

# Health Care Coverage Initiative Request for Applications

## Introduction

The California Department of Health Services (CDHS) is pleased to announce the availability of federal funds to expand health care coverage. CDHS is soliciting applications from a county, a city and county, a consortium of more than one county, or a health authority that wishes to develop and implement a health care coverage program.

Each selected applicant will be required to enter into a contract with CDHS prior to being reimbursed for expenditures for health care coverage programs implemented under the Health Care Coverage Initiative (Coverage Initiative). The contract will include, but not be limited to, specific details of the health care coverage program and reimbursement of expenditures to selected applicants.

CDHS is requesting, but not requiring, that each potential applicant submit a Letter of Intent within three weeks after the release of this Request for Applications (RFA), expressing the applicant's intent to submit an application for Coverage Initiative funding. The Letter of Intent will assist CDHS in planning for the evaluation of the applications.

This RFA, including any part of the process described in this document for selecting applicants' health care coverage programs and determining the allocations, and any agreements entered into with a county, a city and county, a consortium of counties, or a health authority, is not subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code. (Welf. & Inst. Code, § 15907, subd. (e).)

Requirements, processes, and procedures set forth in this RFA do not constitute incorporation or affirmation of either the provisions of Part 2 of Division 2 of the Public Contract Code or any implementing regulation. Likewise, use of certain provisions and terminology in this RFA is for administrative convenience only and does not, by that use, constitute adoption or incorporation of any provisions of Part 2 of Division 2 of the Public Contract Code or any implementing regulation.

## Background

In August 2005, the federal Centers for Medicare & Medicaid Services (CMS) approved California's five-year section 1115 *Medi-Cal Hospital/Uninsured Care Demonstration* (Demonstration) (No. 11-W-00193/9). The Demonstration provides \$180 million in federal funds in years three, four, and five of the Demonstration for the development and implementation of the Coverage Initiative if the State meets the requirements set forth by CMS.

Senate Bill (SB) 1448 (Stats. 2006, ch. 76) was subsequently enacted to provide the statutory framework for the development and implementation of the Coverage Initiative by adding Part 3.5 (commencing with section 15900) to Division 9 of the Welfare and Institutions Code. Implementation of the Coverage Initiative is subject to the availability

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of an annual federal allocation of \$180 million as referenced above. The provisions of SB 1448 are incorporated by reference into this document.

## **Funding Purpose**

The federal funding available under the Coverage Initiative may only be used to expand health care coverage to eligible persons in accordance with the requirements of SB 1448 and the Special Terms and Conditions (STCs) of the Demonstration.

Funding is available for health care services only. Allocations cannot be used for administrative costs. However, selected applicants may be paid for administrative activities associated with the Coverage Initiative pursuant to CDHS's processes and procedures for administrative claiming.<sup>1</sup> Selected applicants that have existing Medi-Cal administrative claiming agreements and claiming plans may submit appropriate amendments to these documents. Selected applicants that do not have administrative claiming agreements and claiming plans in place would be required to submit a claiming agreement or plan to CDHS in accordance with existing instructions prior to beginning the claiming of administrative costs for Coverage Initiative administrative activities. Further, all administrative claiming must be in compliance with CMS's rules and policies governing such claims.

SB 1448 requires that expansion of health care coverage for eligible low-income, uninsured individuals cannot diminish access to health care available for other low-income, uninsured individuals, including access through disproportionate share hospitals, county clinics, or community clinics. Health care coverage programs funded under the Coverage Initiative are not considered "entitlement" programs.

## **Definitions**

For the purpose of this RFA the following definitions shall apply:

- (1) "Allocation" means the identification of a portion of the available federal funding for the selected applicants. "Allocation" does not mean a grant or a payment from the State.
- (2) "Applicant" means a governmental entity that is a county, a city and county, a consortium of counties serving a region consisting of more than one county, or a health authority that applies for Coverage Initiative funds.
- (3) "Care Management" means the coordination of health care services in order to reduce fragmentation, duplication and unnecessary utilization of services; care management also includes prevention of disease and promotes individual responsibility for a healthy lifestyle.

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<sup>1</sup> Claiming administrative activities under the Medi-Cal Administrative Activities (MAA) program is authorized pursuant to Welfare and Institutions Code section 14132.47.

