M E M O R A N D U M
HEALTH AND HUMAN SERVICES
ADMINISTRATIVE SERVICES
County of Placer

TO: Board of Supervisors DATE: March 9, 2021

FROM: Robert L. Oldham, MD, MSHA, Director of Health and Human Services

SUBJECT: Transition to County Organized Health System Letter of Intent

---

ACTION REQUESTED
Approve the Board Chair signing a letter to the California Department of Health Care Services (DHCS) indicating Placer County's intent to transition to a local Medi-Cal Managed Care Plan (MCP).

BACKGROUND
Over the past several decades, California has implemented a variety of Medicaid (in California called "Medi-Cal") managed care models, including the County Organized Health System (COHS), the Two-Plan Model and the Geographic Model. In 2013, Medi-Cal managed care was expanded to 28 California counties, including Placer County. Many counties in Northern California sought to enter into the COHS model. The COHS model is generally regarded as offering counties the greatest amount of local control, with counties being directly responsible for governance of their respective plans, either alone or in combination with other counties. Prior to this expansion of managed care Partnership Health Plan, a COHS serving several Northern California counties, already had a strong reputation for superior quality, access, and collaboration with counties and medical providers. Prior to the 2013 managed care expansion, many Northern California counties sought to join the COHS model under Partnership Health Plan. However, at the time DHCS restricted the number of counties allowed to enter into a COHS model, and assigned the remaining counties to the Regional Model, in which the state contracts with two for-profit plans to administer Medi-Cal benefits in a county. Placer County, along with most other counties in our region, was assigned to the Regional Model and Anthem Blue Cross and California Health and Wellness were selected as our 2 Medi-Cal managed care plans. Placer County was not consulted by DHCS on its assignment to the Regional Model or on the procurement process that led to the selection of our 2 Medi-Cal managed care plans.

In 2018, Senator Jim Nielsen requested, and the Joint Legislative Audit Committee approved, a state audit of DHCS' oversight of managed health care in the 18 small and rural counties under the Regional Model. In August of 2019, the State Auditor released a report entitled "Department of Health Care Services: It Has Not Ensured That Medi-Cal Beneficiaries in Some Rural Counties Have Reasonable Access to Care" that found:

- DHCS did not enforce state requirements that limit distances health plans may direct their Medi-Cal beneficiaries to travel to receive health services.
- DHCS failed to hold Regional Model health plans accountable for improving beneficiaries' access to care.
- Regional Model beneficiaries have generally received a lower quality of care than beneficiaries in other areas of the state.
- DHCS did not adequately educate Regional Model counties about the options available to them regarding their transition to managed care.
- DHCS was found to not have assisted Regional Model counties that wanted to create or join a County-Organized Health System (COHS), which may have provided beneficiaries with better access to care.

In addition, the audit report recommended that DHCS assist counties desiring a transition to COHS model in making that change after their current contracts expire. All of the current 18 regional counties are actively pursuing letters of intent to transition to COHS plans.

Also in 2019, the California Health Care Foundation performed an independent evaluation of the Regional Model and found the following:

- Specialty care is somewhat more difficult for Medi-Cal enrollees in Regional Model counties compared to other rural areas of the state.
- The quality of care provided to Medi-Cal enrollees by Regional Model MCPs was worse, on average, when compared to MCPs in other rural counties.
- Overall, Medi-Cal enrollee satisfaction with MCP performance was lower in Regional Model counties relative to other rural areas of the state.

Pursuant to the State Auditor's recommendations, DHCS recently released information on the upcoming statewide procurement of commercial Medi-Cal MCPs and issued an instruction that all counties wishing to transition to a COHS should submit a letter of intent to DHCS by March 31, 2021. Placer County HHS has met with several counties in the region who are excited at the prospect of transitioning together into a COHS Medi-Cal Managed Care model with Partnership Health Plan. Additionally, Tehama, Butte, Plumas, Glenn, Colusa, Sierra, Yuba, Sutter, and Nevada Counties are all planning to submit an LOI to transition to partnership.

FISCAL IMPACT
A letter of intent would be non-binding and there is no anticipated fiscal impact to the County associated with submitting a letter to DHCS indicating Placer County's intent to transition to a COHS model. An eventual transition to a COHS model is expected to streamline care coordination for Placer County HHS clients and may result in modest reductions in Department expenses.

