UnitedHealthcare Community Plan of California, Inc.
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February 28, 2017

State of California
Department of Health Care Services

RE: Public comment on DHCS proposal addressing network adequacy standards for its Medi-Cal managed care, County Mental Health, Substance Use Disorder–Drug Medi-Cal, and Dental Managed Care plans

UnitedHealthcare Community Plan of California, Inc. is pleased to respond to the State of California, Department of Health Care Services' Network Adequacy Policy Proposal. Our response to the proposal is included in the following pages. Should you have any questions or seek further information, please do not hesitate to contact me at (916) 403-0630 or kevin_kandalaft@uhc.com.

Sincerely,

Kevin Kandalaft, CEO
UnitedHealthcare Community Plan of California, Inc.

UnitedHealthcare Community Plan

# TABLE OF CONTENTS

# INTRODUCTION

The Department of Health Care Services (DHCS) has requested feedback regarding its proposed network adequacy standards and monitoring plan. UnitedHealthcare appreciates the opportunity to provide insights to the State, including potential methods to safeguard beneficiary protections while ensuring the developed standards are meaningful and attainable.

UnitedHealthcare Community & State has extensive experience supporting states' goals of caring for vulnerable populations, demonstrated by our participation in Medicaid programs across 24 states plus Washington D.C. and the nearly 6 million Medicaid beneficiaries we serve. For more than 28 years, we have developed, in partnership with states, models to improve the quality and outcomes of healthcare by providing fully-insured, risk bearing models that bend the cost curve and create more predictable Medicaid budgets.

Serving more than 3.7 million individuals in the State, we have a keen understanding of healthcare delivery patterns and provider capacity in California and an appreciation of the local provider communities. This local expertise, coupled with our experience building provider networks nationwide, has allowed us to identify best practices and successful approaches for DHCS' consideration as it implements the Medicaid Managed Care rule requirements. Our feedback and recommendations focus on the development of networks adequate to meet the needs of the Medi-Cal population, while simultaneously being responsive to local provider supply and the move toward value-based care.

# NETWORK ADEQUACY AND TIMELINESS STANDARDS

UnitedHealthcare welcomes the implementation of network adequacy standards that provide beneficiary protections while increasing transparency and consistency in network assessments, and we appreciate DHCS' prompt response to the Medicaid Managed Care Final Rule (the "Final Rule") in the publication of draft standards. We provide in this response several considerations for DHCS as it continues to refine its network adequacy standards.

## GENERAL METHODOLOGICAL SUGGESTIONS

UnitedHealthcare has experience building and maintaining provider networks across the nation, as well as working within the context of various network adequacy frameworks at the state and national level. As a result of this experience, we have witnessed several process-related/methodological best practices (discussed below) that serve to strengthen network adequacy review, more accurately reflect actual access, and support a sustainable managed care program.

## ***Provide Managed Care Plans with Underlying Beneficiary File***

An important aspect of assessing and understanding network adequacy is accurately identifying and mapping against an appropriate underlying (base) population. For example, the Medi-Cal population is not necessarily distributed similarly to the general population and as such, mapping against the general population likely will result in an incorrect understanding of patterns of care and access to providers. We recommend as part of its efforts to improve network adequacy standards in the State, DHCS provide managed care plans with an annual beneficiary file that provides geocoded locations of the underlying population against which DHCS and DMHC will assess networks. In addition to increasing accuracy and transparency around the network assessment process, such a file also allows managed care plans to regularly assess their network to identify any potential gaps or opportunities for improvement as membership or State eligibility changes or grows.

## ***Allow for a Margin of Error in Mapping***

Several mapping software packages are available to determine the adequacy of networks based on predefined adequacy standards. However, each of these mapping tools uses proprietary algorithms (e.g., anticipated driving speed for a given ZIP code; geocodes at a ZIP centroid versus street level) and as a result, the calculated adequacy of a network often varies across the tools. We appreciate the flexibility DHCS affords in allowing managed care plans to determine which mapping tool to use and encourage this continued flexibility; however, we recommend that in the assessment of networks, DHCS consider these algorithm differences by applying a margin of error. For example, one mapping vendor's calculation of percent beneficiary coverage might vary by several percentage points from another vendor's calculation. While providing a geocoded beneficiary file (as discussed above) will reduce some of this discrepancy, it will not address all of it and as such, DHCS should allow a margin of error such as +/- 3.0 percentage points.