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- (4) “Case Management” means the monitoring and coordination of the delivery of health care services for an eligible person to enhance care, while at the same time, manage costs, for those eligible persons who require high cost or extensive health care services.
- (5) “Eligible person” means a person who is to be served by the health care coverage programs funded under the Coverage Initiative who is low-income, uninsured and at the time eligibility is determined, is not eligible for the Medi-Cal program, the Healthy Families program, or the Access for Infants and Mothers program.
- (6) “Health Authority” means a separate public agency established by the Board of Supervisors of a county (or city and county) pursuant to State law, and that has the authority and scope of services available to participate in the Coverage Initiative.
- (7) “Medical home” means a single provider or facility that maintains all of an eligible person’s medical information and that is a licensed provider of health care services, and that provides primary medical care and prevention services.
- (8) “Program year” means each of the following twelve-month periods:
- (a) September 1, 2007, through August 31, 2008.
  - (b) September 1, 2008, through August 31, 2009.
  - (c) September 1, 2009, through August 31, 2010.

### **Eligibility**

#### Applicants

Only those applicants defined in Item 3 of the “Definitions,” above, may apply for an allocation of federal funding from the Coverage Initiative.

#### Eligible Persons

Only those persons defined in Item 6 of the “Definitions,” above, may be served by a health care coverage program funded under the Coverage Initiative.

### **Coverage Initiative Funding Amount**

Federal funds in the amount of \$180,000,000 will be available for each of the three consecutive program years (listed above) to develop and implement health care coverage programs for eligible persons.

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## Funding Requirements

### Allocation/Reallocation Process and Requirements

CDHS will allocate available federal funds to be claimed under the Coverage Initiative to applicants that are selected as a result of the selection process beginning on page 12 of this RFA. CDHS intends to make allocations of federal funding for health care coverage programs for the entire three-year period.

Selected applicants must make expenditures for health care coverage programs according to a schedule that will be determined by CDHS. Prior to the end of the second quarter of each program year, CDHS will request verification of program expenditures to ensure adequate spending levels are met.

If a selected applicant is not meeting CDHS's expenditure schedule in a program year, CDHS may terminate the contract (referred to on page 1 of this RFA) with the selected applicant. CDHS may redirect the remaining funds to another initially selected applicant, or to another applicant whose program was not previously selected for funding.

In addition, if a selected applicant fails to substantially comply with any of the terms of the contract, which will incorporate applicable CMS requirements, CDHS may terminate the contract and redirect remaining funds to other selected applicants or to other applicants whose programs were not previously selected for funding.

### Certified Public Expenditures

Selected applicants will be reimbursed solely through the use of the certified public expenditure (CPE) mechanism specified in federal regulations (see 42 C.F.R. 433.51).<sup>2</sup> Each selected applicant must certify its expenditures in accordance with federal guidance for the program as required for CDHS to claim the federal funds made available from the federal allotment. CPEs submitted to CDHS must reflect the total-funds expenditure for the services provided. Based on the CPEs submitted by each selected applicant, which must be reduced by 17.79 percent, as described below, CDHS will claim federal financial participation (FFP) and pay those amounts to the certifying selected applicants. The selected applicants are responsible for providing the total-funds to be expended; no State General Fund monies will be paid.

The amount that each selected applicant certifies must be reduced by a factor of 17.79 percent to comply with the limitation specified in the STCs of the Demonstration that Safety Net Care Pool funds (the available funds under the Demonstration for uninsured care costs) cannot be claimed for costs associated with the provision of non-emergency

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<sup>2</sup> Although SB 1448 allows the use of IGTs to the extent permitted under the Demonstration, IGTs are not currently permitted under the Demonstration outside of the Disproportionate Share Hospital (DSH) Program.

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services to undocumented immigrants. To implement this limitation, the STCs require that 17.79 percent of each selected applicant's expenditures or claims for services to eligible persons are treated as expended for non-emergency services to undocumented immigrants. Taking into account the 17.79 percent reduction, it is estimated that, in the aggregate, the selected applicants must have total-funds expenditure equal to approximately \$440 million per year, in order for the State to claim the annual federal allotment of \$180 million.

### Number of Allocations

At least five applications will be selected to operate health care coverage programs, and no single selected applicant will receive an allocation greater than 30 percent of the total federal allotment. CDHS will limit the allocation to a selected applicant if the amount requested exceeds 30 percent of the total federal allotment.

