County of Santa Cruz

HEALTH SERVICES AGENCY

P.O. BOX 962, 1080 EMELINE AVENUE
SANTA CRUZ, CA 95061
(831) 454-4066 FAX: (831) 454-4770

HEALTH SERVICES AGENCY
ADMINISTRATION

November 26, 2001

AGENDA: December 11, 2001

BOARD OF SUPERVISORS
County of Santa Cruz
701 Ocean Street
Santa Cruz, CA 95060

Re: Quarterly Reports from Central Coast Alliance for Health

Dear Members of the Board:

Your Board has requested that the Central Coast Alliance for Health submit quarterly reports. We have attached their latest report, dated November 20, 2001, which presents an overview of their activities to that date. It includes a summary of their strategic planning goals.

It is, therefore, RECOMMENDED that your Board:

Accept and file the quarterly report from Central Coast Alliance for Health.

Sincerely,

Rama Khalsa, Ph.D.
Health Services Administrator

RECOMMENDED:

Susan Mauriello
County Administrative Officer

cc: CAO
Auditor-Controller
County Counsel
HSA Administration
Central Coast Alliance for Health

CENTRAL COAST ALLIANCE FOR HEALTH
375 Encinal Street ~ Suite A ~ Santa Cruz ~ CA ~ 95060
(831) 457-3850 ~ FAX (831) 466-4310

FOUR-MONTH PROGRESS REPORT

TO

THE COUNTY OF SANTA CRUZ

BOARD OF SUPERVISORS

NOVEMBER 20,2001

This report serves as a progress report to the County of Santa Cruz Board of Supervisors from the Central Coast Alliance for Health ("the Alliance"). The Alliance previously reported to the board on August 21,2001 and on April 17,2001 in the form of a four-month progress reports and on January 29,2001 in its Annual Report to the Board of Supervisors. Following is a summary of the Alliance's activities from August 22, 2001 through November 20,2001 as requested by the Clerk of the Board:

Member Welfare

The Alliance Commission has continued its focus on member welfare throughout the last three-month period. The Commission has received staff quarterly reports of member complaint and grievance activity and on timeliness of requests for authorization of wheelchairs for its members. (See Exhibit A for copies of the Second Quarter 2001 Complaint and Grievance Report and Second quarter 2001 Wheelchair Timeliness Report.)

On September 26,2001, the Commission reviewed findings fi-om an extensive regional "Health Education and Cultural and Linguistic Group Needs Assessment" conducted by Alliance staff. The objectives of this research were to: identify the health education needs of Alliance members, identify cultural and linguistic needs of members related to their health services, identify available health plan and community resources (and gaps in resources), and integrate the findings into plans to address needs. Survey methods included review national, local and health plan data, focus groups, interviews, and surveys of members, providers and community agencies. (See Exhibit B for a summary of findings from the Alliance's Group Needs Assessment),

Fiscal Performance

The Alliance continues to operate efficiently, with a year-to-date administrative budget that is operating at ***5.8%*** of revenue. As July 31,2001, the Alliance's total fund balance is $22.7M. (See Exhibit C for the Alliance's most recent monthly financial statements.)

The Alliance conducted its semi-annual interim risk settlement in September 2001. The Alliance operates a shared risk payment system in which primary care physicians, hospitals and pharmacists share deficit and surplus risk, and specialty care physicians share surplus, to encourage and reward effective access and case management. Medical budget surplus is earned when members' health care needs are met more effectively than in the prior Medi-Cal FFS system. Since the Alliance's inception in 1996, over $14M in surplus has been shared among local contracted providers as avoidable cost and suffering has been reduced.

In June 2000, the Alliance's board authorized staff to conduct mid-year, interim risk settlements in addition to the annual settlement, in order to improve provider satisfaction and increase fiscal performance monitoring. For the first six months of 2001, the Alliance's interim risk settlement resulted in regional provider surplus earnings of $1.3M for the Alliance's Medi-Cal and Healthy Families programs. (See Exhibit D for a detailed report on the Alliance's interim risk settlement for the six month period ending June 30, 2001).

Strategic Planning

On August 22, 2001, the Alliance Commission held a board retreat to determine strategic priorities to complement and enhance the board's mission-related activities. The board had previously worked with Alliance staff and consultants to identify potential strategic options in areas of quality of care, integration of care, and eligibility outreach and insurance options. The board's retreat was facilitated by Ms. Linda Bergthold, a local health care consultant, and by **Ms.** Elinor Hall, consultant and former Health Services Agency Director for Santa Cruz County. The Commission concluded its retreat by prioritizing for staff three specific options of disease management programs, integration of excluded services, and expansion of eligibility outreach. The Commission also requested further board orientation to the issues of long term care integration via staff reports. (See Exhibit E for Background Information on Alliance Board Retreat Topics).

EXHIBIT A

CENTRAL COAST ALLIANCE FOR HEALTH

001- Second Quarter Member Complaint and Grievance Report 0128

1. Complaints

From 3/01 through 6/01 the Alliance documented 22 member complaints. The following is a breakdown of these complaints by category (reason), location (geographic), and provider site.

