Report of the Planning Group on Medi-Cal Managed Care
To the Sonoma County Department of Health Services Director

November 2006

I. Background:

In January 2005 the California Department of Health Services (CDHS) issued a Medi-Cal Redesign Plan that recommended the expanded use of Medi-Cal managed care as a strategy to contain costs while improving access and quality. The Redesign Plan called for 13 counties to move from their current fee for service system into one form or another of managed care. The Plan called for Sonoma County to join an existing County Organized Health System (COHS), the Partnership HealthPlan of California. Partnership HealthPlan of California (PHC) was founded in Solano County in 1996 and currently serves Solano, Napa, and Yolo Counties. Marin, Mendocino, and Lake Counties are also slated to join Partnership.

While becoming part of the Partnership COHS appeared to be a viable option, the Department of Health Services requested and received authorization from the Board of Supervisors to convene a local planning group to study the options, gather input, and make recommendations. Per the December 2, 2005 agenda item, the Director of Health Service appointed a Managed Care Planning Group made up of health care providers, consumer representatives and County staff. This is the Planning Group's report to the Director regarding Medi-Cal Managed Care as an opportunity for the county.

II. Planning Group Organization and meetings:

The Medi-Cal Managed Care Planning Group is made up of 23 members. Appendix A lists each Planning Group member and the organization or stakeholder group he or she represents. Each of the hospitals in the County is represented as is the Medical Association, the county's network of community clinics, skilled nursing facilities and specialty physicians. Medi-Cal beneficiaries are represented by individuals who were nominated by community-based organizations based on their experience and expertise. The beneficiary representatives include the major categories of Medi-Cal eligibility including people with disabilities, elders, foster children and women and children. The Planning Group includes representatives from the Departments of Health and of Human Services. Group members agreed that they would communicate with the organizations and interest groups that they represent, thus helping to educate the larger provider and beneficiary communities.

The Planning Group has been chaired by the County Health Officer and staffed by the Department of Health Services. Planning Group meetings are open to the public and have been attended by interested community members, Sonoma County legislative staff

members, State Medi-Cal managers and executives from the Partnership HealthPlan. Each meeting has a period for public comment. All meeting materials are posted on a Medi-Cal Managed Care Planning web site (www.sonoma-county.org/managedmedi-cal) including agendas, minutes, and documents utilized in the meeting or submitted by members.

The Planning Group held its first meeting in February 2006; then met twice in March and September and once in April, May, June, July, August, and November for a total of eleven meetings.

III. Planning Group Activities and Accomplishments:

The Planning Group meetings have been an opportunity for members to learn about different Medi-Cal models for managed care and in particular the option of joining PHC while sharing their perspectives on the problems and opportunities in the current systems. During its ten months of meetings the Planning Group accomplished the following:

A. Assessment of Sonoma County and current system

- Reviewed data on the Medi-Cal program in Sonoma County including the demographics of Medi-Cal beneficiaries and data on participating providers and the program expenditures. Sonoma County's Medi-Cal data is attached as Appendix B.
- Appointed a Communications Committee and approved a plan to hold meetings and focus groups with Medi-Cal beneficiaries and providers in order collect their input to the planning process.
- Conducted 10 focus groups with Medi-Cal beneficiary groups
- Gathered input from Sonoma County physicians through meetings and written surveys.
- Heard a report on the results of the 10 focus groups held with consumers and advocacy organizations to discuss the strengths and challenges of the current Medi-Cal fee-for-service system and gather consumer perspectives on desired features in a new system. Also reviewed the results of questionnaires returned by physicians regarding the Medi-Cal program and how it could be improved.

B. Study of potential models of Managed Medi-Cal

- Studied the characteristics of the Medi-Cal fee-for-service system and California's three Managed Care models including Geographic Managed Care (GMC), the Two-Plan Model and County Organized Health Systems (COHS) plans.
- Reviewed the constraints relating to each model including the types of Medi-Cal beneficiaries that would be served in each model, the number of members that could be anticipated in Sonoma for each model, the plan size that is required for efficient effective operation, and the federal legislation that would be required for

the formation of a new COHS. The document summarizing this data is in Appendix C.

- Heard a presentation by the Medical Director of Inland Empire Health Plan, a Two-Plan, Local Initiative Health Plan, regarding operations and quality of care.
- Heard a presentation from Partnership HealthPlan of California, the County Organized Health System that now serves Solano, Napa and Yolo Counties. The Executive Director, Medical Director and Governmental Liaison provided an overview of PHC organization and accomplishments (document posted on web site). Members asked questions and discussed issues.

C. Development of Criteria for an Improved Medi-Cal Program

- Developed criteria for an improved Medi-Cal program for use in evaluating potential new models of care. The overarching criteria for an improved Medi-Cal program adopted by the Planning Group states: ***The Medi-Cal system provides access to a continuum of high-quality services supported by fair reimbursement rates to providers. System operations are efficient and responsive and system governance is publicly accountable and invests its resources wisely.*** Additional criteria and bullet points address access to care, quality care, provider reimbursement, operations and governance of the system (see Appendix D)

D. Evaluation of Partnership HealthPlan option

- Heard a second detailed presentation by Partnership HealthPlan on the following topics:
    - **Governance:** exploration of how health care providers, beneficiaries and local officials are part of PHC at all levels of governance; details on governing board and committees.
    - **Finance:** explanation of risk-sharing arrangements, quality improvement funds and payment mechanisms for different services.
    - **Program Issues, including Maternal and Child Health, Skilled Nursing Facilities and Transportation:** learned more about how existing Medi-Cal programs such as CPSP, CCS and CHDP coordinated with PHC; reviewed birth outcomes and Partnership's programs to improve them. Explored the impact of managed care on Skilled Nursing Facilities, particularly as it relates to payment of actual costs under AB 16290.
- Held a special meeting at Partnership headquarters for Planning Group members interested in budget and fiscal issues. PHC's Chief Financial Officer answered questions and shared information.
- Adopted findings (Appendix D) regarding how Partnership measures up to the Planning Group's Criteria for an Improved Medi-Cal System. This document demonstrates the many advantages that PHC is offering its current counties in comparison to the fee-for-service system.
- Developed and approved a letter to the Director of the County Department of Health Services recommending that Sonoma County express its intent to join PHC provided certain key issues are satisfactorily resolved prior to final action.

- Approved this Final Report from the Planning Group to the Director of the Department of Health Services.

IV. Planning Group's findings and recommendations:

At its November meeting the Planning Group approved the following findings and recommendations as a part of the final report.

A. There are many deficiencies in the current Medi-Cal fee-for-service program which is an under-funded, "non-system."

Problems with the current fee-for-service Medi-Cal program include low payment rates leading to an insufficient number of participating providers and a lack of genuine access for many beneficiaries. Cumbersome eligibility and enrollment requirements, bureaucratic administrative processes and limited options to resolve problems impact beneficiaries and providers alike. The lack of care management for complex patients, lack of patient education, and few chronic disease prevention and treatment programs mean that the quality of care is not optimal.

B. The Planning Group considered two alternative managed care models (Geographic Managed Care and the Two-Plan model) and found them not appropriate for Sonoma County.

- GMC and Two-Plan model counties need relatively large population bases in order to be cost-efficient plans. Administrative costs will take a higher proportion of the budget in a small plan. Sonoma County by itself is quite small for either of these models and the State would not support either model in this County.
- In GMC counties, commercial plans are approved by the State and compete within the region for patients and providers. Commercial health plans participate with the intent to make a profit. Local providers and consumers have very limited involvement with system governance or operational decision-making.
- In Two-Plan model counties, one commercial plan (selected by the state) and a Local Initiative Plan compete for patients and providers. Patients may benefit by having a choice of plans but there are additional costs associated with marketing and having two administrative systems. The commercial plan operates with the intent to make a profit and does not provide for local input and governance.
- GMC and Two-Plan models do not mandate enrollment of seniors and people with disabilities into managed care. Thus, many high-need beneficiaries remain in the fee-for-service system and do not benefit from the enhanced services and programs available through a managed care system. In addition, local healthcare providers must assume the administrative burden of working with fee-for-service Medi-Cal as well as two or more managed care plans.

C. The Planning Group considered the creation of a new Sonoma County COHS, but determined that this option has significant costs and barriers.

Starting a new COHS for this County would require:

- Amendment of federal legislation that currently limits California to five COHS Plans. The State supported this legislation last year but it did not pass and is not likely to be reintroduced in the future. Without federal legislation creating a new COHS is not an option for Sonoma County.
- $3-5million in start-up capitalization funding which would be difficult to secure. In the past the State provided funds for COHS start-ups but no funds are currently available for this. Several of the large health care foundations have said that they would not prioritize funding for COHS start-ups.
- Additional start-up time would be required. The County could join Partnership Health Plan by spring of 2008, whereas starting a new COHS Plan could take considerably longer. Sustaining political will and focus over a long period of time can be difficult.
- Financial risk: Sonoma's Medi-Cal population would create a COHS that is relatively small and subject to greater financial risk, ie, a small number of high cost claims could adversely impact the plan. A new COHS Plan may require several years of operation before it could build financial reserves and reach a secure, stable state.
- Administrative systems**:** Developing the administrative systems and securing experienced management for a new COHS/health plan would be challenging.

D. Partnership Health Plan Meets or Exceeds Plan Criteria for an Improved Medi-Cal System.

The Planning Group established five major criteria for evaluating alternative models for the delivery of health care to the Medi-Cal beneficiaries. The Planning Group assessed PHC's performance against these criteria. The detailed findings are included in Appendix D. A summary of the major findings include:

- Access to Care: The Partnership regional model demonstrated an ability to expand access to primary and specialty care and provide for a continuum of accessible, appropriate care to its members.

- Quality Care: Partnership documented a quality improvement system that works with providers to systematically measure and improve the quality of care, including preventative services, provided to Medi-Cal beneficiaries. PHC programs and systems measure and improve other aspects of care including linguistic and cultural accessibility.

- Provider Reimbursement*:* The Partnership regional model documented improved reimbursement for both primary care and specialty care and support for the outpatient safety net system. Partnership demonstrated the ability to work with all hospitals to provide care in the regions it serves. The Partnership regional model demonstrated willingness to address hospital financial needs, but does not specifically protect small community hospitals.

- Operations: The Partnership regional model documented administrative efficiency and low administrative costs as well as an ability to identify and meet the needs of providers and beneficiaries.

- Governance: The current model requires the cooperation and consensus of a regional board with representatives from all participating counties. The model has shown an ability to meet the goal of regionally directing services to provide quality health services and improve community health.