ATTACHMENT
Draft Letter of Intent

March 31, 2021

Bambi Cisneros,
Assistant Deputy Director
California Department of Health Care Services

Ms. Cisneros,

In 2013, 18 counties formed the Regional Model of Medi-Cal managed care. Over the last few years, a subset of these counties have approached Partnership HealthPlan of California (PHC) about possible expansion of the plan to include 10 of these counties. With the support of the PHC Board of Commissioners, please accept this as our letter of intent for Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba counties to join PHC in 2024.

The counties have spent years of discussion with area hospitals, outpatient Medi-Cal providers, affected county departments and many area ancillary health providers regarding the change. Moving from the Regional Model to PHC would be in the best interest of the counties' residents. This decision was made after careful deliberation and extensive discussion with health care and community partners.

Many factors motivated the 10 counties to pursue a County Organized Health System (COHS) model of Medi-Cal managed care with PHC. Some of these included:

- The organization is non-profit;
- Each county in the service area appoints members to PHC's Board of Commissioners;
- PHC's reinvestment into important community programs and benefits for members and providers, in part due to the PHC's low administrative overhead;
- PHC's long established record of working collaboratively in the local communities it serves;
- The emphasis on quality and quality incentive programs, including accreditation by the National Committee on Quality Assurance (NCQA);
- High member and provider satisfaction scores; and
- PHC's experience with the challenges of health care delivery in rural California.

PHC and the counties understand this is a significant change for all parties, including Medi-Cal beneficiaries in these counties. We are committed to working diligently to respond to all questions and inquiries from DHCS, community partners, and beneficiaries. The counties and PHC have reviewed the readiness requirements and can attest:

1. PHC is in good financial standing and is able to assume financial risk for Medi-Cal managed care plan services for Medi-Cal beneficiaries in these 10 counties, assuming revenue rates for the expansion area are determined to be sufficient by PHC. PHC is able to meet all financial readiness requirements.
2. PHC and counties will work together to self-fund all pre-implementation activities.
3. PHC and the counties will meet non-financial readiness requirements and timelines as provided by DHCS.
4. PHC will meet network capacity requirements for all of the eligible beneficiaries in these counties.
5. PHC will implement all applicable Medi-Cal managed care plan requirements.
6. PHC is committed to a robust network contracting strategy.
7. The Counties are not aware of any new state statute that would be required to enact a transition, but if at some point it is determined that new legislation is required, then all of our counties will work together with DHCS, PHC, the County Health Executives Association of California (CHEAC), the Health Officers

Association of California (HOAC) and the Rural County Representatives of California (RCRC) to develop and enact such legislation.

8. All ten counties attest that each of our Board of Supervisors will enact local ordinances by October 2021 authorizing the shift of our counties to Partnership HealthPlan of California.

PHC and the counties understand this non-binding letter of intent, and that an expansion of PHC's service area to include these counties is contingent upon DHCS and CMS approval. We acknowledge that under federal Medicaid rules, beneficiaries are required to have a choice of at least two managed care plans. An exception to this rule does apply for COHS plans, provided that total enrollment does not exceed 16 percent (16%) of the total Medi-Cal population. Further, Medi-Cal beneficiaries residing in rural areas are also exempted from federal managed care plan choice requirements. Currently, the number of beneficiaries falling under this provision appears to be below the cap. Based on PHC's initial legal review, it also appears that under current federal agreements for managed care operations that this federal enrollment cap may be waived. We note, however, that DHCS may have a different view of the application and impact of this enrollment cap. PHC and the counties will need to engage in further conversation with DHCS regarding the interpretation of this cap; and/or potential waivers needed for approval.

PHC and the counties acknowledge this is a large initiative for DHCS and appreciate the opportunity to improve the care our Medi-Cal members receive. We look forward to ongoing collaboration during this transition.