Santa Cruz County	Total Complaints	Access	Accept-ability	Quality of Care	Billing	Other	Private PCP	Clinic PCP	Pharmacy	Allied	Specialist	LTC	Hospital	Lab
North County	3	0	1	2	0	0	1	2	0	0	0	0	0	0
South County	2	0	0	1	0	1	0	0	0	0	0	0	1	0
Mid County	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Out of County	1	0	0	1	0	0	0	0	0	0	1	0	0	0
Totals	6	0	1	4	0	1	1	2	0	0	1	0	1	**0**

Monterey County	Total Complaints	Access	Accept-ability	Quality of Care	Billing	Other	Private PCP	Clinic PCP	Pharmacy	Allied	Specialist	LTC	Hospital	Lab
Greater Salinas Area	9	1	2	9	0	0	9	0	0	0	0	*0*	*0*	**0**
South Monterey County	4	3	2	2	0	0	0	4	0	0	0	*0*	*0*	*0*
Monterey County	3	1	3	0	0	0	1	1	1	0	0	*0*	*0*	*0*
Totals	16	5	7	11	0	0	10	5	1	0	0	*0*	*0*	*0*
Santa Cruz & Monterey County Totals	**22**	**5**	**8**	**15**	**0**	**1**	**11**	**7**	**1**	**0**	**1**	***0***	**1**	**0**

Access *complaints are characterized by complaints about an ability to access an appointment in a timely manner, office hours, telephone access, etc.* ***Acceptability*** *complaints are related to member's complaints about experiences that may affect the doctor patient relationship (e.g., communication issues, office standards of cleanliness, etc.)* ***Quality of Care*** *complaints are those complaints related to the receipt of medical care, including decisions regarding appropriateness of referrals. Some complaints encompass more than one complaint category, thus the total number of complaints by category may be greater than the total number of complaints documented.*

2, Santa Cruz County Grievances (2) and State Fair Hearings (0)

The Alliance received two (2) member grievances during the second quarter of the year 2001. One member grievance involved a reimbursement issue, and the other involved a quality of care issue. Both grievances were resolved within thirty **(30)** days.

A State Fair Hearing was held on 4/26/01 regarding the long tem care placement issue previously documented in the first quarter report. Subsequent to the hearing, the member's representative conditionally withdrew member's repest and accepted the resolution proposed by the Alliance.

There were no State Fair Hearing requests during the second quarter.

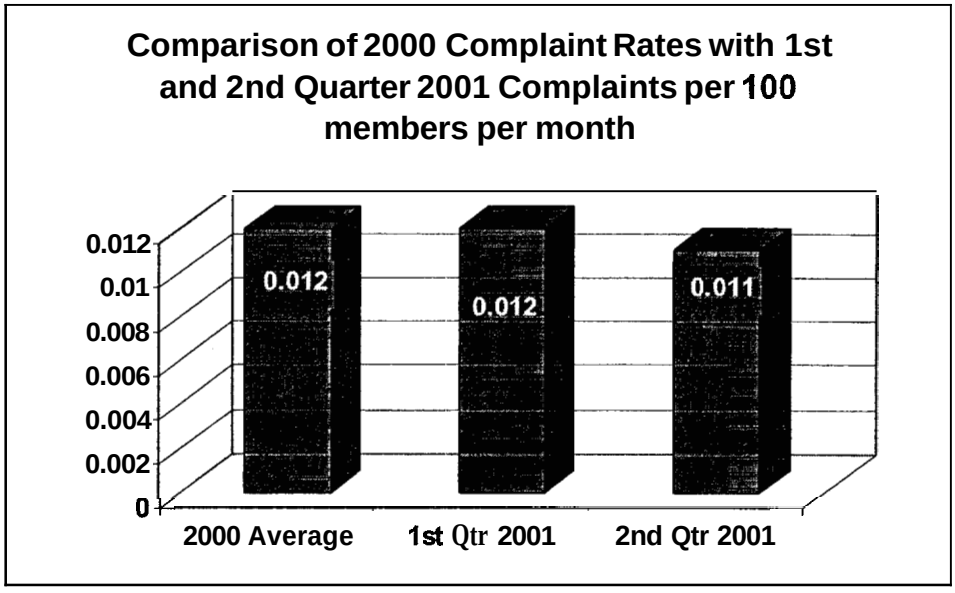
3. Monterey County Grievances (6) and State Fair Hearings (0)

The Alliance received six (6) member grievances during the second quarter. Two member grievances involved the denial of Administrative member status, one involved quality of care and acceptability issues, one involved billing issues, and three involved issues categorized as "Other". All grievances were resolved within thirty **(30)** days.

There were no State Fair Hearing requests during the second quarter.