E. The Planning Group recommends that Sonoma County join Partnership HealthPlan of California provided certain issues can be resolved prior to final actions.

The Planning Group devoted three meetings to articulating the most important issues for Sonoma County with regard to the option of joining PHC. These are summarized in the Group's Letter to the County Director of the Department of Health Services (Appendix E). The Group's key findings are:

- The Planning Group determined that becoming a part of regional managed Medi-Cal plan with Partnership HealthPlan of California (PHC) represents a real opportunity to improve the Medi-Cal program for Sonoma County beneficiaries and health providers alike.

- The Planning Group determined that in the three counties where Partnership now operates, PHC has successfully expanded access to care, improved the quality of care, supported safety net providers and operated a competent and efficient organization. The Planning Group believes that PHC will bring those same desirable attributes to its work in Sonoma County.

- The Planning Group recommended that several key issues be addressed in the second phase of the planning and implementation process. These are:

    - Development of local/regional office and appropriate services in Sonoma county;

    - Agreement on policies for assignment of members to medical homes and on provisions for continuity of care during the transition along with other operational issues;

    - Creation of a local implementation committee to help plan and implement the transition in Sonoma county from fee-for-service Medi-Cal to a Medi-Cal Managed care program;

- Appropriate representation on the PHC Governing Board and committees. Board and committee representation should reflect the proportional size of the Counties participating in the Plan.

- A governance structure that provides Sonoma county provider and community members the on-going opportunity to address local issues and be actively involved in the decision making process.

The Planning Group believes that one of the key success factors in the operation of the County Organized Health System is the involvement and support of the local community. As PHC expands to include Sonoma, Marin, Mendocino and Lake Counties, developing and maintaining this local involvement and support is one of the challenges which must be addressed.

The Partnership HealthPlan has expressed a commitment to discuss and work to resolve all of these issues during the implementation process.

V. Next Steps:

A. Implementation Activities

The Planning Group recommends that the Director of Health Services appoint an implementation and design group to work with Partnership on implementing Managed Medi-Cal in Sonoma County. Membership of the group should include members of the original Planning Group who are willing to remain engaged and should be supplemented by others selected in consultation with Partnership HealthPlan.

This group will be charged with:

- Evaluating the adequacy of rates proposed by the State Department of Health Services
- Assisting Partnership with local system design and implementation planning
- Resolving outstanding issues identified in this report as well as issues that surface during system design and transition
- Reporting progress to the Director of Health Services

B. Timing:

Provided the Board of Supervisors supports Medi-Cal managed care for the county, the State anticipates a start date for PHC in Sonoma in mid-2008. In order for this to occur, PHC would spend 2007 in implementation planning. A key task

which has yet to occur is the evaluation of the amount the State Medi-Cal program will pay the Plan (the rates) and the development of an initial budget. The implementation phase also involves working intensively with local providers, the County Department of Health Services and community organizations representing beneficiaries, on operational issues and plan design features. A top priority will be building an adequate network of physicians and other providers capable of caring for all the Medi-Cal beneficiaries. PHC will meet with and offer contracts to all qualified local providers currently serving Medi-Cal beneficiaries and will attempt to recruit new providers, particularly new specialists.

The Planning Group anticipates that additional reports will be provided to the Board of Supervisors during 2007. Assuming that the rates from the state are sufficient and that the implementation planning process is successful, the Board will be asked to adopt an ordinance authorizing an agreement to join PHC. This ordinance will delineate the number of PHC Governing Board members from Sonoma County and the process whereby they will be appointed by the Board of Supervisors. The County Department of Health Services will continue to provide support and leadership during the implementation planning process.

IV. Conclusion:

The Managed Medi-Cal Planning Group, appointed by the Director of the Department of Health Services has met regularly over the past year to study the best option for providing health services to Medi-Cal beneficiaries in Sonoma County. The Planning Group studied the various models of managed care and determined that the County Organized Health System, of which PHC is one, is an excellent model that optimizes resources for all beneficiaries and particularly those with the greatest needs. The Planning Group finds that joining Partnership HealthPlan is a good option for Sonoma County and will improve the Medi-Cal program for providers and beneficiaries alike.

The Planning Group looked carefully at Partnership HealthPlan and determined that it is a well-run organization with an excellent reputation and many notable accomplishments in regard to access and quality of care. The Planning Group identified issues regarding how best to expand the Health Plan to a large new county such as Sonoma and is pleased that these issues are recognized and that an process for their resolution has been identified.

Becoming part of a regional health plan that is “owned and controlled” by its stakeholders represents a new commitment for Sonoma County. Local residents appointed by the Board of Supervisors to the Plan’s Governing Board will contribute to the continued success of Partnership. Additional providers, beneficiaries and community representatives will volunteer to serve on PHC committees to assure that the organization is fulfilling its mission. In addition, Sonoma County government will need to support the Health Plan by helping to

secure continued financial and policy support for managed care system improvements from the State.

During 2007 the Health Plan and the local community will work closely to plan for implementation of Medi-Cal managed care in 2008. The Department of Health Services will continue to support this process and will provide regular progress reports to the Sonoma County Board of Supervisors, which is responsible for local approval of the expansion plan to Sonoma County.

Appendix A: Medi-Cal Managed Care Planning Group Membership
Appendix B: Medi-Cal Data for Sonoma County
Appendix C: Medi-Cal Managed Care Models, Context Considerations
Appendix D: Criteria for an Improved Medi-Cal Program, PHC Evaluation
Appendix E: Planning Group Letter with Recommendations to the County Director of the Health Services Department

Managed Care Planning Group Members Matrix

Member Name **Title**	**Organization or Group Represented**
County Government	**4 members**
Barbara Graves Director, Planning and Prevention	County Department of Health Services
Mary Maddux-González, MD, Health Officer	Public Health Division, Department of Health Services
Robin Schaef, Division Director, Adult and Aging Services	Area Agency on Aging, County Human Services Dept.
Linda Kalenik - Division Director, Economic Assistance	Economic Assistance, County Human Services Dept.
Health Care Providers	**13 members**
Sean Gaskie Director, Special Projects	Primary Care Physicians Sonoma County Medical Society
Kirk Pappas, MD	Specialty Care Physicians Sonoma County Medical Society
Kelly Pfeifer Medical Director	Clinic Physicians Sonoma County Medical Society
Don Ransom Director, Managed Care	Sutter Medical Foundation – North Bay
James Vaughn Controller	Sutter Medical Center of Santa Rosa
Mich Riccioni CFO	St. Joseph's Health Systems Sonoma County
Dianna Ball	Kaiser Permanente Santa Rosa
Naomi Fuchs Treasurer, Board of Directors	Palm Drive Hospital
Jim Mc Sweeney CFO	Sonoma Valley Hospital
Jack Neureuter CEO @ AMC	Healdsburg General Hospital
Nancy Oswald Executive Director	Redwood Community Health Coalition
Mary Szecsey Executive Director	Community Health Centers

Paul Duranczyk	Creekside Convalescent Hospital
Representatives of Beneficiary	**6 members from community organizations**
Christine Tschummi	Represents seniors w Medi-Cal
Madrone Williams	Represents pregnant women and families w Medi-Cal
Michael Humphrey	Represents people w disabilities w Medi-Cal
Ann McGee	Represents children w Medi-Cal
Damon Doss	Represents Medi-Cal beneficiaries at large
Joann Froess	Represents Medi-Cal beneficiaries at large

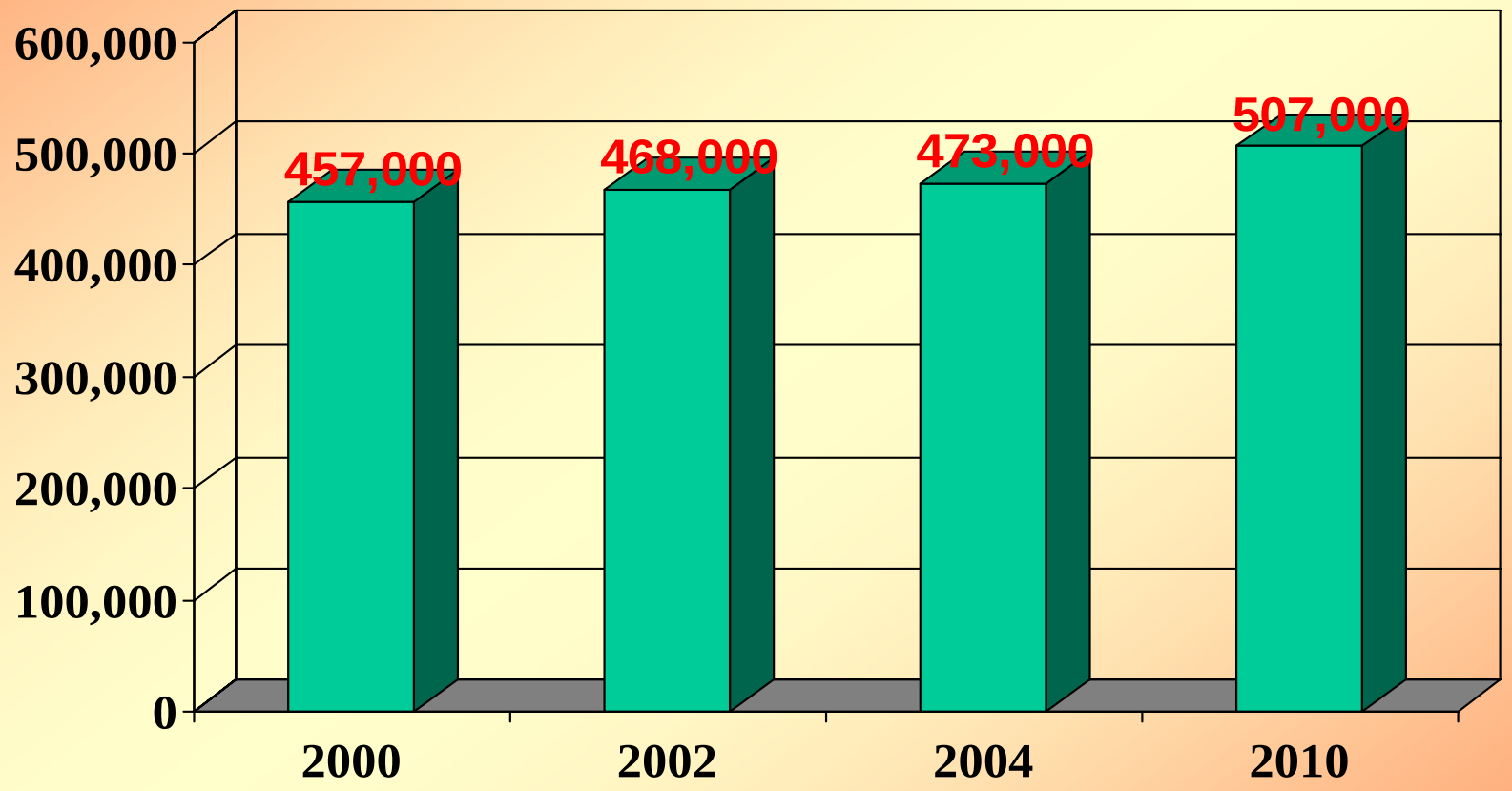
Sonoma County
Managed Medi-Cal Planning Group