## ***Leverage Provider Supply in the Development of Standards***

Rather than implement broad standards across the State based solely on a county's size, we encourage DHCS to consider the available supply of providers, similar to the methods CMS has recently undertaken in its ongoing refinement of Medicare Advantage network adequacy standards. Published standards are not meaningful if they are not attainable, and can contribute to administrative burdens both for the State and managed care plans in the development and review of unnecessary exceptions and documentation. We encourage DHCS to map the available supply of eligible Medi-Cal providers in each county against that county's eligible beneficiaries to determine instances where the proposed time and distance standards need to be revised. As an example, we compared CMS' published Medicare Advantage standards for each of the medical provider types and across every California county to the standards DHCS has proposed, and identified numerous counties and specialty types where the DHCS

standards may be more aggressive than the available supply of providers (see the Appendix).[1]

Additionally, as DHCS considers its final network adequacy standards, providers not accepting new Medi-Cal patients should be excluded from any supply-based analyses, which in 2008 was 46% of primary care providers and 41% of specialty providers in California.[2] While such providers may count toward meeting network adequacy insofar as they serve a managed care plan's enrollees, network adequacy standards should be developed with an accurate representation of local provider supply and access; including providers that do not (or are not permitted to) accept Medi-Cal patients will artificially inflate attainable local access for newly eligible individuals or new managed care plans.

## ***Implement Fee Schedule Thresholds***

Network adequacy standards should include sufficient flexibility to encourage the development of high-performing networks that offer optimal quality and value to the program and beneficiaries. The Final Rule includes tools to facilitate such networks, including a focus on value-based purchasing as well as by allowing states to specify minimum and maximum fee schedules.[3] We encourage DHCS to consider such fee schedule thresholds as it moves to implement revised network adequacy standards. This is particularly important to safeguard budget stability of the Medi-Cal program and ensure long-term program effectiveness.

- A minimum fee schedule must be predicated on past experience, and must ensure that providers are fairly reimbursed (given regional and historic trends).The minimum fee schedule also must be adequately funded and must be realistic given current and future availability of State and federal resources.
- A maximum fee schedule can facilitate network development and beneficiary access by increasing provider confidence in the Medi-Cal program and discouraging unrealistic provider rates, particularly in regions where supply of providers is limited. This must be carefully examined to ensure that providers are not dis-incented from participating in a network as a result of maximum payment levels that are set too low, resulting in high quality providers in needed specialties choosing not to participate in the program. Additionally, DHCS should be aware that providers may assume the maximum allowable amount. Given this, maximum fee schedules should be completely funded in managed care capitations and should not dis-incentivize a shift to value-based approaches.
- Separate fee schedules should exist for providers who do not participate in managed care networks after reasonable attempts to contract. Specifically, a differentiated minimum fee amount creates incentives for participation and should

[1] While we recognize that DHCS and CMS use different methods in assessing network adequacy, the Medicare Advantage time and distance metric discrepancies might serve as a starting point for DHCS to consider potential supply-related challenges in their proposed standards.

[2] CHCF California Health Care Almanac. California Physician Facts and Figures. July 2010.

[3] 42 CFR 438.6(c)(1)

be established at a rate lower than the minimum established for participating providers.

## PROVIDER TYPE RECOMMENDATIONS

UnitedHealthcare appreciates DHCS' clear alignment of provider types with the Final Rule, and there are several points DHCS makes in its proposal that are reflective of strong network adequacy standards. For example, we agree with DHCS' proposal not to vary primary care time and distance metrics across the pediatric and adult population, as the same provider often will serve both populations, particularly in rural areas (e.g., family practitioners). We also agree with the proposal not to include hospital-based providers in the time and distance review, as beneficiaries typically do not schedule appointments directly with these providers but rather, access them upon a hospital admission or indirectly through another provider (e.g., radiology). Finally, we support flexibility around telehealth and pharmacy mail order as innovative methods to ensure adequate access. However, we do recommend DHCS consider several provider-specific modifications to its proposals for time, distance, and timeliness standards, discussed below, informed by our experiences working across states and programs.

### ***Consider County Size in the Implementation of Primary Care Requirements***

While we recognize the State currently does not adjust primary care requirements based on county size (and the proposal maintains this approach), we encourage DHCS to consider how the availability of primary care providers varies across the State and whether 10 miles/30 minutes is a feasible metric. In particular, there likely are rural areas of the State where beneficiaries must drive farther than this distance, such as Alpine, Inyo, and Trinity counties. As noted previously, we recommend that DHCS include provider supply in the development of its network adequacy standards to ensure that the final metrics are meaningful and accurate, and to reduce administrative burden associated with unnecessary exceptions to unattainable criteria.