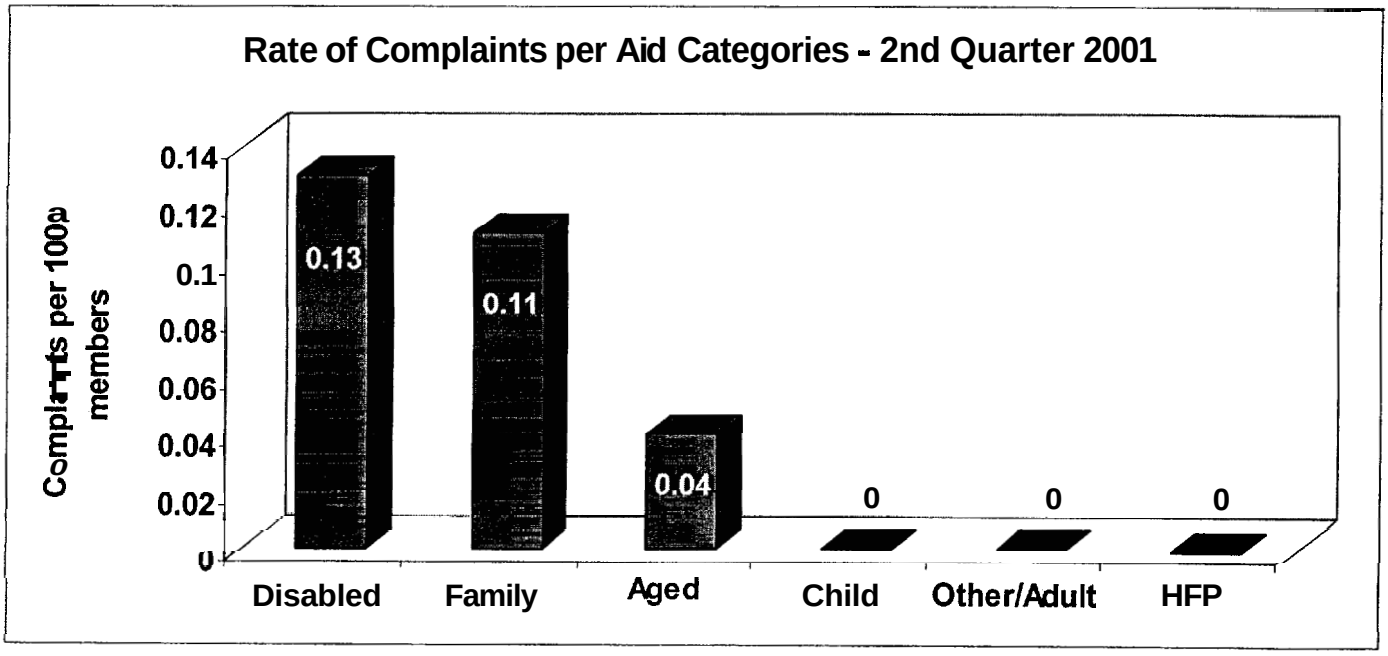
4. Complaint Rates Regional Membership

The chart below is a comparison of the complaint rates for calendar year 2000 to the 1st and 2nd quarter rates for 2001. The rate for the second quarter of 2001 was **one complaint for every 9,331 members.**



5. Rate of Complaints per Aid Categories and Geographic Area

0130



Rate of Complaints per Geographic Area - 2nd Quarter 2001

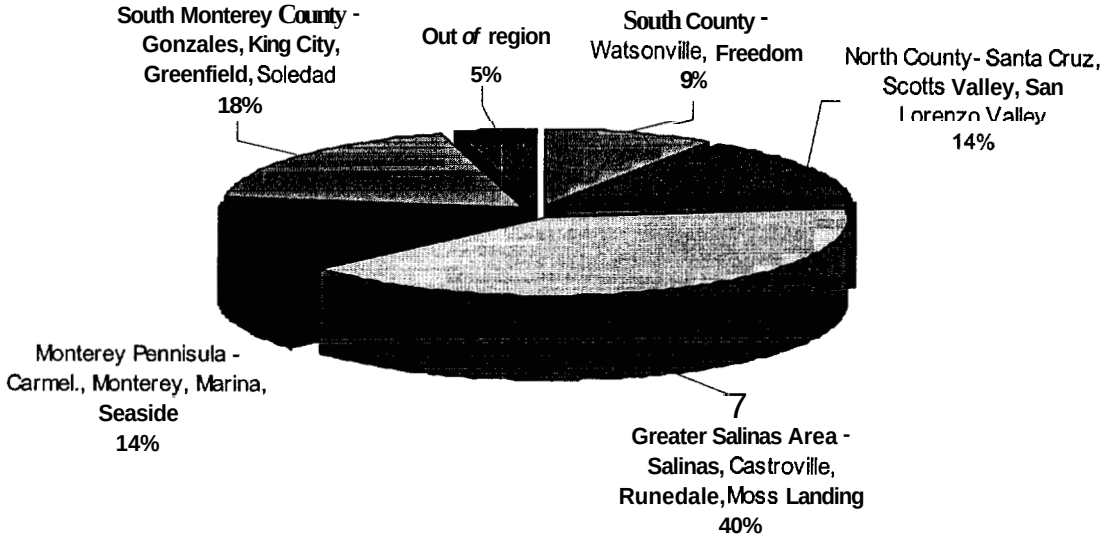


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EXHIBIT A
0131

CENTRAL COAST ALLIANCE FOR HEALTH
375 Encinal Street ~ Suite **A** ~ Santa Cruz ~ **CA** ~ 95060
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Health Services Department

Timeliness Report

2nd Quarter 2001 Authorized TARs for Purchase of Wheelchairs with accessories, by the Alliance

Summary of Wheelchair Purchases:

*Santa **Cruz** County members:* 16 wheelchairs: 11 manual *&* **5** power

Monterey County members: **16** wheelchairs: 12 manual *&* 4 power

*Out of Area **Members:*** 2 wheelchairs: 1 manual *&* 1 power

Denials: None.

The Alliance internal review processing time 1 – 15 business days, the average number of days was 5.

50% completed within 1-4 business days
73% completed within 1-6 business days
88% completed within 1-7 business days
12% completed within 8-15 business days

Note:

- Internal review process includes member eligibility verification, review for completeness of TAR submission, procedure coding and pricing review and medical necessity review with the Alliance Medical Director.
- All wheelchair purchase cases will have Alliance follow up calls to both the member and provider until wheelchair is delivered.

Santa Cruz County Members

Provider B: 1 manual wheelchair, authorized in **4** days, delivered to member in 70 business days. This chair was delayed by the manufacturer, it is a Bariatric chair designed specifically for this member who weighs 450 lbs. 1 Power chair, authorized in 8 days, delivered to member in 9 business days.