Medi-Cal Data & Trends In Sonoma County

March 3, 2006

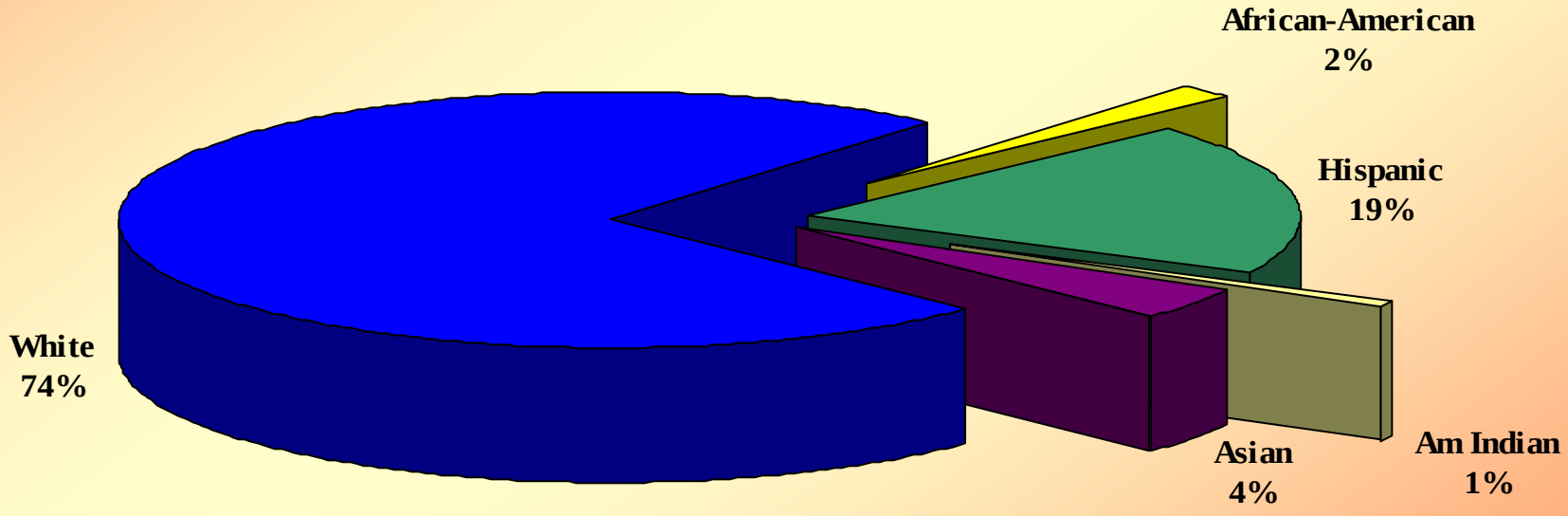
Sonoma County Population

Population expected to grow 1.2% Annually



Source: State of California, Department of Finance

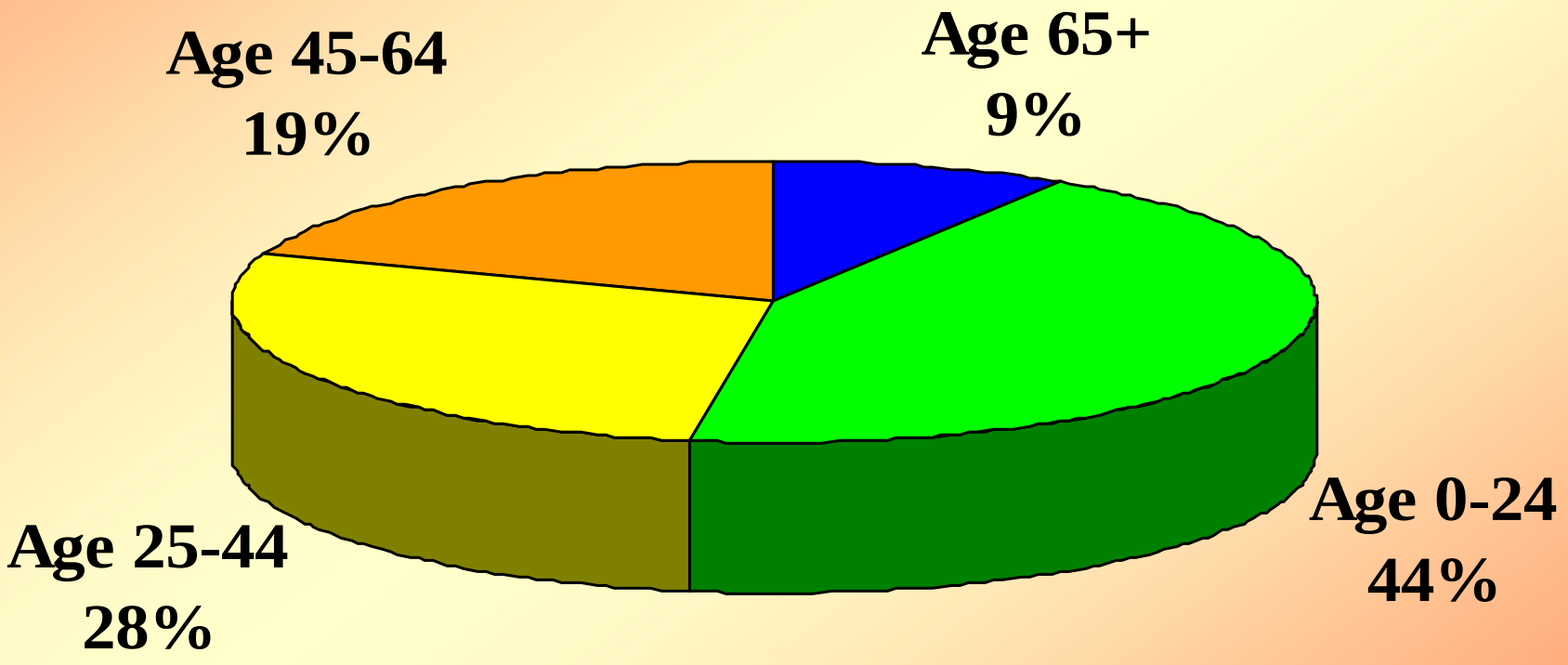
Sonoma County Population, Ethnicity 2004



Source: Sonoma County Economic and Demographic Profile

Sonoma County Individuals Below Federal Poverty Guidelines By Age

Total – 36,362 (8.1% of Population)