CDHS is not required to fund the entire amount requested in any one particular application, and may reduce requested allocations to fund additional selected applicants' programs. However, CDHS will not reduce allocations solely to maximize the number of applications for health care coverage programs that could be funded. Further, CDHS is required by SB 1448 to seek to balance the allocations by selecting programs in different geographic areas of the State.

### Use of Funds

Federal funds allocated to selected applicants must supplement, and not supplant, any county, city and county, health authority, State, or federal funds that would otherwise be spent on health care services in that county, city and county, consortium of counties serving a region, or health authority.<sup>3</sup>

In order to demonstrate that Coverage Initiative funds will supplement, and not supplant, health care services, applicants must describe the population currently served (see Item 1(d) of the "Elements for Evaluation"), explain the standards utilized in determining eligibility for those services, and specifically articulate the health care services currently covered within the community and how the services are budgeted in Fiscal Year 2006-2007. Funding, such as a grant, that is currently received from a particular source that is specifically targeted for a specified purpose or program cannot be used as the non-federal share of funds for programs under the Coverage Initiative. However, those programs could be expanded by additional expenditures of non-federal funds. Then, applicants must clearly explain how their proposed health care coverage program will expand coverage options beyond those already received (if any) for individuals currently uninsured (see Item 1(d) of the "Elements for Evaluation"). Welfare and Institutions Code section 15904, subdivision (k), requires that expenditures for the expansion must be at least equal to the amount of federal funding received. This expansion of services could be accomplished by for example, offering additional services, modifying current

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<sup>3</sup> See Welfare and Institutions Code section 15904, subdivision (k).

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standards of eligibility, or providing insurance for benefits to the target population. The base year data to identify the number of eligible persons will be Fiscal Year 2006-2007, subject to final reconciliation in the program year.

Federal funds allocated to selected applicants must reimburse the selected applicants for the benefits and services described in the section entitled “Elements for Evaluation” beginning on page 13 of this RFA.

Federal funds that are available in a particular program year can only be paid for services provided in that particular program year. To the extent that these funds are not claimed for services provided in a given program year, they cannot be paid for expenses incurred for services provided in a later program year.<sup>4</sup> Therefore, it is critical that programs be able to demonstrate that they can begin enrollment no later than September 1, 2007, and that they can submit the necessary documentation of CPEs to substantiate reimbursement in a timely manner.

Enrollment of new eligible persons in a health care coverage program during the last six months of the Coverage Initiative (March 1, 2010, through August 31, 2010) will not be permitted unless CMS approves an extension of the Coverage Initiative.

The total-funds expenditure certified by the selected applicants must be from an appropriate source of local funds. The source of funds utilized must not include other federal funds (federal funds received as revenue for providing patient care services are exempted from the limitation on the use of federal funds) or impermissible provider taxes or donations, as defined under section 1903(w) of the Social Security Act, and applicable federal regulations.

### Timeline

CDHS has established the following timeline for the RFA process.

Event	Due Date	Time
RFA is released to the public	November 1, 2006	5:00 PM
Voluntary pre-application conference in Sacramento	November 13, 2006	9:30 AM
Questions about RFA instructions or process to CDHS	November 27, 2006	5:00 PM
Voluntary Letter of Intent to CDHS	November 27, 2006	5:00 PM
Applications to CDHS	December 13, 2006	5:00 PM
Program selection and allocation notices are posted/issued	January 31, 2007	5:00 PM
Selected applicants begin enrollment of eligible persons	September 1, 2007	

<sup>4</sup> Reimbursement may be made in a subsequent program year for health care coverage program expenditures incurred for services provided in a prior program year.

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## Questions

CDHS requests that prospective applicants notify CDHS if there is a need for clarification regarding the instructions and/or requirements specified in this RFA. Questions can be e-mailed to CDHS at: [coverageinitiative@dhs.ca.gov](mailto:coverageinitiative@dhs.ca.gov). CDHS may contact prospective applicants to seek clarification of any issues that may be presented.

## Pre-Application Conference

Prospective applicants are encouraged to attend an informational pre-application conference on:

Date:	November 13, 2006
Time:	9:30 a.m. – 12:00 p.m.
Location:	Ziggurat Building, 707 Third Street West Sacramento, CA 95798

This conference will:

1. Allow prospective applicants to ask questions about submitting an application.
2. Allow prospective applicants to ask questions about the requirements for the health care coverage programs.
3. Provide responses to the general questions and issues received before the conference.

While attendance at the conference is recommended, it is not required.