Provider C: **4** manual wheelchairs, all authorized in 4 days, delivered to members in 10 to 30 business days, except 1 chair which had custom power tilt and recline features, which took **69** business days.

Provider D: **4** Manual chairs, authorized in 5-6 days, **2** delivered in **2** & 25 days, **2** were previous rentals. The 25-day delay for one member involved a custom part for the chair to accommodate special needs for the member.

Provider H: 1 Manual chair, authorized in **4** days, delivered in **14** days.

Provider L: **3** Power chairs, authorized in 4-6 days, **2** delivered in 34 & **45** business days, the 3rd chair has not been delivered as yet. Due to the authorization dates and this report date, delivery time cannot be reflected on this report.

Provider M: 1 Manual chair, authorized in **4** days, 1 Power chair, authorized in 7 days. Neither chair has been delivered as yet. Due to the authorization dates and this report date, delivery time cannot be reflected on this report.

Monterey County Members

Provider C: **4** Power Chairs, authorized in 2-15 business days, 1 delivered in 40 days, the other three have not been delivered as yet. 6 Manual chairs, authorized in **4-9** business days, **5** delivered in 16-25 business days. One has not been delivered as yet. Due to the authorization dates and this report date, delivery time cannot be reflected on this report. The chair that took 15 days to authorize was delayed due to the fact that the member was residing in a skilled nursing facility and we do not provide chairs for members in these facilities. Extensive records were reviewed and discussions with the facility were engaged to assure that the member had a discharge plan.

Provider J: 5 Manual chairs, authorized in 3-7 business days, 1 delivered in 13 days, 3 were previous rentals, 1 has not been delivered as yet. Due to the authorization dates and this report date, delivery time cannot be reflected on this report.

Provider N: 1 Manual chair authorized in 7 business days. This was a previously rented chair.

Out Of Area Members

Provider H: 1 Manual chair authorized in 13 business days but not delivered, as yet member has not met his Share of Cost. This authorization was delayed due to this member living in a sub-acute facility and this authorization falls out of our normal scope of coverage. Extensive records were acquired and reviewed.

Provider C: 1 Power chair, authorized in 1 day, has not been delivered as yet. Due to the authorization dates and this report date, delivery time cannot be reflected on this report.

Summary of Wheelchair Repairs/Modifications

Alliance internal review process as described above in purchase report.

Santa Cruz County Members

Provider B: 1 Power chair, authorized in 6 days, with repair of tires.

Provider C: 37 Wheelchairs: 10 manuals and 27 power.
TAR received to approval date: 35% in 2-3 business days, 62% in 2-4 business days, 94% in 2-6 business days and 37% in 5-12 business days, with the average 4.2 business days.

Major repairs listed on individual TARs as follows: 4 backs, 10 tires (usually pairs of tires), 7 wheels, 1 wheel assembly, 3 wheel locks, 1 wheel hub, 1 pivot clevis, 1 knee pad, 1 fork and stem assembly, 3 batteries, 2 arm rests, 1 arm tube, 1 arm pad desk; 2 trays, 1 pr anti-tips, 3 belts, 3 chargers, 9 cushions, 2 cushion covers, 1 foam cushion pad, 1 pr ankle huggers, 1 pr plastic coated hand-rims, 4 leg rest/foot plates, 1 elevated leg rest assembly, 3 bearings, 3 joysticks, 1 forks, 1 frame, 1 headrest, 5 motor/gear box; 1 power tilt system, 4 arm pads, 3 extension tubes, 1 back slings/sleeves, 1 seat, 3 caster plate/fork, 1 electronic upgrade kit, 1 drive train, 1 boot arrow, 2 torso support, 1 thoracic support, 1 Latch-box, 1 boot arrow, 1 cable swivel and assembly, 1 quad link and 20 miscellaneous small parts.

Provider D: 3 manual chairs, authorized in 2,5, and 9 days, with replacement of a seat and 2 ramps.

Provider H: 3 power chairs, all authorized in 4 days with repairs to 1 cushion, 1 back, 1 set of brakes, 1 headrest, 1 pr anti-tips, 1 pr wheels, extension tubes, 1 pr elevating leg rests, 1 pr of foot-plates, and 8 misc. small parts.

Provider K: 1 power chair, authorized in 3 days with replacement of custom seating system, hip/thigh pads, arm-rests pads, and an adductor swing away.

Note: All above repairs also include labor charges.

Monterey County Members:

Provider C: 26 Wheelchairs: 14 manual and 12 power chairs.
TAR received to approval date: 19% 2-3 business days, 46% 2 –5 business days, and 96% in 2-8 days, with the average of 5.6 business days.
Major repairs listed on individual TARs as follows: 5 arm rests, 4 arm pad desks, 1 neck collar, 1 thoracic support, 2 headrests, 1 arm rest channel, 1 tube assembly, 2 wheel assemblies, 2 calf panels, 3 belts, 3 forks, 1 remote box, 1 calf panel fabric sling, 1 horn

switch, 1 wheel lock, 1 seat sling and rod, 1 arm receiver and assembly, 1 interconnect box, 1 vent tray, 1 oxygen tank holder, 10 tires (usually pairs of tires), 2 batteries, 8 backs, 1 motor/gear box, 7 foot/leg rests, 1 foot rest assembly, 7 cushions, 2 cushion covers, 1 battery box with strap, 2 control assemblies, 2 extension tubes, 1 caster plate, 1 caster housing, , and 10 miscellaneous small parts.