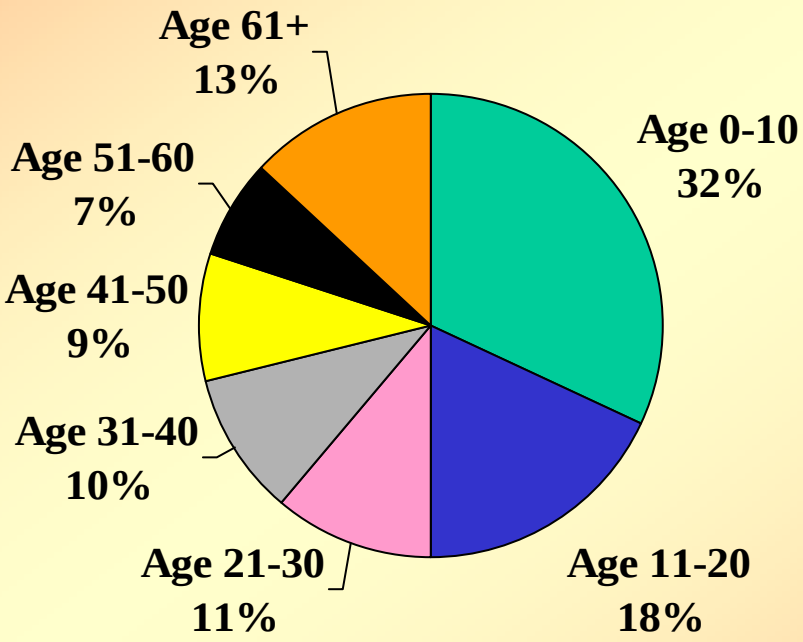


Source: U.S. Census 2000

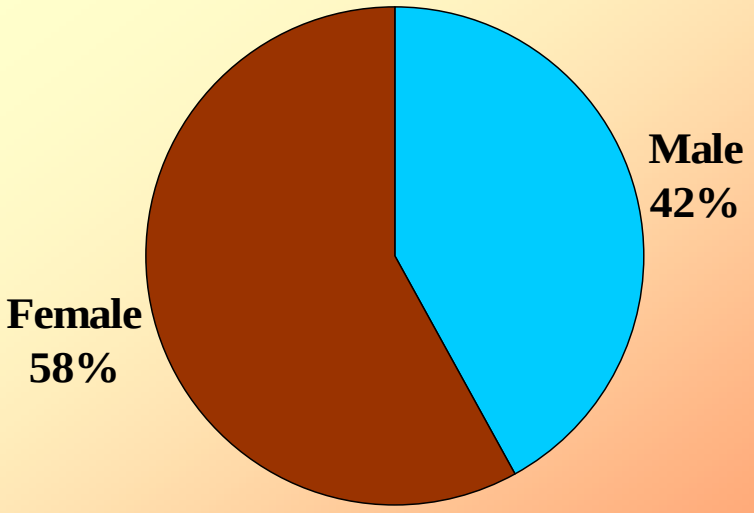
Medi-Cal Beneficiaries

People who are certified as eligible for Medi-Cal,
Sonoma County
Total: 46,838

By Age

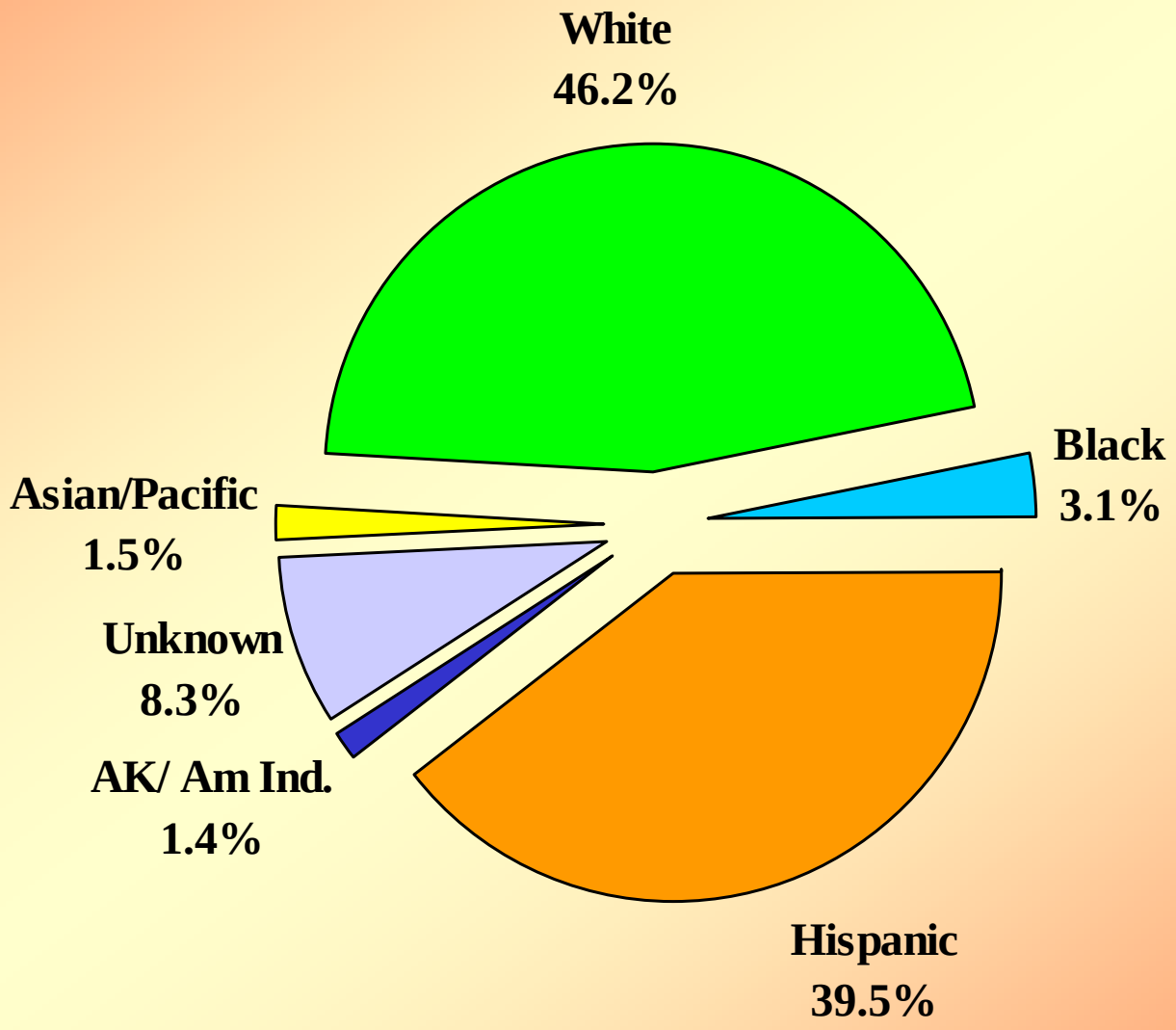


By Gender



Source: California DHS 2005

Sonoma CountyMedi-Cal Beneficiaries By Race/Ethnicity



Source: California DHS 2005

Sonoma County Medi-Cal Utilization, 2004

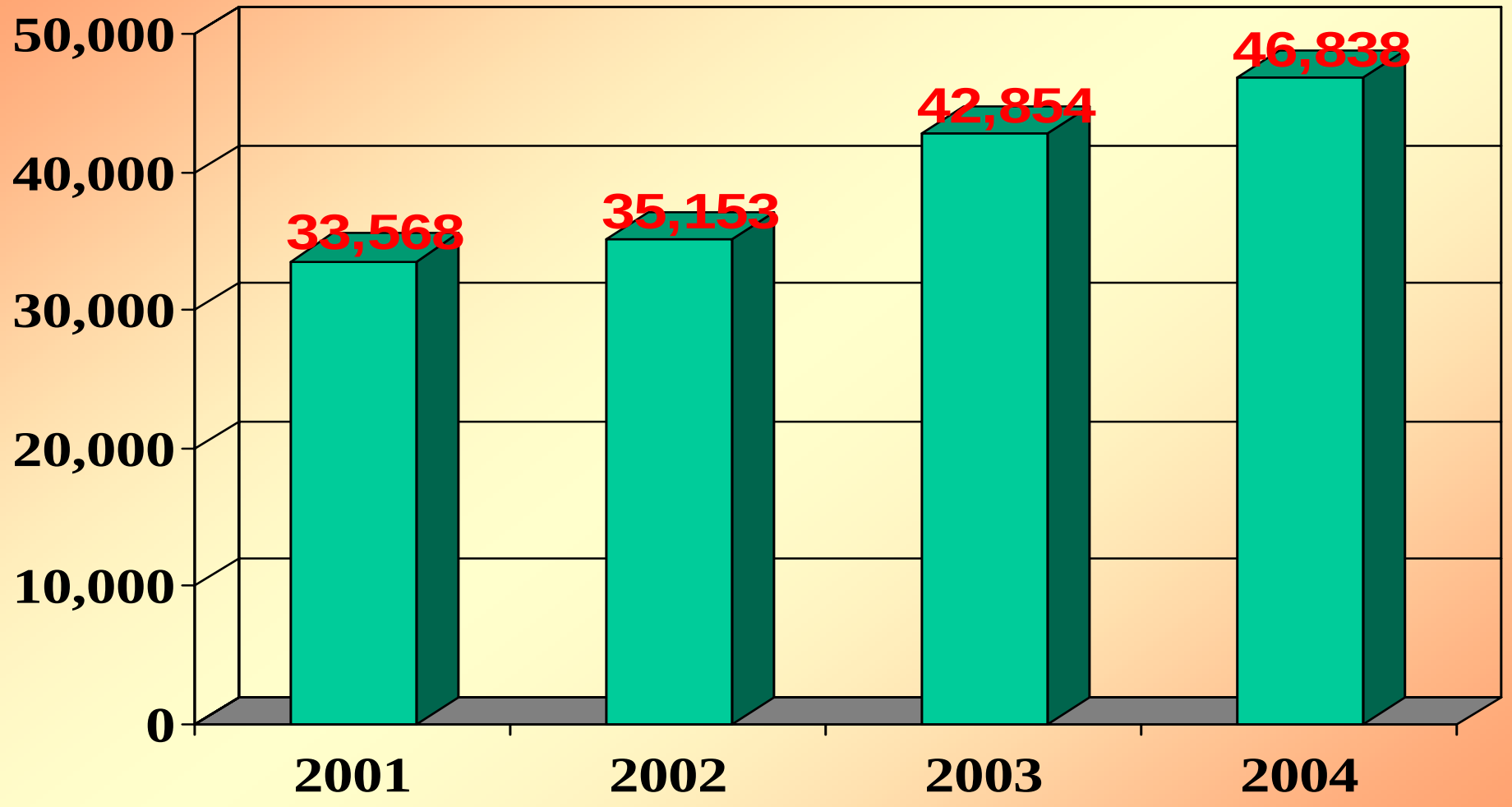
Total Beneficiaries	46,838
Total Users	25,716

54.9% of Medi-Cal beneficiaries utilized services in 2004.

Definitions: Beneficiary – Certified eligible
User – Utilized services

Source: California DHS 2004

Sonoma County
Medi-Cal Beneficiary Trend



Source: Sonoma County Economic and Data Profile

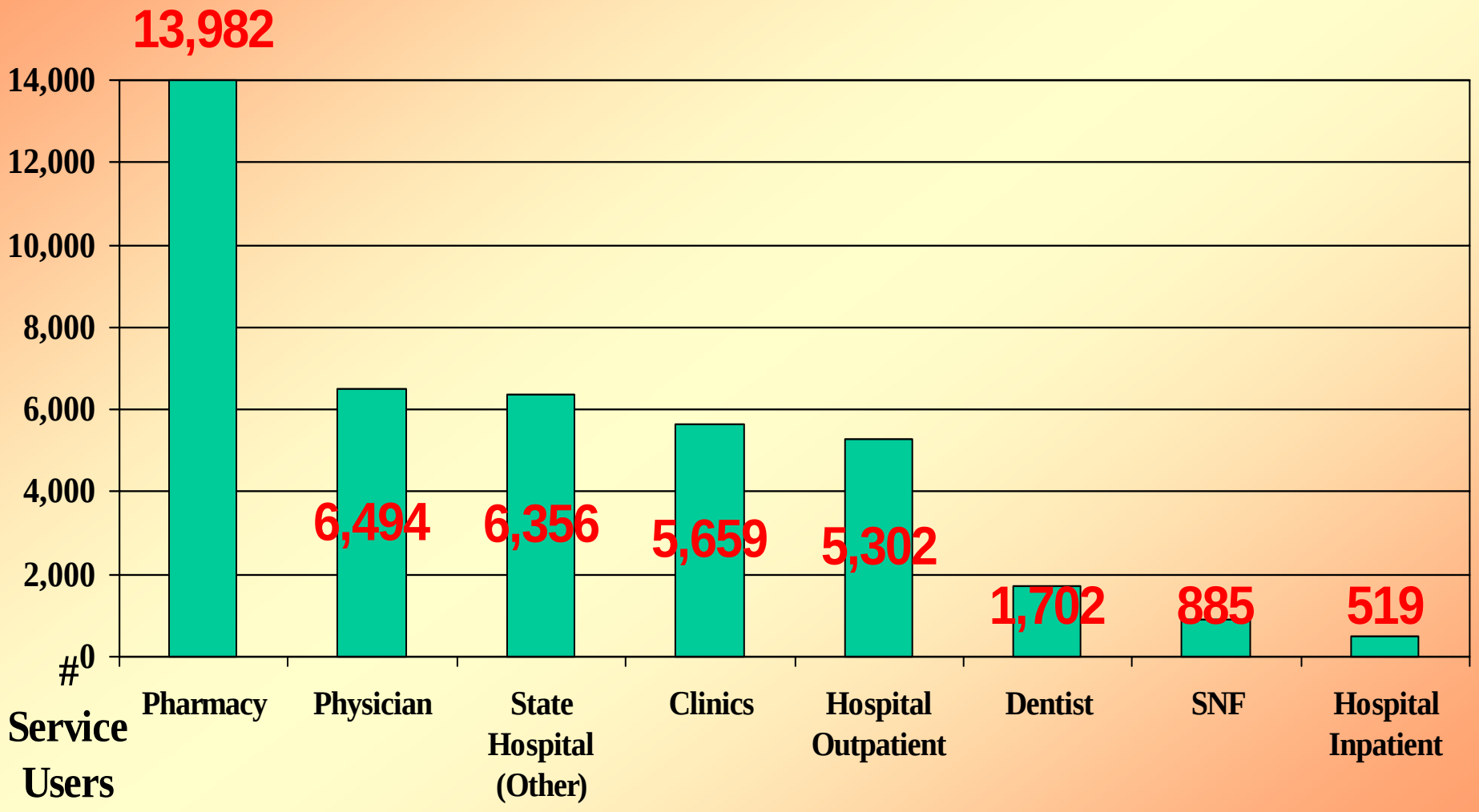
Sonoma County
Medi-Cal/Medicare

- Of the 46,838 total Medi-Cal Beneficiaries, 9,041 receive Medicare

- 14,582 Medi-Cal Beneficiaries are Blind, Disabled or Long-Term Care – 5,249 are over 65

