8 | PLAN & ADMINISTRATIVE VENDOR SELECTION

Selecting Accountable Plan Partners

Publicly administered and owned health plans such as local initiatives and county organized health systems are community-oriented organizations uniquely suited to operating CHI-created Healthy Kids programs. These plans are already invested in their local community's health and access to care, are generally at the center of most community health projects, initiatives, and campaigns, and are under the oversight of governing boards with specified local representation requirements.[1] These characteristics mean that local public plans are also more likely to participate in new ventures with real value for the community but with minimal or no profit potential, as long as the venture will not imperil their financial solvency. In contrast, while commercial health plans may be excellent community partners with a proven interest in a community's well-being, they are less likely to be able to enter into or to continue to operate a line of business that is unprofitable or insufficiently profitable over time.

Several of the second generation CHIs planning to launch Healthy Kids programs may be able to partner with a local public plan that is expanding its Healthy Families service area. These counties will have many of the favorable administrative start-up conditions of the operational CHIs.

CHIs unable to partner with local public plans will need to contract with a commercial plan or plans that have demonstrated a strong performance track record and a sound reputation in the local community. CHI governing boards will need to oversee the process for selecting a commercial plan partner or partners to provide the new Healthy Kids product. Fortunately, there are some inherent operational advantages for CHIs that partner with commercial plans. One of these advantages is that commercial plans will have in-house systems, capacity and experience to bill and collect family premiums. This capability means that commercial plans will also have the ability to engage in pro-active renewal processing.

In searching for a commercial plan partner or partners, CHI governing board members and staff should first identify which health plans contract with the Healthy Families and Medi-Cal programs since there are many practical reasons for partnering with Healthy Families and Medi-

Cal participating plans. However, CHIs should also investigate how a plan's public program participation is locally regarded as well as its track record according to state and federal assessment activities and reports.

As discussed previously, many Healthy Kids enrollees are undocumented or in mixed status families. These families generally have had limited interaction with a community's mainstream providers and will be most comfortable in a plan that includes familiar traditional and safety net providers. Since both Medi-Cal and Healthy Families participating health plans are contractually required to have provider networks that include traditional and safety net providers, they may increase a mixed status family's comfort level in accessing preventive as well as other types of services.

A third advantage of contracting with a health plan that participates in public programs is that it may enable children in mixed status families to establish a relationship with the same primary care provider. Plans that participate in public programs also offer provider continuity for children who may lose eligibility in one program and become enrolled in another. For example, a child from a family whose income surpasses the 250% FPL threshold for Healthy Families, but remains below the income cutoff for Healthy Kids, could continue to see the same provider after being disenrolled from Healthy Families and enrolled in Healthy Kids.

This ability to transfer a child between programs without changing providers is also a clear advantage from the health plan's and provider's perspective since it allows them to retain enrollees whose program eligibility changes, as well as decreases the likelihood of unnecessary health care expenditures or inadequate care management during periods of ineligibility. As a consequence, commercial plans that otherwise would be reluctant to take on a relatively small number of Healthy Kids enrollees (because of the organizational and administrative fixed costs associated with launching a new line of business) may be more inclined to contract with Healthy Kids enrollees if their costs may be offset through increased volume in their Healthy Families line of business.

The fourth advantage for CHIs to contract with participating Healthy Families and Medi-Cal plans is that these plans should already comply with guidelines set by the Centers for Medicare and Medicaid Services (CMS), the State's Health and Human Services Agency, the Managed Risk Medical Insurance Board, and the Department of Managed Health Care. In general, plans successfully meeting these compliance requirements should have the capacity to meet CHI-determined performance standards in delivering health care services to Healthy Kids subscribers. These standards would be set by the governing board and would likely focus on plans' performance on the Health Plan and Employer Data Information Set (HEDIS), the Consumer Assessment of Health Plan

Survey (CAHPS), and in some cases, National Committee for Quality Assurance (NCQA) certification.

A final reason to contract with health plans that have public program experience is that they generally already have the infrastructure and capacity to administer a Healthy Kids program. Plans that already participate in Medi-Cal, for example, are more likely to have an established system interface and protocols in place with the local Social or Human Services Agency to exchange data on enrollments and renewals. This interface could be expanded to include appropriate data exchange of Healthy Kids subscriber information as well.

