PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

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. There are no health related financial sanctions or corrective action plans currently in place for PHC or the counties.
3. PHC will explore if direct contract or subcontract/delegation arrangements are needed for this transition.
4. PHC and counties will work together to self-fund all pre-implementation activities.
5. PHC and the counties will meet non-financial readiness requirements and timelines as provided by DHCS.
6. PHC will meet network capacity requirements for all of the eligible beneficiaries in these counties.
7. PHC will implement all applicable Medi-Cal managed care plan requirements.
8. PHC is committed to a robust network contracting strategy.
9. 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.

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

PHC and the counties understand this is a 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
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Sierra County

Keith Corum
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Sutter County

Dan Miller
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Nevada County

Dennis Garton
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Robert Weygandt
Chair, Board of Supervisors
Placer County

Gary Bradford
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Yuba County

Enclosure (3):
1. Contact Information for PHC and Counties
2. Readiness Planning Document
3. PHC Financial Documents

Enclosure 1: County and PHC Contact Information

County/Name of Contacts	Contact type	Phone	Email	Address
Butte County				
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Colusa County				
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Placer				
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County/Name of Contacts	Contact type	Phone	Email	Address
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Partnership HealthPlan of California				
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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.