Source: California DHS 2005

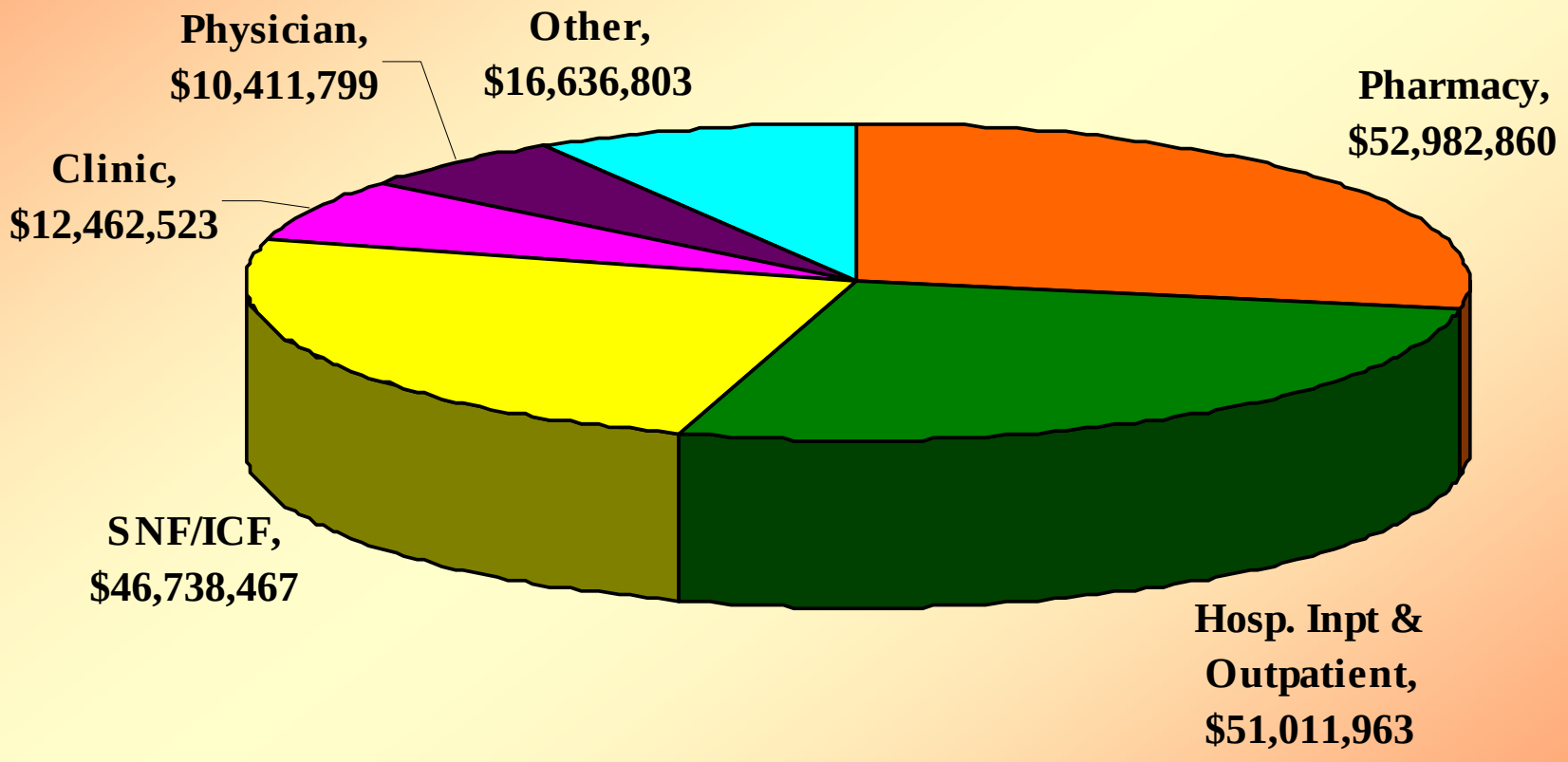
Sonoma County Medi-Cal
Average Monthly Users By Service



Source: California DHS 2004

Medi-Cal Expenditures in SonomaCounty 2004

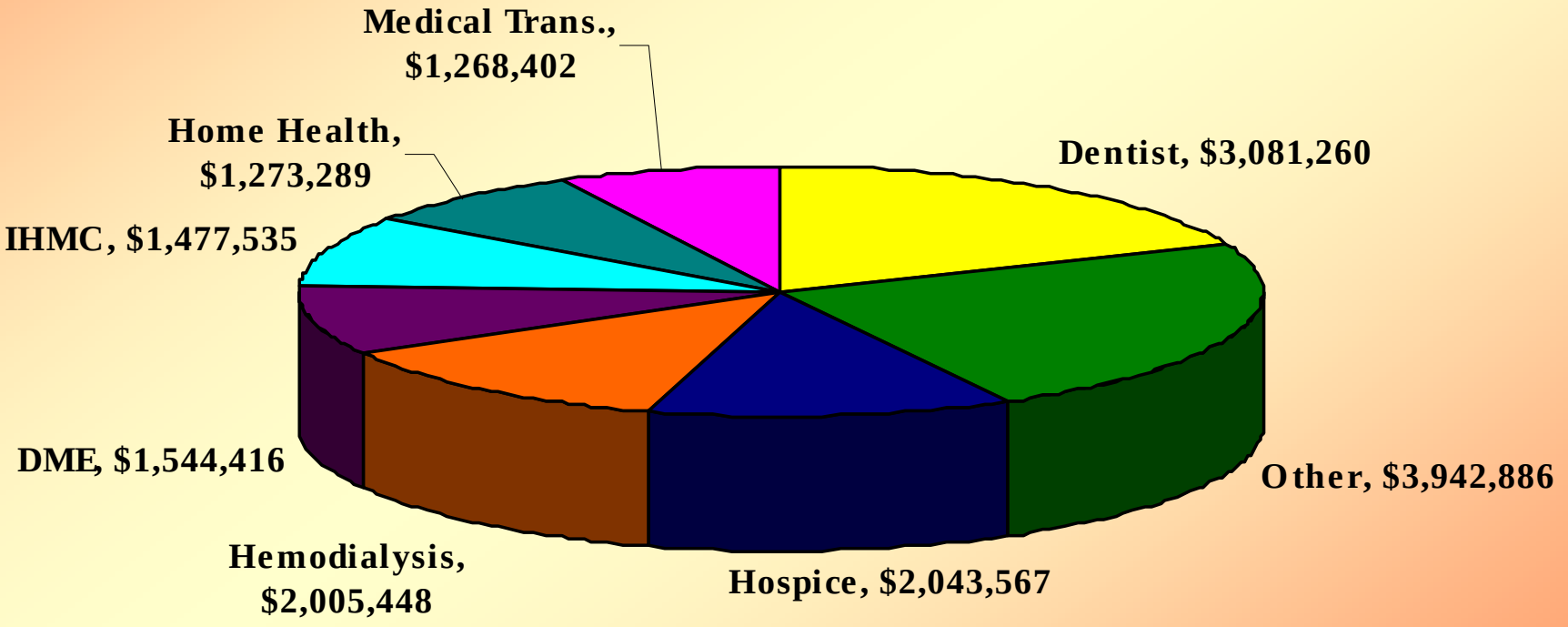
Total - $190,244,415



Source: California DHS 2004

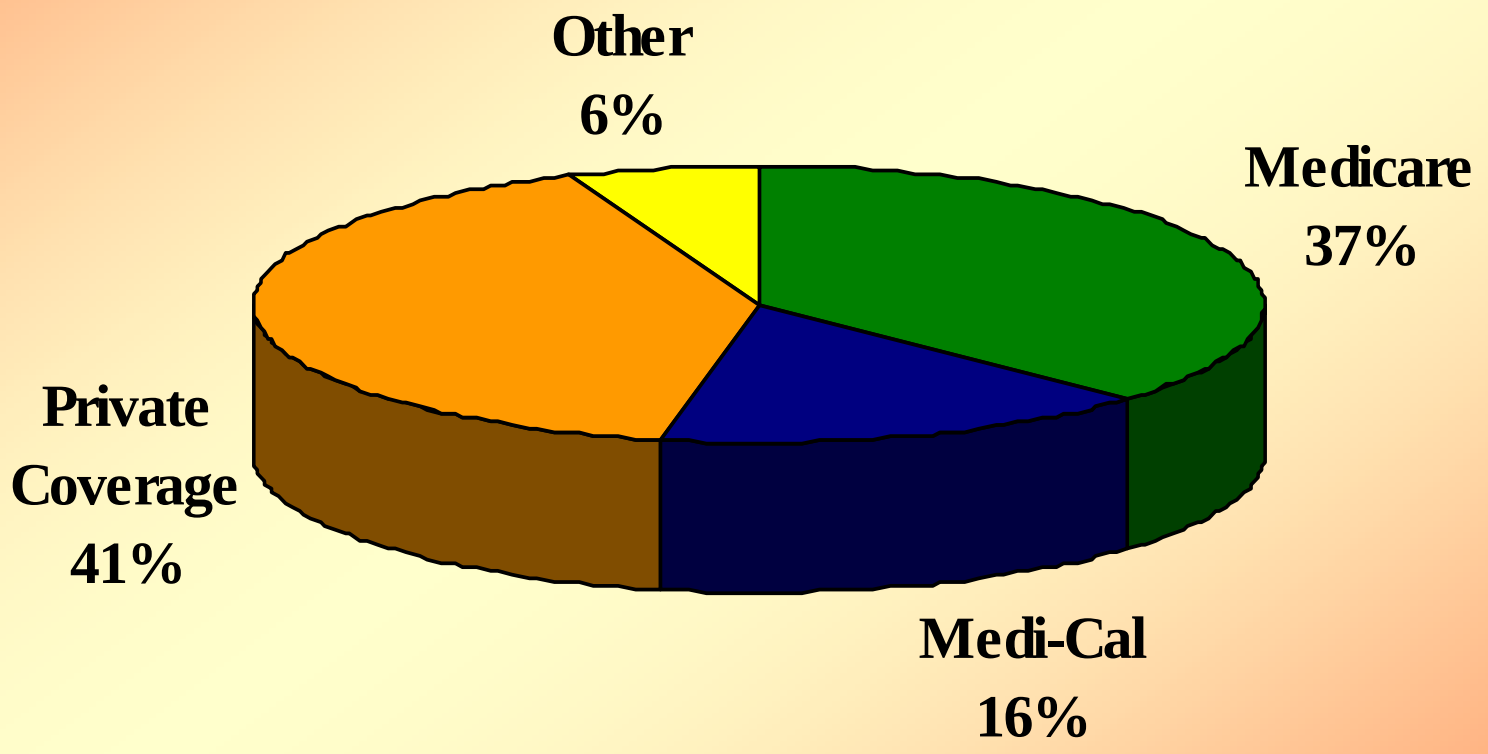
Medi-Cal Expenditures in Sonoma County 2004