Each prospective applicant should carefully review the entire RFA before the conference to become familiar with the submittal process, eligibility requirements and elements for evaluation. Prospective applicants are encouraged to have their own copy of this RFA available to refer to during the conference.

If CDHS is unable to respond to all inquiries received before and/or during the conference, written responses will be provided following the conference. CDHS will summarize the general questions and issues that are raised before and during the conference, and provide written responses on the Internet at: <http://www.dhs.ca.gov/coverageinitiative>.

Following the pre-application conference questions must be directed to CDHS by November 27, 2006, at 5:00 p.m. to allow CDHS adequate time to summarize the questions and post them on the Internet.

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Applicants are responsible for their costs to attend the conference. These costs cannot be charged to CDHS, or be included in any cost element of the applicants' proposed budgets.

Reasonable accommodations will be made for individuals with disabilities. CDHS will provide assistive services such as sign language interpretation, real-time captioning, note takers, reading or writing assistance, and conversion of pre-application conference handouts (if any), this RFA, questions/answers, RFA addenda, or other administrative notices into Braille, large print, audiocassette, or computer disk. The range of assistive services available may be limited if requestors do not allow three State working days prior to the date that the alternate format material is needed.

To request such services or copies in an alternate format, please contact Ms. Debra Otto at the numbers below, no later than November 8, 2006.

Ms. Debra Otto  
Hospital/Uninsured Care Demonstration Section  
Direct line: (916) 552-9424  
(TTY) California Relay:  
1-711-735-2929  
1-800-735-2929

CDHS may amend the RFA. Modifications will be made, or new information provided, by addenda issued in accordance with this paragraph. Addenda will clearly indicate the provisions in the RFA that are being amended; paragraphs or pages may be replaced in their entirety to ensure clarity.

### **Application Format**

#### General Instructions

Each applicant must:

1. Complete applications by following **all** RFA instructions, which may include subsequent clarification issued by CDHS in the form of question and answer notices, clarification notices, or RFA addenda.
2. Seek timely written clarification of any requirements or instructions that the applicant believes to be vague or ambiguous.
3. Limit the application to 25 pages, excluding any requested attachments. The attachments consist of the following: budget form(s), identification of the geographic area to be served, list of health care providers, explanation of the source of funds to be used, and the consent form. Attachments cannot be used as a mechanism to expand the 25-page application limit.

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4. Arrange for the timely delivery of the application package(s) to one of the addresses specified on page 11 of this RFA.

### Format requirements

Each applicant must:

1. Submit an application describing the health care coverage program in the order outlined in the “Elements for Evaluation” beginning on page 13 of this RFA.
2. Format the narrative portion of the application as follows:
  - (a) Use one-inch (1”) margins at the top, bottom, and both sides.
  - (b) Use Arial 12-point font.
  - (c) Print pages single-sided on white paper.
  - (d) Number each page in the application, including any attachments.
3. Bind or staple each application set in the upper left-hand corner.
4. Write “Original” on the original application.
5. Ensure that all copies of the application are complete when submitted.

### **Application Content**

Applications submitted to CDHS must include complete and thorough responses to each of the eleven elements for evaluation described in the section entitled “Elements for Evaluation” beginning on page 12 of this RFA, budget display and additional requirements described below.

### Budget Display

The application must contain budget information as described below:

1. Complete the Budget Form available for downloading on CDHS’s Internet page at: <http://www.dhs.ca.gov/coverageinitiative>.
2. Project estimated total expenditures, not just the non-federal share of the expenditures, to provide program services for each year of the entire three-year period.
3. Provide specific expenditure breakdowns for the budget line items.

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4. Multiply and total all unit rates/expenses (e.g., unit cost per patient served, expenses to develop a new system/change an existing system, or the expenses associated with health related publications, etc.) for each program year.
5. Report expenditures by rounding to the nearest whole dollar amount.
6. Enter a total annual expenditure for each program year. Ensure that all itemized expenditures total this amount.

Please note: The Budget Form is not intended to limit the specific expenditures that can be claimed for reimbursement, but is intended to show budgeted expenses in the required format. Use as many pages as necessary to display budgeted expenses for the term specified. Use of computerized reproductions or images is permissible.