Provider H: 1 manual chair, TAR received to approval date: 2 business days. Repair/Modification- Heel pads, knee adductors and trunk support.

Provider J: 1 Power chair, 1 manual chair, TAR received to approval dates, 2 and 7 business days. Repairs included batteries, cushion, and leg rests.

Note: All above repairs also include labor charges.

Worksheets attached

Respectfully submitted,

Teresa Wahala, RN

Teresa Wahala, RN
Utilization Review Nurse
July 20,2001

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2nd Q 2001 Authorized TARs for Wheelchairs, purchased by The Alliance
Santa Cruz County

Pt. Initial	P or M W/chair	TAR Rec. date	TAR Auth date	Alliance rev. proc. # work days	Vendor del. date or sched. date	# work days: auth - del.	Vendor ID
IM	P	5-24	5-31	5 days	7-18	34	L
EL	P	6-22	6-29	6 days	*	*	L
JO	P	5-22	5-25	4 days	7-16	45	L
NS	P	6-11	6-19	7 days	*	*	M
RD	P	5-24	6-5	8 days	6-15	9	B
GM	M	5-16	5-21	4 day	6-9	14	H
PS	M	4-5	4-10	4 days	6-29	69	C
HS	M	4-3	4-6	4 days	7-16	70	B
DS	M	5-11	5-16	4 days	6-15	23	C
CP	M	5-29	6-4	5 days	7-9	25	D
BC	M	4-12	4-19	6 days	4-20	2	D
VE	M	6-1	6-8	4 days	*	*	M
AG	M	6-15	6-21	5 days	Previous Rental	N/A	D
BH	M	6-6	6-12	5 days	Previous Rental	N/A	D
SJ	M	6-15	6-18	2 days	6-29	10	C
HG	M	4-5	4-10	4 days	5-18	30	C

*** Due to authorization dates and this report date, delivery cannot be reflected on this report.**

2nd Q 2001 Authorized TARs for Wheelchairs, purchased by The Alliance Monterey County

Pt. Initial	P or M W/chair	TAR Rec. date	TAR Auth date	Alliance rev. Proc # work days	Vendor del. date or sched. date	# work days: auth-del.	Vendor ID
JC	P	6-4	6-22	15 days	*	*	C
ED	P	5-7	5-8	2 days	7-6 *	40	C
AG	P	6-20	6-28	7 days		*	C
RH	P	6-11	6-15	5 days	*	*	C
FB	M	4-24	4-26	3 days	Previous Rental	N/A	J
GS	M	3-26	4-3	7 days	5-8	25	C
JS	M	6-4	6-14	9 days	*	*	C
JW	M	5-11	5-16	4 days	6-8	17	C
JZ	M	6-20	6-25	4 days	7-17	16	C
EM	M	3-26	4-3	7 days	Previous Rental	N/A	N
PN	M	5-25	6-1	5 days	6-29	21	C
RR	M	6-26	6-28	3 days	** *	**	J
NS	M	4-5	4-10	4 days		*	C
JL	M	4-25	4-26	3 days	Previous Rental	N/A	J
JR	M	4-3	4-12	7 days	4-30	13	J
JG	M	4-9	4-11	3 days	*	e	J

*Due to authorization dates and this report date, delivery cannot be reflected on this report.
** Chair approved by State MediCal and honored by Alliance retroactively.

2nd Q 2001 Authorized TARs for Wheelchairs, purchased by The Alliance
Out of Area Members

Pt. Initial	P or M W/chair	TAR Rec. date	TAR Auth date	Alliance rev. proc. # work days	Vendor del. date or sched. date	# work days: auth - del.	Vendor ID
JC	P	6-26	6-26	1 day	*	*	C
DS	M	3-21	4-6	13 days	***	***	H

*Due to authorization dates and this report date, delivery cannot be reflected on this report.

*** Chair approved for this member, but member's Share of Cost has not been met and chair has not been delivered.

EXHIBIT B

0138

CENTRAL COAST ALLIANCE FOR HEALTH
375 Encinal Street ~ Suite A ~ Santa Cruz ~ CA ~ 95060
(831) 457-3850 – FAX (831) 466-4370

September *26,* 2001

Health Education and Cultural and Linguistic Group Needs Assessment

Staff will present a summary to the board of the findings of the Alliance's Health Education and Cultural and Linguistic Group Needs Assessment (GNA). This study was conducted locally over several months, and is required of all Medi-Cal managed care health plans.

The objectives of this Assessment were to:

1. Identify the health education needs of members.
2. Identify cultural & linguistic needs related to health service provision
3. Identify available plan and community resources (and gaps in resources)
4. Integrate the findings into plans to address identified needs

Survey methodology included review of existing national and local data, administrative and plan level data, focus groups, interviews, and surveys of members, providers and community agencies.

The findings and conclusions of the GNA will be used by Alliance staff to plan effective programs to serve members and assist network providers.