### ***Implement Variation within Specialty Types***

We appreciate DHCS explicitly enumerating the specialty types against which time and distance standards will be assessed; this transparency allows for more efficiency as health plans develop their networks and ensures that the developed networks align better with the needs of the population. As with primary care, we encourage DHCS to consider the availability of specialty providers in the development of final network adequacy standards. Such an approach might start by varying the standards by specialty type to reflect that certain provider types are more prevalent than others, followed by supply-specific adjustments in counties where availability is particularly limited. For example, as of 2013 there were nearly twice as many active OB/GYN providers in the State as there were cardiologists or orthopedic surgeons, and the number of overall providers varied considerably across the State.[4]

[4] CHCF California Health Care Almanac. California Physicians: Surplus or Scarcity? March 2014.

Additionally, we encourage DHCS not to map pediatric providers separate from adult providers for each of the specialty types listed in the proposal. The supply of pediatric specialists is considerably limited and these specialists tend to practice on or near hospital campuses; thus their locations often are contingent on the location of hospitals. Rather, we recommend that DHCS allow for the aggregate mapping of each specialty type (across adult and pediatric providers) and address the availability of pediatric specialists through an attestations process that accounts for provider supply. As another option, DHCS might aggregate all of the pediatric specialists into a single category and map the entire category under the specialty "Pediatric Specialists."

We also request clarification from DHCS regarding the specialty physical medicine and rehabilitation (physiatry), as this is not a specialty type currently captured by the State's network efforts, and utilization of this physician type is low. We inquire whether DHCS intended for this specialty to instead be physical therapy, a non-MD specialty type.

## ***Exclude Obstetrics / Gynecology Providers from Primary Care Mapping***

While we agree with DHCS that OB/GYNs serve both in a primary care and specialist capacity for different beneficiaries, we caution that OB/GYNs should not be assessed against primary care network adequacy requirements. We are concerned with the potential that a network's primary care access would be overstated when many members of that plan in fact would not have access to the provider (e.g., all males). Rather, DHCS might consider this distinction as part of ongoing access monitoring.

## ***Limit the Hospital Standard to Acute Inpatient Hospitals***

We encourage DHCS to apply the proposed network adequacy review to acute inpatient hospitals only and not separately evaluate specialty or pediatric hospitals. Such specialty hospitals are geographically disperse and typically limited to urban areas, which results in network adequacy standards that are not meaningful in most regions. Managed care entities should be permitted to continue providing single case agreements and transportation services as necessary to such hospitals to ensure that appropriate access is provided. Additionally, as discussed earlier, DHCS could implement a fee schedule approach that encourages provider participation in managed care networks by increasing provider confidence in the Medi-Cal program and discouraging unrealistic provider rates.

## ***Clarify Substance Use Disorder Standards***

We request clarification from DHCS regarding opioid treatment programs, and whether it is DHCS' intent for this specialty type to align with facility-based or physician-based programs. Given the nature of these programs we encourage DHCS to focus on facility-based treatment in the assessment of network adequacy; however, we reiterate that supply is important in the development of appropriate standards. The abuse and misuse of opioid medications has increased rapidly in recent years, but whether the supply of providers to treat this epidemic has kept pace is less clear, particularly in rural settings. For example, a recent analysis published in the American Journal of Public Health

found opioid dependence to occur at rate of approximately 7.5 per 1,000 individuals over the age of 12 in California, but that medication-assisted treatment capacity in the State was only slightly more than half of that.[5]

We also note that substance use disorder outpatient services are contingent upon county resources as a result of the carved-out structure of the program. Thus, health plans cannot ensure appointment timeliness if a county is unable to provide adequate access to a clinic site. DHCS should consider this point as it implements network standards for this specialty type.

Finally, we request clarification on the timeliness standards across the broader substance use disorder specialty category, as the proposed standards do not align with DHCS' existing routine-urgent-emergent approach to other specialty types. We encourage DHCS to leverage these existing timeliness standards are they are contingent on an individual's need and more reflective of adequate access. Also, DHCS should consider the impact of wait lists on access, and the degree to which such wait lists conflict with timeliness standards.