### Additional Requirements

The application must include the following items in the form of attachments:

1. Identification of the geographic area that the program will serve.
2. A list of the health care providers who have agreed to participate and provide services to the target population and documentation that all providers in the network will be compensated at similar rates for similar services.
3. An explanation of the source of the funds to be used by the applicant to fund the proposed healthcare coverage program.
4. A consent form signed by the applicant to provide requested data elements as required in the STCs of the Demonstration. An example is available on CDHS's Internet page at: <http://www.dhs.ca.gov/coverageinitiative>.

### **Application Submission**

Each applicant must:

1. Submit its application in hard copy. No electronic media will be accepted.
2. Sign the application and any attachments in blue ink. The application must be signed by an individual with authority to submit the application on behalf of the applicant.
3. Prepare an original and five (5) copies of the application. Place the application set marked "Original" on top, followed by the five (5) copies.

(a) Place all originally signed documents in the application marked "Original."

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- (b) The five copies of the application may reflect photocopied signatures.
4. Place the original and five (5) copies in a single envelope or package, if possible.
  5. Label each envelope or package, if submitting more than one envelope or package.
  6. Ensure applications are postmarked by December 13, 2006, or hand delivered to CDHS by 5:00 p.m. on December 13, 2006.
  7. Submit applications using one of the following options:

Hand Delivery or Overnight Express	U.S. Mail
<p><b>Coverage Initiative Application</b>            CA Dept. of Health Services            Medi-Cal Operations Division            Attention: Betsi Howard            1501 Capitol Avenue, Suite 71.3002, MS 4506            Sacramento, CA 95814</p>	<p><b>Coverage Initiative Application</b>            CA Dept. of Health Services            Medi-Cal Operations Division            Attention: Betsi Howard            1501 Capitol Avenue, MS 4506            P.O. Box 997419            Sacramento, CA 95899-7419</p>

If the hand delivery option is chosen, please allow adequate time to locate parking and to wait at the security desk on the street level until a CDHS staff member accepts the application. Upon arrival in the building, inform the security personnel that you have a delivery for Ms. Betsi Howard, at telephone number: (916) 552-9175.

Applicants are responsible for all costs of developing and submitting an application. These costs cannot be charged to CDHS or be included in any cost specified in the applicants' proposed budget.

Please note: If the applicant is a consortium of counties serving a region consisting of more than one county, the consortium of counties must designate one county as the applicant to be responsible for completing and submitting the application.

### Evaluation Committee

The evaluation committee will be comprised of staff employed by CDHS and other individuals who are not affiliated with local governments or employed by CDHS. The evaluation committee members will have background and experience necessary to complete the review and evaluation of proposed health care programs. The committee will evaluate the merits of the applications and score them as described in steps 3 and 4 of the section entitled "Application Evaluation" beginning on page 16.

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## Application Evaluation

There are four evaluation processes that will be used to determine the allocation of the available federal funds to prospective applicants: a preliminary review, a pass-fail review, a technical review, and a secondary review.

Step 1: Preliminary Review: The preliminary review is described on page 16 of this RFA.

Step 2: Pass-Fail Review: The pass-fail review is described on page 16 of this RFA.

Step 3: Technical review: The technical review is described on page 16 of this RFA.

Step 4: Secondary Review: The secondary review, which will result in the final scoring of the applications, is described on page 17 of this RFA.

## Required Outcomes

In evaluating the responses to each of the eleven “Elements for Evaluation,” the evaluation committee will assign points based on how well each response, when implemented, would contribute to achieving the following outcomes, as applicable:

1. Expand the number of Californians who have health care coverage.
2. Strengthen and build upon the local health care safety net system, including disproportionate share hospitals, and county and community clinics.
3. Improve access to high quality health care and health outcomes for individuals.
4. Create efficiencies in the delivery of health care services that could lead to savings in health care costs.
5. Provide grounds for long-term sustainability of the programs funded under the Coverage Initiative beyond August 31, 2010, when the annual federal allocation for the Coverage Initiative ends.
6. Implement programs in an expeditious manner in order to meet federal requirements regarding the timing of expenditures.

## Elements for Evaluation

All of the following elements will be evaluated and scored using the four-point scale as described on page 16 of this RFA:

1. Enrollment processes, with an identification card system to demonstrate enrollment of eligible persons into the proposed health care coverage program.