While plans participating in public programs will already have some traditional and safety net providers in their networks, their networks may need to be further expanded to meet geographic or other types of requirements of Healthy Kids enrollees. CHIs should assess each plan's provider capacity prior to beginning conversations with prospective health plan contractors. This initial provider capacity assessment is also the time to ask different types of providers—in particular safety net providers—about their reimbursement and claims experience with each health plan; their answers will provide important information about children's access if enrolled in a specific health plan.

Soliciting, Evaluating and Negotiating with Accountable Health, Dental and Vision Plans

Once a CHI's potential health plan partners are identified and an initial provider capacity assessment is conducted, CHI governing board members will need to select the organization or organizations to lead health plan contracting for the Healthy Kids insurance product. This activity will require a well-established governing board with roles of key parties clearly defined (See Chapter 3). While the responsibilities for plan selection tasks can be divided in a variety of ways—among CHI staff, governing board members, external consultants or some combination thereof—it is strongly recommended that CHI board members and staff be an integral part of this process. Effective governance and program management hinge on a comprehensive understanding of the expectations and operations of the health plan and administrative contractors.

The governing board will also need to discuss and agree on specific arrangements for coordinating outreach between the health plan(s), the Social Services or Human Services Agency, and community-based organizations. Agreements between the health plan, the Social/Human Services Agency and those organizations already involved in outreach and enrollment will need to be made prior to the launch of the program. Certain program restrictions are already in place under Medi-Cal and Healthy Families for health plans to conduct outreach. An understanding of these restrictions will ensure that those in charge of coordinating outreach will craft program policies that work for the health plan and the community-based organizations engaged in outreach activities.

Preliminary steps to successfully negotiating and contracting with plan partners are (1) an identification or inventory of the full range of functions that may be performed by the health plan and (2) an evaluation of the advantages and disadvantages of performing various functions in-house versus through external contractors. There is no single "best" way to contract with commercial health, dental and vision plans, as individual county or regional conditions may often determine which approach is most appropriate. A major goal in soliciting a health plan or health plans to provide the Healthy Kids insurance product is to generate interest among a number of contractors. This goal is more likely to be met if a CHI uses a lengthier and more flexible process.

The RFP and RFI Processes

The CHI governing board will need to decide whether to issue a single Request for Proposal (RFP) for a health plan to manage the medical, dental, vision and behavioral health benefits for the CHI, or to issue separate RFPs for medical and behavioral health, dental, and vision care. By issuing a single RFP for a bundled benefit package, a CHI will streamline its responsibility in overseeing multiple contracts, but may limit flexibility in determining the price and terms for each set of benefits. In a bundled benefit scenario, the health plan will assume the financial risk for the entire per member per month (PMPM) premium. If the governing board chooses instead to issue separate RFPs, CHI staff will be required to manage multiple contractual arrangements but will have more flexibility in determining the terms of each contract. If the CHI has the staffing and administrative capacity for the second option, issuing separate RFPs ensures that specific attention can be paid to the scope of services and performance of each plan.

The health plan solicitation process can be conducted in various ways, including through issuance of Requests for Qualifications (RFQs) and/or issuance of RFPs.

An RFQ can:

- Notify health plans of the program's purpose and intent. Health plans with an interest in administering a Healthy Kids program will need time to conduct their own strategic planning process, assess the compatibility of the business opportunity, and determine the extent to which their infrastructure will require modification to handle the new line of business.
- Solicit information on potential health plans and their level of interest in the program. For example, an RFQ can identify which plans are serving specific health care market segments and communities and in which geographic locales and zip codes.
- Establish an early communication link with the plans. Potentially interested plans may be more receptive if they are initially approached informally through an RFQ. It creates a more relaxed atmosphere within which a CHI selection team may explore compati-

bility with specific health plans and solicit valuable insights from plans that may not be sufficiently interested to respond to a more formal RFP process.

AN RFP can:

- Provide a more comprehensive set of qualifications with which to assess plan capability. A satisfactory RFP response will be a formal health plan bid and will contain a complete listing of plan capabilities and relevant relationships and business ventures. A full proposal will provide necessary regulatory health plan information such as licensure and solvency information; service area data; cultural and linguistic competency standards; willingness to comply with and relevant experience in meeting program parameters and contract language. Additionally, a responsive bid will include a premium quote for a specified set of services.

The RFQ and RFP processes can be combined. A combined approach can reduce the time frame within which to assess and select a plan partner but may be riskier for a CHI than a more protracted process. A shortened and more intensive process may reduce the pool of potential partners earlier in the process and thereby more greatly restrict a CHI's ability to negotiate on price and other considerations. Health plans are unlikely to provide premium bids until they fully understand program specifications and feel that they are both very interested in and very likely to be awarded the contract.

