*, and the aggregate amount of reimbursement and revenue generated. The Director of Health shall provide annual reports, no later than ~~*July*~~ *September* 1, 2015, ~~*July*~~ *September 1*, 2016, ~~*July*~~ *September* 1, 2017, *September 1, 2018, September 1, 2019, September 1, 2020, and September 1, 2021,* to the Mayor and the Board of Supervisors, identifying the contracts approved and the aggregate amount of reimbursement and revenue generated.

Section 2. Effective Date. This ordinance shall become effective 30 days after enactment. Enactment occurs when the Mayor signs the ordinance, the Mayor returns the ordinance unsigned or does not sign the ordinance within ten days of receiving it, or the Board of Supervisors overrides the Mayor's veto of the ordinance.

Section 3. Scope of Ordinance. In enacting this ordinance, the Board of Supervisors intends to amend only those words, phrases, paragraphs, subsections, sections, articles, numbers, punctuation marks, charts, diagrams, or any other constituent parts of the Municipal

Code that are explicitly shown in this ordinance as additions, deletions, Board amendment additions, and Board amendment deletions in accordance with the "Note" that appears under the official title of the ordinance.

APPROVED AS TO FORM:
DENNIS J. HERRERA, City Attorney

By: _____
VIRGINIA DARIO ELIZONDO
Deputy City Attorney

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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.

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OFFICE OF THE MAYOR
SAN FRANCISCO

EDWIN M. LEE

TO: Angela Calvillo, Clerk of the Board of Supervisors

FROM: Mayor Edwin M. Lee

RE: Administrative Code - Department of Public Health Managed Care Contracts

DATE: May 31, 2016

Attached for introduction to the Board of Supervisors is an 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.

I respectfully request a waiver of the 30-day hold and that this item be calendared in Budget & Finance Committee on June 17, 2016.

Should you have any questions, please contact Nicole Elliott (415) 554-7940.

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BOARD OF SUPERVISORS
SAN FRANCISCO
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BY

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