Detail for Other Providers - Total $16,636,803



Source: California DHS 2004

Sonoma County Acute Hospital Discharges by Payor - CY 2003 - Total 42,488



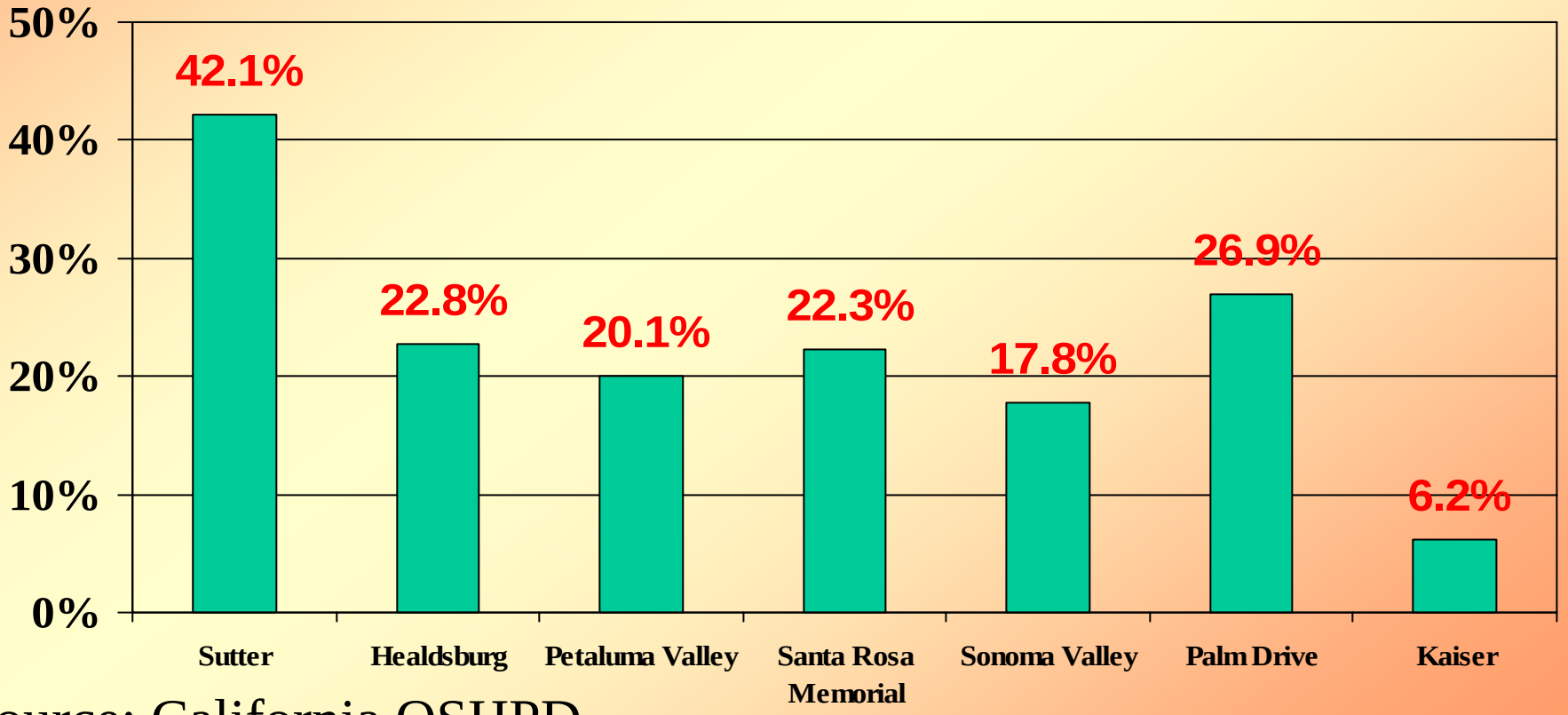
Source: California OSHPD 2003

Sonoma County Medi-Cal Emergency Room Utilization

Jan – Mar 2005

- Medi-Cal accounts for 24.1% of all Emergency Room encounters in Sonoma County Hospitals

Percent by Hospital



Source: California OSHPD

Appendix C: Medi-Cal Managed Care Models Context Considerations

Medi-Cal Managed Care Models: Context Considerations

Sonoma Managed Care Planning Group,
Prepared and presented by Elinor Hall, March 24, 2006

1. The option to remain a Fee-for-Service County

- The State Medi-Cal Redesign Plan as approved by the Legislature calls for Sonoma County to join the PHC County Organized Health System Plan. DHS has said that it will work with the Counties regarding their preferred managed care models, but some model of managed care will be selected and implemented in the expansion counties.
- It is not possible to implement a COHS expansion without County Board support since the Board must adopt a local statute and appoint representatives to the Governing Board. PHC has said it will not expand into a County that is opposed.
- Similarly the Two-Plan Model requires the County Board of Supervisors to oversee the formation of the Local Initiative and appoint Initiative Board members.
- The State has legislative authority to implement Geographic Managed Care (covering CalWORKS beneficiaries only) in a county or region without support from County government. In order to implement GMC, the State would request proposals and select two or more competing commercial plans to serve the Medi-Cal population. The commercial plans would need an adequate provider network in order to meet State requirements.
- Bottom line: The State could attempt to implement the GMC model of Medi-Cal Managed Care without County Government support. GMC feasibility would depend upon the interest of commercial plans (including potentially, Blue Cross, Health Net, Kaiser, etc.) and the willingness of providers to contract with them.

2. Optimal Size for an At-Risk Health Plan

- Commercial Plans (in either GMC or Two-Plan counties) spread costs over multiple counties and over multiple lines of business (i.e. non-Medi-Cal enrollees). Commercial Plans are thus less impacted by the size of the beneficiary population in a particular county than are Local Initiatives and COHS Plans.
- A Two-Plan Local Initiative, or an independent COHS Plan, must have enough members to spread administrative costs efficiently and to have a viable “risk pool.” Smaller Plans spend a higher percent of their revenues on administration and have higher risks of financial instability.
- There is no regulation or hard and fast rule regarding the minimum sized Medi-Cal Plan. However a “rule of thumb” suggests that an independent Plan should be at least 25,000 members; 40-60,000 member plans are more likely to thrive.

- DHS does not believe that a new COHS or LI can be successful with fewer than 40,000 members. This is based on budgetary considerations including estimated start-up costs for a new Plan of $3-5 million and on-going operational costs of $5-$10 million annually.
- The smallest Local Initiative is the San Francisco Health Plan with 29,000 members. The next smallest is the Contra Costa Health Plan with 41,000 members.
- San Mateo is the smallest COHS with 46,000 members; the next smallest is Santa Barbara with 51,000.

3. Size of Sonoma's Medi-Cal population

- Sonoma County has approximately 47,000 Medi-Cal beneficiaries during any given month.
- Statewide, an average of 53% of all Medi-Cal beneficiaries enroll in the GMC or Two-Plan plans in counties with those options. In COHS Counties, 87% of beneficiaries enroll in the COHS Plan.
- If Sonoma became a Two-Plan County, it could anticipate a total of 25,000 managed care enrollees (53% of the 47,000 Medi-Cal beneficiaries). The Local Initiative and a Commercial Plan would compete for enrollees. Based on proportionate enrollment rates in the other Two-Plan Counties, a Local Initiative could expect to enroll 60 to 80% of managed care participants. This would result in a Local Initiative with between 15,000 and 20,000 enrollees (60-80% of 25,000).
- Bottom Line on size for Two-Plan Model: Sonoma's population of beneficiaries is too small for the creation of a single county Two-Plan model. It might be possible to create a regional Two-Plan model that covered more than one county, though neighboring counties may not have the population or medical practice patterns to make this feasible.
- If Sonoma became an independent single county COHS, it would have approximately 41,000 members (based on 87% of 47,000 beneficiaries).
- Bottom Line on size for COHS: Sonoma's total Medi-Cal beneficiary population could potentially support a stand alone COHS Plan, though it would be the smallest of the existing COHS Plans. Sonoma could potentially seek to be a regional COHS to increase the size of its population.

(Data on size of existing Managed Care Plans and enrollment is from the Interim MANAGED CARE ANNUAL STATISTICAL REPORT, published by the CA DHS, August 2004)

4. Federal Restrictions on the number, size of COHS Plans

- California has a Federal Waiver allowing up to five COHS Plans covering up to 14% of Medi-Cal beneficiaries statewide. The five existing COHS Plans cover 8% of total Medi-Cal beneficiaries, or 560,000 enrollees.
- An additional 372,000 beneficiaries could be enrolled in existing COHS Plans before hitting the 14% cap (which is 928,000 of the total 6.7m Medi-Cal enrollees). Sonoma, Marin, Mendocino, San Benito, Merced and Ventura Counties could all join an existing COHS Plan without exceeding the cap.