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A complete response should include:

- (a) A description and estimated number of eligible persons to be served annually.
- (b) A description of the process and/or source of data for identifying the estimated number of eligible persons to be served, and the methods to be used to inform the target population of the availability of the services to be provided.
- (c) A description of the eligibility criteria, such as household income and other criteria as established by the program.
- (d) A description of how the program expands coverage beyond health care service programs currently in effect in the applicant's county or counties, including those programs set forth at Welfare and Institutions Code sections 16809 and 17000 et seq.
- (e) An explanation of how the applicant will ensure target enrollment levels will be reached and maintained.

2. Use of a medical records system, which may include electronic medical records.

A complete response should include:

- (a) A description of the reliable medical record system to be used that may include, but need not be limited to, existing electronic medical records, including a description of the safeguards utilized to comply with the Health Information Portability and Accountability Act (HIPAA).
- (b) A description of the unique identifiers that are assigned to each eligible person receiving health care services.
- (c) A description of the methods used to track and record services provided to eligible persons.
- (d) A description of processes and controls to identify and reduce medical errors and eliminate duplicate services.

3. Designation of a medical home and assignment of eligible persons to a primary care provider, which is a provider from which the eligible person can access primary and preventive care.

A complete response should include:

- (a) A description of the organized health care delivery system(s) to be used for the health care coverage program, including but not limited to, designation of a

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medical home and processes used to assign eligible persons to a primary care provider.

- (b) Identification of the designated medical home and its relationship with the health care coverage program.
  - (c) A description of the delivery systems to provide health care services, such as the relationships, partnerships, collaborations, or arrangements with other health care providers in the community; how those relationships will ensure effective delivery of services; and the applicant's ability to effectively coordinate, manage, and monitor the delivery of services.
  - (d) A description of processes to ensure that health care services match the needs of the target population.
  - (e) A description of how medical information that is necessary to effectively coordinate all medical care including immunizations, labs, specialty care, as well as follow up from any inpatient or specialist care will be maintained.
4. A description of health care services to be included in a benefit package, particularly preventive and primary care services, as well as care management services designed to treat individuals with chronic health care conditions, mental illness, or who have high costs associated with their medical conditions in order to improve their health and decrease future costs. Benefits may include case management services and care management.

A complete response should include:

- (a) A description of the care management services to be provided and the providers of those services, including primary and specialty care providers.
- (b) A list of the health benefits to be provided, including, but not limited to, primary care and preventive care services; and a description of how the health care services will be promoted in the community.
- (c) A description of the system(s) and/or procedure(s) for case management or care management that demonstrates that there is capacity to ensure access and utilization.
- (d) A description of the applicant's processes for conducting periodic utilization reviews for case management or care management to evaluate whether the services provided are consistent with program utilization projections (on a concurrent and retrospective basis) and meet the needs of the target population.
- (e) An estimate of the average cost per eligible person to be served.

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5. Quality monitoring processes to assess the health care outcomes of the eligible person enrolled in the health care coverage program.

A complete response should include:

- (a) A description of the quality monitoring system to evaluate whether the system is technically sound with sufficient capacity to be implemented with the health care coverage program.
- (b) A description of system processes to effectively coordinate, manage, and monitor services to ensure the quality of care.
- (c) An explanation of what standards will be used to quantify, measure, and report on the quality of care.
- (d) A description of the method by which the applicant will ensure that subcontractors have the capability to effectively establish, coordinate, manage, monitor, and maintain quality efforts.

6. Promotion of the use of preventive services and early intervention.

A complete response should describe how:

- (a) Enrolled persons will be educated about the importance of preventive services.
- (b) Providers will be encouraged to provide preventive services and early intervention.

7. The provision of care to Medi-Cal beneficiaries by the applicant, the degree to which the applicant already serves these beneficiaries, and how the proposed health care coverage program will broaden existing services to these beneficiaries.

8. A description of the screening and enrollment processes for individuals who may qualify for enrollment into the Medi-Cal, Healthy Families, or the Access for Infants and Mothers programs prior to determining eligibility and enrollment into the health care coverage program.

9. The ability to demonstrate how the health care coverage program will promote the viability of the existing safety net health care system.

10. Documentation to support the applicant's ability to implement the health care coverage program by September 1, 2007, and to fully use its allocation for each program year.

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11. An explanation of how the health care coverage program will offer consumer assistance to individuals applying to, participating in, or accessing services in the program.

### **Evaluation Process**

#### Preliminary Review

CDHS will review each application to ensure that the applications meet the requirements in the sections entitled, "Application Format, Application Content, and Application Submission." Any application that does not meet the requirements of these three sections will not be further evaluated.