Thank you,

Liz Gibboney
CEO, Partnership HealthPlan of California

Bill Connelly
Chair, Board of Supervisors
Butte County

Jeff Engel
Chair, Board of Supervisors
Plumas County

Gary Evans
Chair, Board of Supervisors
Colusa County

Lee Adams
Chair, Board of Supervisors
Sierra County

Keith Corum
Chair, Board of Supervisors
Glenn County

Dan Flores
Chair, Board of Supervisors
Sutter County

Dan Miller
Chair, Board of Supervisors
Nevada County

Dennis Garton
Chair, Board of Supervisors
Tehama County

Robert Weygandt
Chair, Board of Supervisors
Placer County

Gary Bradford
Chair, Board of Supervisors
Yuba County

Enclosure (3):

1. Contact Information for PHC and Counties
2. Readiness Planning Document
3. PHC Financial Statement

Enclosure 1: County and PHC Contact Information

County/Name of Contacts	Contact type	Phone	Email	Address
Butte County				
Danette York	Primary	(530) 552-3820	DYork@buttecounty.net	Butte County Public Health, 202 Mira Loma Dr. Oroville, CA 95965
Dr. Robert Berstein	Secondary	(530) 552-3902	rbernstein@buttecounty.net	Butte County Public Health, 202 Mira Loma Dr. Oroville, CA 95965
Colusa County				
Elizabeth Kelly	Primary	(530) 458-0250	Elizabeth.Kelly@colusadhhs.org	Colusa County HHS, 251 E. Webster St., Colusa, CA 95932
Annie Mitchell	Secondary	(530) 458-0250	annie.mitchell@countyofcolusa.com	Colusa County HHS, 251 E. Webster St., Colusa, CA 95932
Glenn County				
Brenda Enriquez	Primary	(530) 934-1496	Benriquez@countyofglenn.net	Glenn County HHS, 420 E. Laurel St., Willows, CA 95988
Nan DiLouie	Secondary	(530) 934-1439	NDiLouie@countyofglenn.net	Glenn County HHS, 420 E. Laurel St., Willows, CA 95988
Christine Zoppi	County Rep.	(530) 934-6683	Czoppi@countyofglenn.net	Glenn County HHS, 420 E. Laurel St., Willows, CA 95988
Nevada				
Phebe Bell	Primary	(530) 470-2784	Phebe.Bell@co.nevada.ca.us	Nevada County Behavioral Health, 500 Crown Point Circle, Grass Valley, CA 95945
Ryan Gruver	Secondary	(530) 265-7226	Ryan.Gruver@co.nevada.ca.us	Nevada County HHSA, 950 Maidu Ave, Suite 120, Nevada City, CA 95959
Placer				
Joe Arsenith	Secondary	(530) 889-7145	jarsenith@placer.ca.gov	Placer County HHS/Public Health, 11484 B Avenue, Auburn, CA 95603
Rob Oldham	Primary	(530) 745-3191	roldham@placer.ca.gov	Placer County HHS, 3091 County Center Drive, Auburn, CA 95603
Plumas				
Andrew Woodruff	Primary	(530) 283-6342	andrewwoodruff@countyofplumas.com	Pluma County Public Health Agency, 270 County Hospital Road, Suite 206 Quincy, CA 95971
Tony Hobson	Secondary	(530) 283-6307 ext 1007	thobson@pcbh.services	Plumas County Public Health Agency, 270 County Hospital Road, Suite 206 Quincy, CA 95971
Sierra				
Vickie Clark	Primary	(530) 993-6707	vclark@sierracounty.ca.gov	Sierra County Public Health and Social Services, 202 Front St., PO Box 1019, Loyalton, CA 96118