Crafting an Effective Multi-step Process

For the reasons stated above, CHIs should invest the time necessary to conduct a thoughtful multi-step process. These steps include:

- Establish an independent evaluation committee. Prior to sending out an RFP, the CHI governing board will need to designate an independent evaluation committee. This committee will need to decide how to operationalize the CHI's objectives into evaluation criteria. Clear, consistent and objective criteria for evaluation will simplify the proposal evaluation process.

- Issue the RFP, including an RFP questionnaire. The RFP questionnaire is designed to ensure that a health plan or plans have the management expertise to perform the functions required by the CHI, and that there are no organizational conflicts that may represent a conflict of interest. Most RFPs also ask health plans to name the individuals with primary responsibility for health plan activities associated with the CHI. See text box on this page.

- Designate a comment period and invite potential applicants to a bidders conference. RFP release should be followed by a clearly defined comment period. Plan to hold a bidder's conference at which RFP questions will be presented by potential bidders and

Topics to include in an RFP questionnaire

- Information about the health plans' ownership and management
- Approach to account management and identification of key individuals responsible for reporting to the CHI governing board and staff
- Financial information
- Nature and extent of current business in the county
- Provider network characteristics
- Experience performing necessary functions, such as:
  - Claims administration
  - Utilization management
  - Quality assurance
  - Referral management
  - Grievance resolution
  - Member services
  - Data analysis and reporting
- Sample of selected materials (for example, performance report formats, quality assurance, and provider profiling reports)

written or verbal answers can be given by the program sponsors either on-site or later after any needed additional research or analysis is conducted.

- Revise the RFP. Rely on information and questions received during the comment period and bidder's conference to refine the RFP.

- Issue the final RFP and request premium quotes. Based on input received from the health plans and others, the program sponsors can issue the final RFP, which will serve as the bid document for health plans. Health plans should respond to all RFP items by a specified date.

- Identify finalist plans using a formal bidder assessment process.

- Negotiate and sign contracts with the health plan(s). To the extent the CHI intends to be an aggressive purchaser, the final negotiations center around the organization's willingness to meet price, performance standards, and other criteria as defined by the CHI.

Assessing Provider Networks

A coverage program that focuses on wellness, preventive and primary care requires a strong primary care network. However, access to quality dental providers is another major area of need for Healthy Kids target populations. The RFP process should gather sufficient information about both medical and dental provider networks to comparatively assess each bidding plan's health and dental provider network strengths and gaps. RFPs should require plans to demonstrate linkages with safety net providers as well as private physicians and dentists with open and accessible practices. Specific RFP questions should include the total number of physicians and dentists by specialty with open practices, geographic distributions (by zip code), percent board certified, percent that have faced any formal sanctioning for practice irregularity or not meeting practice standards of care, and turnover rates.

Summary data tables will be critical components of both health and dental plans RFP responses. Requested summary tables should include distributions of primary care physicians, specialists and dentists by geographic region (zip codes) and listings of current enrollees by zip code. When compared, this summarized data should quickly provide reviewers with a sense of a health plan or dental plan's network strength and any gaps. Plans that respond by submitting provider directories should not be considered fully compliant with the data request since it will be more difficult for CHI staff to make plan to plan comparisons relying on directories. Additionally, directories are unlikely to be as current as data provided by the plans.

Assessing Quality Assurance and Management

A number of different topics fall under the category of quality assurance and quality improvement. Quality management activities are designed to:

- Support the provision of necessary care in a high-quality, efficient manner;
- Eliminate unnecessary and inappropriate care;
- Systematically assess the intermediate and final outcomes of care; and
- Promote consistency in medical practice.

Questions in this section of the RFP will cover the health plan's credentialling and recredentialling of network providers, development and use of practice parameters and clinical protocols, routine tracking of key indicators of quality for process and outcomes of care, and quality management program evaluation activities. An important quality consideration is the plan's data collection and reporting systems for quality assurance. The RFP should include questions about quality information management systems, including the ability to produce routine and customized reports. Most CHIs require that the administering plan comply with the audited clinical quality measures issued by the National Committee on Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS), and age relevant HEDIS measures for children ages 0-18. Health plans have also been asked to comply with the most recent recommendations of the American Academy of Pediatrics (AAP) for preventive pediatric health care and the Recommended Childhood Immunizations Schedule/United States, adopted by the Advisory Committee on Immunization Practices (ACIP).