CENTRAL COAST ALLIANCE FOR HEALTH

Cultural and Linguistic Needs Assessment – 2001

Findings for Medi-Cal Membership

I. MOST COMMON HEALTH PROBLEMS

A. Alliance claims data

1. Top hospitalization dx: childbirth, pneumonia, heart disease/failure, diabetes differences by ethnicity: Caucasians: heart disease, emphysema; Latinos: bronchiolitis, gall bladder, appendicitis; Afric. Amer: gall bladder, emphysema, Sickle cell; Asian Amer.: diabetes, heart disease, septicemia
2. Top ER dx: fever, ear infections/pain, abdominal pain, URI, bronchitis differences by ethnicity:
   a. Caucasians migraines & headaches
   b. Latinos: viral infections
   c. Afric. Amer. and Asian Amer.: asthma
3. Rates of cardiovascular, cerebrovascular, diabetes, asthma, injuries by ethnicity:
   a. Caucasian highest rate of cardiovascular
   b. Latinos lower rates of all (younger population)
   c. asthma highest for African Americans, Asian/PI children

B. Providers and CBO surveys

1. Adults: pregnancy, diabetes, hypertension, cholesterol, obesity, mental health, dental
2. Children: dental health, childhood obesity, ear infections, common cold, asthma/allergies

C. Member reported health risks

1. 31% smoke (higher than regional rate of 16.5%)
2. 74% do not eat a low fat diet
3. 52% do not get regular exercise
4. 55% don't sleep well; 40% feel stressed out
5. 27% high blood pressure, 21% high cholesterol, 15% diabetes, 11% heart disease

II. UTILIZATION PATTERNS

A. Alliance data – Hospital admissions, emergency room, PCP, specialist visits/1000 members

1. Caucasians: Above average utilization of all types of visits for all age groups except 65+
2. Latinos: low utilization for children and adults, but highest hospital and specialist visits for age 65+
3. African Americans: low PCP use, very high emergency room for all age groups
4. Asian Pacific Island Americans: lower hospital and emergency room use and high specialist visits at all ages, average use of PCP

B. HEDIS 2000 data – above Medi-Cal state average in all but diabetes eye exams

1. Immunizations by age 2: 56.5% (Latinos 61.3%, Caucasians 47.1%)
2. Prenatal care first trimester: 72.8% (Latinos enter later than Caucasians; teens enter later)
3. Timely postpartum exam: 57.8%
4. Well baby exams in first 15 months: 49.5%
5. Adolescent well-care: 33.8%
6. Diabetes eye exam: 29.4%

C. Member survey
   1. **86%** of Caucasians, **80%** of Latinos used well-care in last 12 months
   2. Of those that didn't, 41% of Latinos didn't know service was available; 21% of Caucasians thought care not needed

D. Provider survey
   1. Pt. want antibiotic when not appropriate
   2. Some don't understand need for well-care, cancer screening

III. CULTURAL ISSUES

A. Provider understanding of culture
   1. **63%** of Caucasians vs. **38%** of Latinos say provider understands their culture
   2. 9% of Caucasians vs. 17% of Latinos say provider doesn't understand their culture.

B. Latino cultural beliefs/issues
   1. Economics: health competes with other needs
   2. Beliefs about health care: use care only when sick, preventive services are only for children. Cultural values about being self-reliant and not expressing pain may cause people to delay seeking care.
   3. Latinos, especially women, taught to keep their bodies private.
   4. Work with traditional health practices and *curanderos* – ask about other sources of care and integrate
   5. Bad past experiences with health care system, believe typical Medi-Cal doctors does not give good quality care
   6. Traditional diet as translated in this country is rich in fats and salts; diet becomes worse in **U.S.** with access to fast foods, more meat, etc.
   7. Problems understanding the plan, don't want to ask questions
   8. Low literacy skills, may not read materials sent to them
   9. Trust, respect, personal connection with provider is very important
   10. Family opinion is very important, involve family in care

C. Oaxacan population (indigenous peoples of Mexico): culture and health practices not well understood locally, most do not speak Spanish or English, strong emphasis on traditional/natural health care, don't understand medical care/system/preventative health care

D. Seniors: need to feel safe in PCP waiting room (if frail, children running around are a hazard)

E. Adolescents: need teen-friendly practice or clinic day, confidentiality

F. People with disabilities: providers need to self-assess **ADA** compliance, deaf awareness training

II. LINGUISTIC **ISSUES**

A. Members
   1. **38%** speak Spanish as primary language.
   2. 90% do not have problems communicating because of language (CAHPS 1999)
   3. Of those who need interpreters, **70%** said they got one (CAHPS 1999 – may be better now.)
   4. Low literacy skills. All materials should be written to 4th grade reading level

B. Providers
   1. **73%** of providers have at least some patients who speak Spanish. Of these, 75% have staff who speak Spanish. Overall, 60% of providers have staff who speak Spanish.
   2. **18%** of providers have patients who speak Tagalog. Of these, **30%** have staff who speak Tagalog.

3. Only **4%** of providers have used interpreter or language line. **45%** didn't know existed.
   a. Awkward when interpreter shows up but patient doesn't.
   b. Need for interpreters in other languages besides Spanish, especially Oaxacan languages.
4. **66%** use family member of pt., **48%** use friend of pt, **34%** use front office staff, 15% try to communicate with gestures. Several commented that they "ask patient to bring translator"
5. **3%** of providers have Certified Medical Translator on staff.
6. 19% do no assessment of staff bilingual fluency/interpreting skills.
7. **30%** feel that limited English patients access preventive care less frequently than other patients.
8. Provider surveys included a few worrisome comments, such as: " Have them learn English!!", "They should bring their own interpreter."