## ***Align LTSS Timeliness Standards with Individual Need***

We support DHCS' decision not to include time and distance standards for the LTSS provider types enumerated in the proposal. Given the array of size and capacity among these provider types, time and distance standards are difficult to determine in a meaningful way even with the use of supply data, in instances where the beneficiary may have to travel. However, similar to our comment addressing the substance use disorder specialty, we encourage DHCS to leverage its existing timeliness approach of whether an appointment is routine, urgent, or emergent rather than arbitrary appointment timeframes based on county size. An individual's LTSS needs should determine their timely access to an appointment, not the size of the county in which they reside. Further, we recommend DHCS consider additional discussions with managed care plans and other stakeholders to determine how to address the lack of available SNF/ICF beds in certain counties and how this impacts meaningful access standards.

## ***Adjust Pediatric Dental Standards***

We agree with DHCS' proposed timeliness standards for pediatric dental. However, we again caution that DHCS should consider supply in its determination of appropriate time and distance metrics for this specialty type. Our commercial experiences in the State suggest that 10 miles may not be sufficient in many counties, particularly rural areas. While we acknowledge the commercial and Medi-Cal beneficiaries likely are distributed differently across the State, we encourage DHCS to leverage provider supply to ensure that its proposed pediatric dental standards are meaningful and attainable.

[5] Jones CMS, Campopiano M ,et al. National and State Treatment Need and Capacity for Opioid Agonist Medication-assisted Treatment. Am J Public Health. 2015 Aug; 105(8):e55-63.

### ***Allow for an Effective Exceptions Process***

As noted throughout our response, we encourage DHCS to incorporate provider supply into its development of network standards, which will reduce the number of exceptions that managed care plans continually submit and the State must review. However, while provider supply and capacity can be incorporated into network adequacy standards development, constantly refining standards to reflect provider behavior would be administratively burdensome to the State. An exceptions process allows for real-time accommodation of provider behavior that might impact access, such as moving locations, mergers, retiring from practice, reaching capacity, etc. Thus, we support DHCS' proposal to continue leveraging an alternative access standards ("exceptions") process.

In addition to the considerations listed in the proposal, we encourage DHCS to consider the following examples as valid reasons for exceptions:

- Lack of sufficient provider supply or capacity within the prescribed time/distance
- Provider refusal to participate in managed care efforts
- Provider inability to meet plan credentialing and provider quality requirements
- Local pattern of care and/or provider utilization

Additionally, we support the use of modalities such as telemedicine and pharmacy mail order in ensuring beneficiaries have adequate access to services. Such innovative solutions provide access to care for individuals who are otherwise unable to travel to the nearest available provider, and also allow providers to expand their reach beyond a bricks and mortar setting to patients.

## STAKEHOLDER ENGAGEMENT

Appropriate standards are important to ensuring the success of a program and can mitigate potential negative consequences of one-sided development, such as disconnected networks that are less effective at coordinating care for Medi-Cal recipients. We appreciate DHCS' willingness to work with stakeholders in the development and ongoing refinement of network adequacy standards in the State. Such engagement ensures meaningful network adequacy standards that provide beneficiary protections while allowing for high-quality, value-based networks.

In addition to the stakeholders listed in the proposal, we encourage DHCS to engage directly with managed care plans in the development and ongoing refinement of network standards. We have found similar approaches productive in other programs, for example Medicare Advantage. Managed care organizations can provide states a working knowledge of local delivery systems and provider availability, facilitating the development of enforceable and market-appropriate standards.

## MONITORING PLAN

As with the development of the network standards, we encourage DHCS to consider provider supply as part of ongoing monitoring activity. Local supply is sensitive to incoming and outgoing (e.g., retiring) providers, as well as office location changes and seasonality. While DHCS may not have the capacity to refine the network standards on an annual basis, the Department could consider annual internal mapping on provider supply to identify counties and specialties for which beneficiary coverage has decreased. Such an analysis could be accomplished by using the underlying beneficiary file for a given year (as discussed earlier), mapped against current eligible Medi-Cal providers (e.g., as identified in fee-for-service and encounter data). The State also might use this analysis to support evolution of the delivery system, for example identifying opportunities to develop incentive programs that attract providers to serve in shortage areas.

Another monitoring consideration we recommend is the focus on "extended hours" rather than hours of operation. We believe the availability of extended hours more accurately reflects accessibility to vulnerable populations and is more measureable than hours of operation. Provider hours of operation can change weekly and as a result, can skew monitoring results both positively and negatively, depending on when DHCS or the External Quality Review Organization (ERQO) contacts a given provider.