- New COHS Plans can not be created without an amendment to the federal legislation that authorized the original CMS waiver. The State was hoping to secure such legislation as part of the Budget Reconciliation act in January 2006.
- The proposed language would have doubled the number of allowed COHS Plans to ten and would have permitted enrollment of up to 24% of Medi-Cal beneficiaries.
- The hoped-for legislation was never voted on. Merced and Ventura, which have asked to become COHS counties, plan to propose such legislation and anticipate State support. They and the State would like the support of other Counties and their Congressional representatives.
- Bottom Line for a new COHS: Federal legislation would be required before Sonoma County could become a new COHS, either as a stand-alone Plan or as a regional COHS Plan. The prospects for this legislation are uncertain.
- Bottom Line on an existing COHS: Sonoma could join Partnership Health Plan of California without additional federal Legislation. A routine amendment to the Medi-Cal waiver creating COHS Plans would be required to add new counties to an existing COHS.

Grid of Medi-Cal Managed Care Models

Traits	**PLAN TYPES**			
	Fee-for-Service	**Geographic Managed Care GMC**	**Two-Plan Model**	**County Organized Health System COHS**
General Description	Enrolled providers bill DHS for services, payment based on rate schedule and/or negotiated hospital per diems.	Commercial Plans meeting State criteria authorized to operate regionally. At-risk contract w State, plans contract w provider network or sub-contract w other Plans, IPAs	Co. Board creates a Local Initiative Plan; One commercial plan is selected by DHS via RFP. Plans compete for enrollees, providers. Contract w IPAs other plans	County forms a new governmental authority that manages all Medi-Cal services for all beneficiaries; no marketing, no competition, no choice. Use direct contracting more frequently.
Administration	Administered by DHS State staff do pre-authorizations, set rates, enroll providers.	Separate commercial plans administer managed care pursuant to their contracts with DHS Nationally CPs spent 9-10% for Medi-Cal Admin in 2001. In CA commercial plans spent 10-15% on admin.	Local Initiative administered by non-profit board appointed by B of S. Commercial Plan administered privately, see GMC info	Administered by a Board of providers, consumers and the public, appointed by the Board of Supervisors. In 2001 COHS Plans spent under 7% on administration
Risk	Risk held by State/feds Costs constrained by eligibility, rates and benefits	Risk held by commercial plans, may be shared with providers. Confidential rates negotiated by CMAC	Risk held by LI and CP, shared w providers. Much sub-contracting w other plans. Rates set by DHS (higher for LI)	At-risk contract, confidential rates negotiated by CMAC (except Santa Barbara). Risk shared with providers; minimal sub-contracting to other plans except for CalOptima

	Fee-for-Service	Geographic Managed Care	Two-Plan Model	County Organized Health System
Enrollees	All Medi-Cal beneficiaries who are not enrolled in managed care are in FFS.	Families, Children, pregnant women must enroll in GMC Plans 53% of beneficiaries join Plans in GMC counties	Families, Children, pregnant women must enroll 53% of beneficiaries join Plans in Two-Plan counties	Families, Children, pregnant women, plus seniors, aged, blind disabled- 87% of beneficiaries join Plans in COHS counties
Benefits	Mental Health, Alcohol and drug, CCS, home and community based services are part of MC but managed separately by the State and the Counties	Mental Health, Alcohol and drug, CCS, optometry, dental home and community based services, CHDP, long-term care are carved out of GMC plans. Benefits are available FFS or through other County managed systems.	Same as GMC	Same as GMC except: • CCS is included in PHC, • MH included in PHC-Solano. L • long- term care included except San Mateo. • CHDP included only in PHC. Most plans cover chiropractic, acupuncture
Regulation	State DHS, contractors oversee FFS	Mandatory Knox- Keene certification by DMHC	Mandatory Knox- Keene certification by DMHC	Knox-Keene exempt, but all COHS Plans are now certified
Consumer Satisfaction	No routine measurement of satisfaction. Very limited to no assistance to individuals, no provider directory	Consumer Assessment of Health Plan Survey (CAHPS)performed every 2 years Every beneficiary has a medical home, receives benefit and provider materials and has access to assistance and the grievance process	CAHPS survey performed every 2 yrs Every beneficiary has a medical home, receives benefit and provider materials and has access to assistance and the grievance process	CAHPS survey performed every 2 years Every beneficiary has a medical home, receives benefit and provider materials and has access to assistance and the grievance process
Provider Participation	57% of physicians are enrolled in Medi-Cal FFS statewide. Provider enrollment back log is lengthy	Data on physician participation not available. Plans enroll providers using higher standards than M/C	Data on physician participation not available. Plans enroll providers using higher standards than M/C	COHS Plans report 90% of providers participating. Plans enroll providers using higher standards than M/C
Provider rates	Low rates: 35-60% of commercial PPO rates. Payments per unit of service (an encounter, a day, a procedure)	Plans have flexibility to pay higher rates –detailed data not available Use of capitation and FFS	Plans have flexibility to pay higher rates –detailed data not available Use of capitation and FFS	Plans pay specialists 20-50% above M/C Use of capitation and FFS
Quality Measures	No routine, systematic measurement	HEDIS measurements and reporting	HEDIS measurements and reporting	HEDIS measurements and reporting
Governance	DHS oversees systems	Commercial Plans are private for- profit corporations (except non-profit Kaiser) Plans set policies, rates, etc. within State parameters	LI: non-profit governed by County- appointed Board, local committees. CP: Same as GMC - Plans set policies, rates within State parameters	COHS is a governmental entity, governed by a County-appointed Board with locally staffed committees Plans set policies, rates, within State parameters

Findings regarding the Sonoma County Criteria For an Improved Medi-Cal System—

Summary Criteria: The Medi-Cal system provides access to a continuum of high-quality services supported by fair reimbursement rates to providers. System operations are efficient and responsive and system governance is publicly accountable and invests its resources wisely.

1. ACCESS TO CARE CRITERIA: The Medi-Cal system offers a continuum of necessary and appropriate healthcare services that are culturally and geographically and physically accessible to all Medi-Cal beneficiaries.

- **Expands benefits for Medi-Cal enrollees**
  - Finding: The Partnership regional model allows for expansion of benefits. The model has demonstrated expanded benefits including health education, case management and some transportation. Pregnant members participate in the "Growing Together" program that includes preventive care incentives and expanded drug and alcohol services.
- **Improves access to primary and specialty physicians and adequate supply of physicians**
  - Finding: Partnership meets State requirements for an adequate network of participating primary and specialty care physicians. However, access to specialty care remains a challenge in all Partnership Counties. Unlike fee-for service (FFS) Medi-Cal, the State requires that appointments for primary care and specialty are available within specific timeframes.
- **Develops and maintains an adequate supply of ancillary providers that meet the needs of the population**
  - Finding: Partnership has demonstrated the ability to provide a network of ancillary providers to meet beneficiaries' needs.
- **Improves access and benefits for dental care:**
  - Finding: No Medi-Cal managed care plan in California includes dental care. The Partnership regional model does not meet this criterion. Partnership does however provide information to beneficiaries on which dentists are taking new Medi-Cal patients and coordinates services with Denti-Cal.
- **Provides community based alternatives to SNF care**
  - Finding: The Partnership regional model does not currently provide community-based alternatives to SNFs. If Partnership becomes a Medicare HMO for dual eligibles, it will have more opportunity and incentive to do this.
- **Provides timely access to the appropriate level of care**
  - Findings: Partnership is required by the State to assure timely access to medical services. Partnership policies require that an urgent primary care appointment be available within 24 hours and a non-emergent, preventative care visit within 14 days.
- **Includes provisions for clients with special needs – provides support to beneficiaries**
  - Finding: Partnership provides a Member Services Department to assist clients in accessing needed care and resolving problems. Special programs for pregnant members and members with chronic conditions provide additional support for beneficiaries. Partnership previously participated in a best practices project for children with special needs to develop improved systems for these members.
- **Provides adequate transportation to all levels of care**
  - Finding: Partnership currently provides taxi transportation coverage for some pregnant members and some members with chronic disease who have no other transportation alternatives. Partnership does not finance transportation for all members for all services.

1. *Summary*: The Partnership regional model has demonstrated an ability to expand access to primary and specialty care and provide for a continuum of accessible, appropriate care to its members. The Partnership regional model meets the criteria.

2. QUALITY CARE: The Medi-Cal system promotes and demonstrates high-quality care that is compassionate, culturally competent, prevention-focused and client-centered.

- **Addresses service planning for key population and health trends**
  - Finding: Partnership works collaboratively with local health improvement initiatives (such as the Solano Coalition for Better Health) to initiate strategies and specific quality initiatives that improve health outcomes. The Partnership Quality Assurance program also identifies and addresses some key community health needs.
- **Provides financial incentives for quality care or value-added services**
  - Finding: Partnership rewards primary care providers by distributing a significant percentage of the PCP risk pool dependent on how well the providers meet four quality measures.
- **Provides compassionate care and culturally competent care**
  - Finding: The Partnership Member Services department performs a regular needs assessment survey of providers and beneficiaries regarding linguistic and culturally appropriate services. The State Department of Managed Care ranks Partnership as "High" in the category of cultural and linguistic competence.
- **Defines and measures quality criteria and achieves high member and provider satisfaction**
  - Finding: Partnership has a quality improvement program that measures and reports HEDIS data. The quality improvement program supports process and outcome improvements for beneficiaries. Member satisfaction is measured every two years by a statewide contractor. Member satisfaction survey scores show 83% express overall satisfaction with health plan and 86% overall satisfaction with health care. Physicians report high satisfaction with Partnership. (97% - 99% per internal survey)
- **Provides case management for critically ill and enrollees with chronic diseases care**
  - Finding: Partnership provides case management for members with diabetes, asthma, renal care and congestive heart failure.
- **Increases preventative aspects of care**
  - Finding: Partnership measures and rewards the provision of preventive services including child and adult immunizations, cancer screening, lead screening, etc. Partnership requires the selection or designation of a medical home and a medical assessment. Infant and children's preventive services under CHDP (Child Health and Disability Prevention) are reimbursed on a fee-for-services basis, providing an incentive for providers to deliver and report these services.
- **Fosters education, communication and coordination and among providers**
  - Findings: The Partnership Physicians and Providers Advisory Committees increase communication and coordination among providers and the Health Plan. Provider Relations representatives visit each primary care provider's office every month and visit high volume specialty providers five times a year. Partnership sponsors periodic focus groups for providers.
- **Educates consumer about appropriate use of services - materials understandable and available**
  - Finding: Partnership mails member newsletters in English, Spanish and Russian quarterly to each member household with information about health services, prevention and self-care. Each new member receives a welcome call from the Plan with information on how to contact Member Services, select a medical home, etc. Partnership also provides educational materials on specific conditions and benefits in a number of languages at appropriate literacy level and makes information available through a web site.
- **Integrates educational and mental/behavioral health services with medical services**
  - Finding: Partnership develops and periodically updates MOUs with the County Behavioral Health programs (Mental Health and Drug and Alcohol) that address the division of responsibilities and coordination of care for individuals using both systems.