C. Pharmacies – problem when no one at pharmacy speaks Spanish

III. COMMUNICATION **WITH** PROVIDERS

A. **73%** willing to ask doctor to explain if don't understand; **6%** would say they understood and ask someone else

B. **21%** of Latinos, **14%** Caucasians want to learn more about communicating with doctor

C. CAHPS, 1999: above state average for providers
   1. listen carefully **(86%)**
   2. show respect for what patient says **(84%)**
   3. spend enough time **(78%)**

IV. **BARRIERS** TO HEALTH OR ACCESSING CARE

A. Member identified
   1. 30% not enough money to buy healthy food
   2. **27%** too many other concerns
   3. 20% don't know how to exercise safely
   4. 16% transportation (Latinos 25%, Caucasians **5%)**
   5. 11% childcare (Latinos 20%, Caucasians **6%)**

B. From Provider and CBO surveys
   1. Transportation
   2. Barriers of language and cultural understanding with providers
   3. Cultural beliefs regarding health care
   4. Literacy
   5. Lack of childcare
   6. Can't get time off from work, late hours in agricultural season
   7. Patients with high share of cost avoid accessing care
   8. Patient not aware service is a benefit
   9. Patient doesn't know who PCP is
   10. Compliance: difficulty keeping appointments, high-risk patient non-compliant with treatment and follow-up

V. **MEMBER** HEALTH EDUCATION NEEDS

A. Member identified
   1. 69% interested in learning more about health, **82%** of Latinos
   2. Topics
      a. highest priorities for all ethnic groups: exercise (48%), lower stress (42%), weight loss **(33%)**
      b. those with diabetes, high blood pressure, etc., want education on managing
      c. 21% want education on using the Alliance **(24%** Caucasians, 20% Latino)
      d. 20% want education on communicating with doctor **(14%** Caucasians, 21% Latino)

B. Members Services and MSAG identified
   1. Member Services: weight management, smoking cessation, diabetes, asthma, lead, chronic pain management/addiction to pain medicine
   2. MSAG: self-advocacy skills, mental health, stress management, chronic disease management, support groups

C. Provider identified
   1. Top health topics for education:
      a. Overall: nutrition, stress management, exercise, proper of antibiotics/antibiotic resistance, advocacy skills
      b. Children: asthma, nutritiodobesity, common cold/ear infections, IZ
      c. Adolescents: sex education, well-care, drug/alcohol abuse, ADHD/depression
      d. Adults: nutrition/obesity, family planning, diabetes, hypertension, cholesterol, well-care
      e. Seniors: nutrition, diabetes, well-care/cancer screening, exercise
      f. Latinos: nutritiodobesity, diabetes, family planning
      g. Vietnamese: well-care/ cancer screening
      h. People with disabilities: well-care, access to care
   2. Services/materials for members
      a. **38%** Ed. on using Alliance, being a wise health consumer
      b. **38%** low-literacy written materials, materials in other languages
      c. **34%** Health education classes
      d. 29% Support groups

D. Best format for delivery:
   1. Very close to home, or at agency where already receiving service (eg: food pantry, WIC). Do outreach in the community, neighborhood meetings, house meetings.
   2. One-on-one education by "expert"
   3. Low-literacy written materials
   4. Television
   5. Groups effective for some topics (eg: cardiac patients, smoking cessation)
   6. Latinos: use Spanish TV and radio, use pictures/models for talking about the body

E. Internet Use: **13%** of Caucasians vs. 7% of Latinos interested in learning through Internet

VI. PROVIDER NEEDS 0143

A. Culture
1. 20% Info on how cultural awareness can improve outcomes
2. **18% Info** on health related cultural beliefs/practices of specific ethnic populations
   eg: traditional healers and remedies, use of lead painted pots, Latino cooking patterns, translations **of** commonly used herbs, Oaxacan population
3. 17% Info on locally used alternative health practices/practitioners
4. How to work with low-literacy populations, how to simplify materials

B. Linguistic
1. **33%** want sample medical forms in Spanish.
2. 19% want training for bilingual staff on medical interpretation
3. **16%** want chart stickers noting language/interpreter preference
4. **16%** want info. on health literacy, how to work with low-lit patients
5. 16% want assistance making patient materials easier to read
6. **14%** want signs directing patient to language/cultural assistance in their language
7. **13%** want info. on working effectively with interpreters, including **ASL**

C. Continuing Education topics
1. Physicians: diabetes, asthma, weight management, hepatitis C
2. Staff: asthma, breastfeeding, adolescent health, reminder/recall system
3. Best time: lunch time (35%), evening (18%)

D. Health Ed materials needed
1. Low literacy materials, all primary care issues (e.g. Griffith's "Instructions for Patients")
2. Materials in Spanish, Korean (Marina), Tagalog **(So.** Mont. Co.)
3. Spanish-language vides on conditions, especially childhood allergies and asthma
4. Information on activities of daily living, safety for elderly
5. Videos on teen development issues
6. Diabetes

E. Case Management/Care Coordination (12% want)
1. Needed for: diabetes, complex/chronic conditions, heart disease, seniors/elderly, dual diagnosis patients, missed appointments

VII. UNMET SERVICE NEEDS

A. Dental care

B. Non-acute mental health services and support groups ("walking worried", anxiety, depression)

C. Health Education needs
1. Few classes **are** culturally and linguistically competent
2. Population based health education prevention programs are usually culturally and linguistically competent, interventions adapted for specific high risk audiences
3. Especially needed:
   a. Nutrition counseling, weight management programs. Especially in Spanish.
   b. Childbirth classes in South Monterey County (Mee Hosp classes are sporadic, bad times)
   c. Free smoking cessation classes

EXHIBIT C

Central Coast Alliance for Wealth
Balance Sheet
for the month ending July 31, 2001 0144
unaudited