Assessing Health Plan Information Systems Capability

CHIs should carefully scrutinize the specific information systems (IS) capabilities and performance record of potential health plan partners prior to making a final partner selection. Data collection and the evaluation of health plan performance and outcomes are paramount to the CHI governing board's ability to be accountable to funders and coalition stakeholders. While this chapter lists a number of critical performance aspects to consider prior to plan selection, insufficient system capacity and too few skilled IS staff to manage system expansions or revisions will severely impede other aspects of plan performance. In determining plan systems capability, key performance areas to investigate include:

1. What are the plan's existing administrative function system capabilities and what types of data reporting and data exchange information does the plan's IS department manage on a regular basis?

2. Does the plan now do any premium collection? And if so, how does the plan propose to incorporate premium collection processes and ensure that they are technically supported?

3. What new functions will the plan need to add to its existing system functions to service the Healthy Kids line of business?

These issues are particularly critical to explore with plans with minimal public program experience. For while commercial plans are likely to have extensive premium collection experience and dedicated systems to support this business function, some plans may have less experience with providing the more extensive member service-related functional capabilities of plans that specialize and/or have long time experience with Medi-Cal and Healthy Families. Make sure to inquire about specific member service and related reporting and member assistance requirements for Healthy Kids that are not typically offered to commercial enrollees.

4. Does the plan have experience establishing a new line of business?

This is a critical area to explore with a potential contractor. There must be comfort in the plan staff's ability to troubleshoot information system start-up problems as they arise such as inability to receive critical new member-related information on a timely basis. Ask the plan to specify their process for identifying and resolving processing and information-exchange system problems. Furthermore, the process will be several orders of magnitude more involved if plans are expected to conduct eligibility determination for Healthy Kids program applicants. This systems area will need particular scrutiny and will require careful coordination with IS and other plan staff to ensure appropriate programming and staff training and careful implementation oversight.

5. Does the plan already have an electronic interface with the local Social Services Agency?

This is another critical IS capability area to explore with plans with minimal public program experience. Some of the Medi-Cal plans will already have an electronic link to the Social Services Agency through which information is already exchanged on a regular basis. However, plans without public program contracting experience are not likely to have the same existing interface capabilities. Creating these linkages will be technically challenging and require health plan IS staff to develop new system protocols and testing procedures.

Member Services

The governing board, staff and/or key subcommittee members will want to assess the capacity of the health plan to identify and directly address issues such as linguistic and cultural competency and access, consumer problems and the health plan's ability to respond to the CHI's concerns about member services.

The RFP questionnaire should elicit descriptions of the plan's formal and informal problem-identification and problem-solving processes. Other related items that might be included in a questionnaire are telephone response rates (for example, abandoned call rates and average wait time), customer service staffing levels (including customer or member services to member ratios) and staff qualifications.

RFP specifications should also clearly identify any particular CHI requirements for coordinating with consumer ombudsman activities. The division of labor between the CHI and the health plan for resolving consumer complaints should also be established prior to contracting. Other specifications may include requirements for tracking and reporting consumer complaints and their resolution.

Obtain Premium Valuation for Benefits

Once communications with the health plans are underway, the CHI may want the services of an actuarial consultant to determine a premium valuation for the proposed benefits package. Actuarial valuation of the benefits will enable the CHI to establish internal premium targets against which it can evaluate plan price proposals.

Financial Solvency

CHIs must assure that health plan bidders have sufficient resources and financial reserves to carry out the proposed programs. CHIs can rely on the Department of Managed Health Care and the Department of Insurance for assurances of financial integrity, because state licensure ensures that an HMO or insurer has met specified financial solvency requirements. However, it is also recommended that RFPs request a complete set of financial statements for at least the two preceeding years.

Other Key Factors

Information about less tangible health plan characteristics can also be critical factors in the negotiating and contracting process. For example, a plan's willingness and ability to forge a satisfactory working relationship with the CHI governing board and staff may override concerns about the plan's capacity to provide certain functions (although if these are mandatory functions there should be an agreement about the plan's intent and timeline for increasing their capacity to provide these functions later on). With a solid working relationship, the CHI can work with the health plan to improve performance over time. Some suggested questions to better gauge these areas of compatibility include:

- Are you willing to incorporate specific quality and performance standards into a multi-year contract?
- Who do you think owns the data related to Healthy Kids members?