## SUMMARY

UnitedHealthcare appreciates the opportunity to comment on DHCS' proposal of network adequacy standards for the Medi-Cal program. Collectively, the recommendations provided in this response can facilitate the development of meaningful network adequacy standards that are both enforceable and that ensure beneficiary protections. We look forward to ongoing collaboration with the State and are eager to engage in conversation with DHCS as it continues to refine its network standards, including the recommendations we presented in this response as well as, for example, determining how certain specialty types (e.g., mental health) are defined. We welcome the opportunity to provide additional insights into any of the recommendations presented in this RFI response should DHCS be interested in further conversation.

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# APPENDIX. EXAMPLE COUNTIES AND SPECIALTIES FOR WHICH SUPPLY MAY NOT BE SUFFICIENT FOR NETWORK STANDARDS[6]

| County | Distance PCP | | Distance Specialist (Compared with Medicare Advantage (MA) Specialties that Align with Proposed Specialties) | | | | | | | | | | | | | | | | Distance Hospital | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *DHCS PCP Standard* | MA PCP Standard | *DHCS Specialty Standard* | MA Cardiology | MA Dermatology | MA Endocrinology | MA ENT/Otolaryngology | MA Gastroenterology | MA General Surgery | MA Gynecology, OB/GYN | MA Infectious Diseases | MA Nephrology | MA Neurology | MA Oncology Medical, Surgical | MA Ophthalmology | MA Orthopedic Surgery | MA Physiatry, Rehabilitative Medicine | MA Psychiatry | MA Pulmonology | *DHCS Hospital* | MA Hospital |
| Alpine | ***10*** | 60 | ***60*** | 85 | 100 | 130 | 110 | 100 | 85 | 110 | 130 | 110 | 100 | 100 | 85 | 85 | 110 | 100 | 100 | ***15*** | 100 |
| Amador | ***10*** | 20 | ***60*** | 35 | 45 | 75 | 60 | 45 | 35 | 60 | 75 | 60 | 45 | 45 | 35 | 35 | 60 | 45 | 45 | ***15*** | 60 |
| Calaveras | ***10*** | 30 | ***60*** | 60 | 60 | 90 | 75 | 60 | 60 | 75 | 90 | 75 | 60 | 60 | 60 | 60 | 75 | 60 | 60 | ***15*** | 60 |
| Colusa | ***10*** | 30 | ***60*** | 60 | 60 | 90 | 75 | 60 | 60 | 75 | 90 | 75 | 60 | 60 | 60 | 60 | 75 | 60 | 60 | ***15*** | 60 |
| Del Norte | ***10*** | 30 | ***60*** | 60 | 60 | 90 | 75 | 75 | 60 | 75 | 90 | 75 | 75 | 65 | 60 | 60 | 85 | 60 | 60 | ***15*** | 60 |
| Glenn | ***10*** | 30 | ***60*** | 60 | 60 | 90 | 75 | 60 | 60 | 75 | 90 | 75 | 60 | 60 | 60 | 60 | 75 | 60 | 60 | ***15*** | 60 |
| Humboldt | ***10*** | 20 | ***60*** | 35 | 45 | 95 | 60 | 45 | 35 | 60 | 75 | 60 | 45 | 45 | 35 | 35 | 60 | 45 | 45 | ***15*** | 60 |
| Imperial | ***10*** | 20 | ***60*** | 35 | 45 | 75 | 60 | 45 | 35 | 60 | 75 | 60 | 45 | 45 | 35 | 35 | 60 | 45 | 45 | ***15*** | 60 |
| Inyo | ***10*** | 60 | ***60*** | 85 | 100 | 130 | 110 | 100 | 85 | 110 | 130 | 110 | 100 | 100 | 85 | 85 | 110 | 100 | 100 | ***15*** | 100 |
| Kern | ***10*** | 15 | ***30*** | 40 | 40 | 45 | 45 | 45 | 35 | 30 | 45 | 35 | 45 | 45 | 40 | 40 | 45 | 35 | 45 | ***15*** | 30 |
| Lake | ***10*** | 20 | ***60*** | 35 | 45 | 75 | 60 | 45 | 35 | 60 | 75 | 60 | 50 | 45 | 35 | 35 | 60 | 45 | 45 | ***15*** | 60 |
| Lassen | ***10*** | 60 | ***60*** | 85 | 100 | 130 | 110 | 100 | 85 | 110 | 130 | 110 | 100 | 100 | 85 | 85 | 110 | 100 | 100 | ***15*** | 100 |
| Madera | ***10*** | 20 | ***60*** | 35 | 45 | 75 | 60 | 45 | 35 | 60 | 75 | 60 | 45 | 45 | 35 | 35 | 60 | 45 | 45 | ***15*** | 60 |
| Mariposa | ***10*** | 30 | ***60*** | 60 | 60 | 90 | 75 | 60 | 60 | 75 | 90 | 75 | 60 | 60 | 60 | 60 | 75 | 60 | 60 | ***15*** | 60 |
| Mendocino | ***10*** | 20 | ***60*** | 35 | 70 | 115 | 60 | 45 | 35 | 60 | 115 | 60 | 45 | 45 | 35 | 35 | 60 | 45 | 45 | ***15*** | 60 |