#### Pass-Fail Review

An initial "pass" or "fail" determination will be made by CDHS for each "Element for Evaluation," as described in full beginning on page 12 of this RFA. An applicant's response will "fail" if any one of the evaluation elements has not been responded to, if the response is totally lacking in substance, or if the response indicates that the applicant cannot comply with the particular evaluation element. Any application that receives a "fail" determination on one or more evaluation element(s) will be eliminated from the application evaluation process.

#### Technical Review

Those applications that advance to the technical review process will be reviewed by the evaluation committee members. The evaluation committee members will assign points to the responses for each of the eleven "Elements" (see the four-point scale below). The points assigned will be based on the likelihood of achieving the "Required Outcomes", as described below. The total points assigned to each "Element" will result in a tentative score, subject to the secondary review.

Each Element for Evaluation will be scored using a four-point scale. The four-point scale will consist of the following ratings:

4 points	=	Excellent
3 points	=	Very Good
2 points	=	Good
1 point	=	Poor

The maximum possible total for Items 1 through 11 is 44 points. The sum of the scores from the eleven "Elements for Evaluation" will constitute a tentative score for the application subject to the Secondary Review and Analysis process described below. The fact that an application receives a high number of points in the technical review process is not a guarantee of funding.

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## Secondary Review and Analysis

Once the total tentative score has been calculated for each application, the evaluation committee will determine the final scores for each application based on a secondary review and analysis. In determining the final scoring of each application the committee will consider the degree to which the application, taken as a whole:

1. Is fully developed, with few, if any, weaknesses, defects, or deficiencies, and does not lack depth, breadth, or significant facts or information.
2. Demonstrates the applicant's capacity, capability and/or commitment to meet or exceed program requirements (e.g., enhanced features, approaches, or methods, and/or creative or innovative solutions).
3. Demonstrates that the applicant would be efficient in operating and administering a program based on the cost per patient in proportion to the total number to be served.

Based on the secondary review and analysis, the evaluation committee may add or subtract up to three (3) points from the total tentative score to arrive at the final score for each application.

The committee will rank applications from the highest to the lowest scoring, and the highest ranked application will be selected to receive an allocation. If the highest ranking application is from Northern California (north of Kern County) then the evaluation committee, to achieve geographic balance, will select the highest ranking application in Southern California (including Kern County and counties located south of Kern) for the second allocation. Likewise, if the highest ranking application is from Southern California, then the evaluation committee, to achieve geographic balance, will select the highest ranking application in Northern California for the second allocation.

In addition to the two selected applications as determined above, the committee will then select at least the next three applications with the highest scores.

Final selection and allocation decisions are subject to the availability of funds and may differ from the amount requested in the applications. CDHS may reject any application or any proposed component of a health care coverage program.

## **Clarifications**

Throughout the evaluation process, CDHS may seek clarifications or question information presented in the applications. Clarification requests will include a reference to the portion of the application that needs clarification. Responses to clarification requests must be submitted within five business days of receipt of the request.

# **Health Care Coverage Initiative Request for Applications**

## **Application Withdrawal and Resubmission**

1. An applicant may withdraw an application at any time before the submission deadline by submitting a written withdrawal request signed by the applicant's authorized representative. All withdrawal requests must be submitted using one of the submission and delivery options specified on page 11 of this RFA.
2. An applicant may resubmit a new application according to the application submission instructions. Resubmitted applications must be received by December 13, 2006, by 5:00 p.m. using one of the delivery options specified on page 11 of this RFA.
3. CDHS requests that applicants confirm with Ms. Debra Otto at (916) 552-9424 that the withdrawal request was received.

## **Disposition of Applications**

1. All materials submitted in response to this RFA will become the property of CDHS and become subject to the Public Records Act (Government Code Section 6250 et seq.) once program selection and allocation notices are posted. Therefore, CDHS requests that applicants do not submit any information with the application that the applicant considers confidential or proprietary.
2. Application contents, applicant correspondence, evaluation committee working papers and any other part of the application process will be held in the strictest confidence until the program selection and allocation notices are issued.

## **No Further Proceedings**

All processes and procedures set forth in this RFA constitute the sole administrative processes and procedures available for applicants. No further administrative remedies (e.g., protests, appeals, or requests for reconsideration) will be available for applicants following CDHS's issuance of its decision concerning selected applications and allocations.