Making the Final Selection

The evaluation committee will develop and rely on a matrix of general evaluation criteria to score final proposal submissions. This matrix should include a scoring range by topic area or component to ensure comparability across committee members. Recommended evaluation criteria include:

- capacity to perform functions (short and long-term);
- quality of services;
- business philosophy and compatibility with CHI's objectives;
- experience;
- flexibility and responsiveness;

- willingness to financially partner;
- capacity/willingness to coordinate with other CHI partners;
- price and willingness to include competitive annual rate caps; and
- financial solvency.

It is important not to underestimate how time-consuming the selection process can be. Proposals are lengthy documents and the matrix and scoring process and range will assist evaluation committee members in comparing health plans (assuming there is more than one) on a number of qualitative and quantitative characteristics. This matrix and scoring process will also help identify gaps in information about individual plans and assist the committee in presenting a clear recommendation to the steering committee.

Final Contract Negotiations

Once health plans submit bids, the next step is to set up meetings with individual respondents. These meetings allow the evaluation committee to clarify any remaining issues and evaluate the more qualitative aspects of each proposal. Plan respondents generally find it helpful to receive some specific guidelines for their presentation before the meeting. For example, the evaluation committee may ask all finalists for a step-by-step accounting of how they intend to implement the program within a specific timeframe. Presentation guidelines also may address any specific concerns about a plan.

Face to face meetings are recommended as they offer the evaluation committee crucial insights into the health plans' philosophy, capabilities and credibility. Health plans' willingness and ability to work with the governing board, staff, Social Services Agencies, outreach contractors and administrative vendor can make or break a contracting relationship.

Responses to the proposals and meetings with finalist health plans can shed light on additional modifications to the model contract. Due to concerns discussed earlier in this chapter, it is recommended that the evaluation committee request a multi-year contract with caps for maximum annual rate increases. Most operating CHIs have settled on a blended PMPM rate for the 0-18 population, but several are moving toward a tiered rate approach with rates negotiated by age categories based on actual enrollments. Typically CHIs sit down with each health plan and negotiate price individually along with other items that vary from plan to plan.

The timeline for solicitation, negotiation, and contracting varies depending on whether the CHI is contracting with a qualified health plan or health plans versus working with a health plan that is not already in the market and a Medi-Cal and Healthy Families provider. In general, three months is the minimum period of time to allow and six months is usually adequate. Some parts of the process, including a health plan's

RFP response period, cannot be condensed beyond a certain minimum amount of time without compromising the number and quality of responses.

Soliciting and Evaluating Potential Administrative Vendors

Once the roles and responsibilities of CHI partners are clarified, it will be necessary to decide how core administrative functions will be handled. If the governing board has the option of contracting with a Medi-Cal and Healthy Families participating health plan, many of the administrative functions may also be contracted to the health plan within the prime contract. However, a CHI may choose to hire a third party administrator (TPA) to handle core administrative activities such as premium collection, member renewal, quality assurance and fraud detection.

Core administration tasks may require specialized skill and capacity. For the contracting entity that already possesses the administrative capacity to perform these functions, contracting out for these services can be more expensive and a waste of resources. Conversely, program sponsors with limited administrative capacity will benefit from contracting for these services with a third-party administrator or insurer.

A CHI may choose to implement either an RFP or RFI process for the reasons discussed earlier. Because administrative vendors vary widely in their capacities and relative strengths, it is recommended that clear selection criteria and an independent panel be established for vendor selection and negotiation. Administrative vendors typically need at least one month to respond to an RFP (depending on the size of the responding organization) but may respond more quickly to an RFI.

Following is a short list to use in evaluating potential vendors:
- Technical expertise and capacity;
- Flexibility and willingness to work with other contractors/parties;
- Track record and experience administering similar programs within and outside the state; and
- Cost.

The operational CHIs have chosen to contract with their health plan partner to provide the full scope of administrative services. As a result, this guidebook provides general information about the third party administration selection process rather than CHI-specific experience to date. More information may be forthcoming on this topic area as the next generation of CHIs transition from planning to implementation.

Advantages of Contracting Out for Administrative Services

- Setting up a CHI administrative system can be complex and time-consuming. A number of potential contractors already have systems that can be put into place with relative ease.
- Since potential contractors have already expended the capital costs of developing systems to administer a CHI, new CHIs can contract for services at the margin and not assume the costs of initial capitalization.
- Administrative systems are also expensive to maintain, and many contractors have had experience in improving and debugging systems over time.

1. Hurley RE and Rice C. *An SOS for COHS: Preserving County Organized Health Systems*. San Anselmo, CA: Pacific Health Consulting Group, May 2004