2. *Summary:* Partnership works with providers to systematically measure and improve the quality of care provided to Medi-Cal beneficiaries, including preventive services. PHC has programs and systems to measure and improve other aspects of care including linguistic and cultural accessibility. The Partnership regional model meets this criteria.

3. PROVIDER REIMBURSEMENT: Medi-Cal system reimbursement is fair to providers and preserves the health care safety net. Providers share equitably in caring for beneficiaries.

- **Preserves safety net providers and viability of small community hospitals**
  - Finding: PHC's incentive payments to safety net providers, including FQHCs, have increased their total reimbursements compared to Medi-Cal FFS. PHC employs a consistent payment methodology for all hospitals, adjusted for services mix. Managed care has resulted in a reduction in emergency room visits and often a reduction in total hospital days.

- **Encourages all hospitals care for a fair share of Medi-Cal enrollees**
  - Finding: Partnership currently contracts with all hospitals in its region; it does not selectively contract nor establish volume requirements.

- **Enhances choice of providers for beneficiaries**
  - Finding: Over 90% of the available primary care providers participate in Partnership Health Plan. Members are required to select (or are assigned) a primary care provider that may be changed as often as monthly.

- **Provides fair rates to hospitals, physicians and other providers**
  - Finding: PHC rates for physicians are substantially better than Medi-Cal FFS rates. Last year primary care physicians received 275% - 300% of Medi-Cal (capitation plus incentives) and specialty care physicians received on average, 90% of Medicare rates. Medi-Cal FFS rates for physicians are roughly 60%of Medicare rates. Hospitals in Partnership regional model counties receive payments equal to or better than Medi-Cal. SNFs are paid at Medi-Cal rates.

- **Provides physician rates that allow for successful recruitment and retention of physicians**
  - Finding: Partnership has demonstrated a track record of paying physicians at higher rates than the FFS system. Physicians working with Partnership report high satisfaction. (97% - 99% per internal survey)

3. *Summary:* The Partnership regional model provides improved reimbursement for primary care and specialists and supports the outpatient safety net system. Partnership has demonstrated the ability to work with all hospitals to provide care in the regions it serves. The Partnership regional model has demonstrated willingness to address hospital needs, but does not specifically protect small community hospitals. The Partnership regional model substantially meets this criteria.

4. OPERATIONS: Medi-Cal system operations are efficient, cost-effective and responsive to providers and beneficiaries.

- **Includes a competent administrative partner/efficient claims payment**
  - Finding: Partnership has developed efficient business systems and utilizes information technology to automate and streamline many administrative functions. Partnership currently pays claims on average in 14 days, which is significantly better than FFS Medi-Cal. Provider services representatives are available to address claims payment problems. Partnership has developed and refined systems over a twelve year period. Administrative costs in the Partnership regional model are among the lowest in the state.
- **Aligns and supports system providers to improve quality, measure outcome data and apply consistent practice protocols**
  - Finding: Partnership utilizes a Physicians Advisory Committee to develop clinical practice guidelines for treatment of asthma, type II diabetes, clinical depression in adults, kidney disease and ADHD. These guidelines improve quality of care for members and other patients receiving services in the practice. Partnership currently provides incentive payment to physicians based on meeting quality standards.
- **Provides administrative efficiencies with ease of use and problem resolution for enrollees and providers.**
  - Findings: The Partnership regional model provides a member services and provider services function for information and problem solving. The provider services department handles 350 calls per day.
- **Integrates medical care with other programs and streamlines eligibility process**
  - Findings: Partnership has demonstrated the ability to coordinate services with California Children's Services (CCS), the Comprehensive Perinatal Services Program (CPSP), the Children's Health and Disability Prevention Program (CHDP), and County Mental Health and Substance Abuse Services. Eligibility for Medi-Cal continues to be managed by County Human Services Departments and is not the responsibility of Partnership Health Plan. Partnership Member Services provides assistance to beneficiaries who request help with an eligibility issue. Partnership currently pays community-based organizations for enrollment of members above a routine baseline level.
- **Integrates and improves provider care and communication**
  - Findings: The Partnership regional model staffs member services and provider services departments to improve care and communication. The model also includes various committees which facilitate communication between providers and administrators. Committees include: Consumer Advisory Committee, Physicians Advisory Committee, Provider Advisory Group, Quality and Utilization Committee, and Pharmacy and Therapeutics Committee.
- **Monitors and reports on key quality, utilization and financial factors**
  - Findings: Partnership monitors and reports on key quality, utilization and financial measures and shares this information with providers and members participating in Plan governance. Reports are also available to the general public and an annual report is issued and widely distributed.
- **Funds from State should include costs of administration**
  - Findings: The State assumes a level of savings for the Med-Cal program based upon the initiation of managed care. The projected savings may include an anticipated reduction in the State's administrative costs, however, this information is not publicly disclosed. Partnership does not have control over how the State establishes Medi-Cal rates.
- **Provides streamlined credentialing for providers**
  - Findings: PHC credentials providers into the Health Plan based on NCQA standards which are more comprehensive than the Medi-Cal standards. The Plan works to make this process as simple as possible for the provider. Most providers are credentialed within 30 to 60 days. All providers must also be credentialed by the State, but participation in PHC can begin before the State process is completed.

4. *Summary:* The Partnership regional model demonstrates efficiency and an ability to identify and meet the needs of providers and beneficiaries. The Partnership regional model meets this criteria.

5. GOVERANCE: Medi-Cal system governance is locally accountable and earns community support. Resources are locally directed to provide high quality health services and improve community health.

- **Includes a system that is transparent/publicly accountable**
  - Finding: Partnership Health Plan is a public entity that is governed by providers, beneficiaries and members of the public. All meetings, materials and reports (with the exception of quality assurance and personnel actions) are public. Partnership is regulated by the State Department of Health Services and the State Department of Managed Health Car. Both departments have an extensive set of requirements that must be met.
- **Fosters system integrity – providers "feel good" about participating**
  - Findings: Partnership has demonstrated an ability to maintain a large network of providers in a three County region for a number of years. Internal surveys of physicians show overall satisfaction with Partnership at 97%-99%.
- **Reflects the community values of Sonoma County**
  - Findings: Partnership is a regional health plan with consistent policies and practices across the participating counties. Sonoma residents, officials and providers will have the opportunity to participate in the creation of those policies in the future but will not establish them unilaterally.
- **Provides the ability to redesign benefits and reimburse providers for innovative care practices (group visits, nutrition etc).**
  - Findings: The Partnership regional model has flexibility with benefit design and reimbursement (as opposed to the Medi-Cal FFS system which does not). Decisions regarding benefit redesign and reimbursement of providers will generally require regional consensus and approval.
- **Provides that uses of funds and savings are locally determined**
  - Finding: The regional nature of the Partnership model means Sonoma County would have input but not control over how funds are spent and savings are used. The policies that establish the use of savings are regionally developed.
- **Includes flexibility to shift funds and services to care for current or expanded populations**
  - Finding: The Partnership regional model has flexibility in utilizing funds to best meet the needs of enrolled Medi-Cal beneficiaries. These decisions are made on a regional basis.
- **Includes governance structure with local representatives, providers and beneficiary groups**
  - Findings: The Partnership regional model is governed by regional representatives, providers and beneficiaries. Governing Board members are appointed by the County Boards of Supervisors pursuant to local statutes that dovetail with Partnership Health Plan by-laws. The Partnership regional model allows for local representation on a board with responsibility for the entire region.

5. *Summary:* The Partnership regional model partially meets this criteria. The model requires the cooperation and consensus of a regional board which will have representatives from several counties. The model has shown an ability to meet the goal by regionally directing services to provide quality health services and improve community health.

Rita Scardaci, Health Services Department Director
Sonoma County Health Services Department
3313 Chanate Road
Santa Rosa, CA 95404

Dear Ms. Scardaci,

With support from the County Health Services Department, the Medi-Cal Managed Care Planning Group has met for the past eight months and carefully considered options for operation of the Medi-Cal program in Sonoma County. Attached is our full report summarizing our activities and our findings. We have determined that becoming a part of regional managed Medi-Cal plan with Partnership HealthPlan of California (PHC) represents a real opportunity to improve the Medi-Cal program for Sonoma County beneficiaries and health providers alike.

The Planning Group adopted criteria for an improved Medi-Cal health system and compared PHC to those criteria. Appendix D of our final report documents how PHC compares to our ideal system. We determined that in the three counties where it now operates, Partnership has successfully expanded access to care, improved the quality of care, supported safety net providers and operated a competent and efficient organization. We believe that PHC will bring those same desirable attributes to its work in Sonoma County. Therefore, we recommend that the County Board of Supervisors notify the State Department of Health Services and PHC of our interest in moving forward to become part of the Partnership HealthPlan of California.

Prior to taking final action to become a part of Partnership, we recommend that the County secure agreement on three important issues:

1. Appropriate representation of Sonoma County residents on the Partnership HealthPlan Governing Board and Committees. We recommend that Partnership consider a Governing Board and certain committee composition that reflects the proportional size of the counties participating in the health plan.

2. A commitment to maintaining a PHC office in Sonoma County with appropriate health plan functions and staff. We recommend that PHC and the Planning Group/Oversight Committee mutually discuss and agree upon the types of services that could efficiently and effectively be located within this county. These might include:
    a. Medical director
    b. Provider services
    c. Member services, including retention and enrollment assistance
    d. Case management
    e. Health education
    f. Disease management

3. The development of a Sonoma County Operations Oversight Committee (transition of the Planning Group to Oversight Committee) with responsibility to work with PHC on the design and implementation of the managed Medi-Cal program in Sonoma County. Specific issues to be addressed and resolved include:

    - Adequacy of provider rates
    - Budget development and structure of risk pools
    - Assignment of members a medical home
    - Specialty physician recruitment and retention
    - Regional office functions
    - Continuity of care for patients during the transition to managed care
    - Evaluation and monitoring of program

The Sonoma County Operations Oversight Committee and the County will work with PHC to determine the need for and the role of an on-going county-based advisory committee. The Planning Group believes that the continued involvement and support of the local community is essential to the success of the Health Plan

We are confident that the issues outlined above will be successfully addressed and resolved during the next phase of the planning process and we look forward to working with the County Health Services Department and Partnership HealthPlan to do so.

Sincerely,

The Members of the Sonoma County Medi-Cal Managed Care Planning Group