[6] While Medicare Advantage network mapping uses a Medicare population as well as slightly different mapping methods, it serves as an illustration of instances where DHCS might consider looking more closely at provider supply to ensure adequate availability of Medi-Cal providers to meet the proposed network standards. We encourage DHCS to consider supply across all counties and specialties; not just those included in this Appendix for illustration.

| County | Distance PCP | | Distance Specialist (Compared with Medicare Advantage (MA) Specialties that Align with Proposed Specialties) | | | | | | | | | | | | | | | | Distance Hospital | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ***DHCS PCP Standard*** | MA PCP Standard | ***DHCS Specialty Standard*** | MA Cardiology | MA Dermatology | MA Endocrinology | MA ENT/Otolaryngology | MA Gastroenterology | MA General Surgery | MA Gynecology, OB/GYN | MA Infectious Diseases | MA Nephrology | MA Neurology | MA Oncology Medical, Surgical | MA Ophthalmology | MA Orthopedic Surgery | MA Physiatry, Rehabilitative Medicine | MA Psychiatry | MA Pulmonology | ***DHCS Hospital*** | MA Hospital |
| Modoc | ***10*** | 60 | ***60*** | 85 | 100 | 130 | 110 | 100 | 85 | 110 | 130 | 110 | 100 | 100 | 85 | 85 | 110 | 100 | 100 | ***15*** | 100 |
| Mono | ***10*** | 60 | ***60*** | 85 | 100 | 130 | 110 | 100 | 85 | 110 | 130 | 110 | 100 | 100 | 85 | 85 | 110 | 100 | 100 | ***15*** | 100 |
| Plumas | ***10*** | 60 | ***60*** | 85 | 100 | 130 | 110 | 100 | 85 | 110 | 130 | 110 | 100 | 100 | 85 | 85 | 110 | 100 | 100 | ***15*** | 100 |
| San Benito | ***10*** | 20 | ***60*** | 35 | 45 | 75 | 60 | 45 | 35 | 60 | 75 | 60 | 45 | 45 | 35 | 35 | 60 | 45 | 45 | ***15*** | 60 |
| Shasta | ***10*** | 20 | ***60*** | 35 | 45 | 75 | 60 | 45 | 35 | 60 | 75 | 60 | 45 | 45 | 35 | 35 | 60 | 45 | 45 | ***15*** | 60 |
| Sierra | ***10*** | 60 | ***60*** | 85 | 100 | 130 | 110 | 100 | 85 | 110 | 130 | 110 | 100 | 100 | 85 | 85 | 110 | 100 | 100 | ***15*** | 100 |
| Siskiyou | ***10*** | 60 | ***60*** | 85 | 100 | 130 | 110 | 100 | 85 | 110 | 130 | 110 | 100 | 100 | 85 | 85 | 110 | 100 | 100 | ***15*** | 100 |
| Tehama | ***10*** | 20 | ***60*** | 35 | 45 | 75 | 60 | 45 | 35 | 60 | 75 | 60 | 45 | 45 | 35 | 35 | 60 | 45 | 45 | ***15*** | 60 |
| Trinity | ***10*** | 60 | ***60*** | 85 | 100 | 130 | 110 | 100 | 85 | 110 | 130 | 110 | 100 | 100 | 85 | 85 | 110 | 100 | 100 | ***15*** | 100 |
| Tuolumne | ***10*** | 20 | ***60*** | 35 | 45 | 75 | 60 | 45 | 35 | 60 | 75 | 60 | 45 | 45 | 35 | 35 | 60 | 45 | 45 | ***15*** | 60 |