County/Name of Contacts	Contact type	Phone	Email	Address
Jamie Franceschini	Secondary	(530) 993-6770	jfranceschini@sierracounty.ca.gov	Sierra County Public Health and Social Services, 202 Front St., PO Box 7, Loyalton, CA 96118
Sutter				
Nancy O'Hara	Primary	(530) 822-7327	nohara@co.sutter.ca.us	Sutter County HHS, 1445 Veterans Memorial Circle, Yuba City, CA 95993
Rick Bingham	Secondary	(530) 822-7327	rbingham@co.sutter.ca.us	Sutter County HHS, 1445 Veterans Memorial Circle, Yuba City, CA 95993
Leah Northrop	Secondary	(530) 822-7226	lnorthrop@co.sutter.ca.us	Sutter County HHS, 1445 Veterans Memorial Circle, Yuba City, CA 95993
Tehama				
Valerie Lucero	Primary	(530) 528-3216	Valerie.Lucero@tchsa.net	Tehama County Health Services Agency, P.O. Box 400/818 Main St. Red Bluff, CA 96080
Jayme Bottke	Secondary	(530) 528-3275	Jayme.Bottke@tchsa.net	Tehama County Health Services Agency, P.O. Box 400/818 Main St. Red Bluff, CA 96080
Yuba				
Homer Rice	Primary	(530) 749-6385	hrice@co.yuba.ca.us	Yuba County HHS, 5730 Packard Ave, Marysville, CA 95901
Jennifer Vasquez	Secondary	(530) 749-6380	jvasquez@co.yuba.ca.us	Yuba County HHS, 5730 Packard Ave, Marysville, CA 95901
Partnership HealthPlan of California				
Liz Gibboney	CEO	(707) 863-4232	egibboney@partnershiphp.org	4665 Business Center Dr. Fairfield, CA 94534
Amy Turnipseed	Sr. Director External and Regulatory Affairs	(661) 203-7836	aturnipseed@partnershiphp.org	4665 Business Center Dr. Fairfield, CA 94534

Enclosure 2: Readiness Planning Document

Partnership HealthPlan of California (PHC) was formed as a health insurance organization, and is legally a subdivision of the State of California, but is not part of any city, county or state government system. PHC began serving Medi-Cal eligible persons in Solano in May 1994. Napa County joined PHC in March of 1998, followed by Yolo in March of 2001, Sonoma in October 2009, and Marin and Mendocino in July 2011. PHC expanded to eight northern counties (Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity) in September 2013.

Today, PHC serves over 570,000 Medi-Cal beneficiaries in 14 counties. PHC is willing to produce supplemental information (policies, reports, etc.) needed to elaborate on our ability to meet readiness criteria; and are proud of our experience with five expansions.

Service Utilization

PHC has systematic processes for monitoring for overutilization and underutilization of services (PHC policy MPUP 3006 and UM program description MPUD 3001, as approved by DHCS). The availability of primary care and specialty care providers and accessibility of primary care and specialty care services are evaluated as part of the network adequacy and availability requirements, following DHCS and NCQA standards.

Network Adequacy

Per our contract with DHCS, PHC submits a complete Provider Network that is adequate to provide required covered services for eligible beneficiaries within PHC's service area.

Within PHC's service area, we ensure and monitor an appropriate network, including adult and pediatric primary care providers (PCPs), OB/GYN, adult and pediatric behavioral health providers, adult and pediatric specialists, professional, Allied Health Care Personnel, supportive paramedical personnel, hospitals, pharmacies, and an adequate number of accessible inpatient facilities and service sites. PHC's network includes American Indian Health Service Programs, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Freestanding Birthing Centers (FBCs), where available. In addition, we have a robust telemedicine program that offers adult and pediatric specialty health care services.

Quality Monitoring

PHC's Quality and Performance Improvement (QI/PI) program provides a systematic process to monitor the quality of clinical care and health care service delivery to PHC members. It includes an organized framework to identify opportunities to improve the quality of health care services provided, promote efficient and effective use of health plan financial resources, and to partner with internal and external stakeholders to support performance improvement and to improve health outcomes. The program promotes consistency in application of quality assessment and improvement functions for the full scope of health care services while providing a mechanism to:

- Ensure integration with current community health priorities, standards, and goals that impact the health of the PHC member population
- Identify and act on opportunities to improve care and service
- Identify overuse, misuse, and underuse of health care services
- Identify and act on opportunities to improve processes to ensure patient safety
- Address potential or tangible quality issues
- Review trends that suggest variations in the process or outcomes of care

Accessibility Standards

PHC is committed to ensuring that its members have access to providers to meet their health care needs. PHC has established standards that meet or exceed DHCS requirements for the numbers and types of clinicians and facilities, as well as for their geographic distribution, appointment accessibility and office and telephone availability. PHC monitors provider availability and accessibility on an annual basis by conducting various surveys. These includes verifying the third next available appointment ("the 3NA"), telephone access, and access to care outside of normal business hours. PHC policy MPNET 100 describes the plan's approach to full compliance with both DHCS and NCQA standards. PHC also ensures the provider network is educated on how our members can access the PHC 24/7 Advice Nurse program, transportation benefits, interpreter services and behavioral health services.