Assets			
	Cash	16,883,530	
	Restricted Cash	15,923,582	
	Short Term Investments	5,842,461	
	Receivables	18,054,192	
	Prepaid Expenses	858,640	
	Other Current Assets	21,830	
	Total Current Assets		57,584,236
	Furniture, Fixtures and Equipment - Santa Cruz	2,009,761	
	Furniture, Fixtures and Equipment - Monterey	928,313	
	Vehicles	24,295	
	Accumulated Depreciation	(2,135,644)	
	Other Non-Current Assets		
	Total Non-Current Assets		826,724
	Total Assets		58,410,960
Liabilities			
	Accounts Payable	45,128	
	Incurred But Not Reported Claims/Claims Payable	31,976,795	
	Accrued Expenses	433,667	
	Lease Payable - Current	-	
	Note Payable - Current	-	
	Interest Payable	-	
	Estimated Risk Share Payable	-	
	Other Current Liabilities	4,108,934	
	Total Current Liabilities		35,664,523
	Long Term Debt		
	Lease Payable - Non-Current	-	
	Notes Payable - Non-Current	-	
	Total Non-Current Liabilities		-
Fund Balance			
	Health Care Expense Reserve	15,923,582	
	Fund Balance - Prior Years	6,784,468	
	Retained Earnings - Current Year	38,387	
	Total Fund Balance		22,746,437
	Total Liabilities and Fund Balance		58,410,960

The Notes to the Financial Statements are an integral part of the statements.

SO

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Central Coast Alliance for Health

Consolidated Income Statement
for the month ending July 31, 2001
unaudited

	Current Month			Year to Date			Actual	VARIANCE
	Actual	Budget	Variance	Actual	Budget	Variance	PMPM	PMPM
State Capitation	14,635,835	14,810,713	(174,878)	100,191,131	101623,423	(1,432,292)	201.36	2.88
Healthy Families Revenue	93,386	89,939	3,447	523,760	531,965	(8,205)	1.05	0.02
Other Revenue	0	0	0	0	0	0	0.00	0.00
Interest Income	119,952	88,916	31,036	1,019,415	531,470	487,948	2.05	-0.98
Total Revenue	**14,849,173**	**14,989,568**	**(140,395)**	**101,734,309**	**102686,858**	**(952,549)**	**204.46**	**1.91**
PCP Capitation	460,494	523,936	63,442	3,512,473	3851,378	338,902	7.06	0.68
Lab Capitation	71,468	71,468	0	507,004	507,004	0	1.02	0.00
Vision Capitation	76,018	76,018	0	514,807	514,807	0	1.03	0.00
Physician FFS	1,084,941	1,477,830	392,889	9,354,058	9710,984	356,926	18.80	0.72
Pharmacy	3,133,054	3,200,789	67,735	19,874,232	19905,363	31,131	39.94	0.06
Hospital Inpatient	4,253,394	4,207,068	(46,326)	25,482,853	26080,589	597,736	51.21	1.20
Hospital Outpatient	524,064	721,260	197,196	4,789,753	4028,394	(761,364)	9.63	-1.53
Long Term Care	3,017,781	3,290,818	273,037	23,510,552	24250,227	739,675	47.25	1.49
Other Medical	570,717	586,848	16,130	4,494,249	4056,854	(437,395)	9.03	-0.88
Lab FFS	28,708	28,708	0	192,236	192,286	0	0.39	0.00
Risk Share	0	0	0	0	0	0	0.00	0.00
Total Health Care Expense	**13,220,639**	**14,184,743**	**964,104**	**92,232,273**	**93,097,885**	**865,612**	**185.36**	**1.74**
Salaries & Fringe Benefits	681,682	695,603	13,921	4,046,532	4038,662	(7,870)	8.13	-0.02
Contract Services	16,701	26,355	9,654	266,300	323,131	56,831	0.54	0.11
Travel & Training	3,015	6,172	3,157	46,834	57,532	10,648	0.09	0.02
Office Supplies & Equipment	89,200	97,330	8,130	737,225	724,244	(12,981)	1.48	-0.03
Rent & Occupancy	36,484	37,200	716	251,390	259,200	7,810	0.51	0.02
Other Expenses	91,325	100,459	9,134	570,986	585,660	14,674	1.15	0.03
Total Administrative Expenses	**918,408**	**963,119**	**44,711**	**5,919,316**	**5,388,429**	**69,113**	**11.90**	**0.14**
	6.2%			5.3%				
Health Care Expense Reserve	**506,333**			**3,544,331**				
Net Income less Reserve	**203,793**			**38,388**				
% of Revenue less Expense and Reserve	**1.37%**			**0.04%**				
Members Current Month	**72,258**							
Monthly Average	**71,082**							

The Notes to the Financial Statements are an integral part of the statements.

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Central Coast Alliance for Health

Income Statement: Santa Cruz

for the month ending July 31, 2001

unaudited

	Current Month			Year to Date			Actual	VARIANCE
	Actual	Budget	Variance	Actual	Budget	Variance	PMPM	PMPM
State Capitation	5,488,211	5,564,384	(76,173)	37,654,582	38,255,371	(600,789)	238.30	3.80
Other Revenue			-	-	0	-	-	-
Total Revenue	**5,488,211**	**5,564,384**	**(76,173)**	**37,654,582**	**38,255,371**	**(600,789)**	**238.30**	**3.80**
PCP Capitation	216,002	262,302	[redacted]	1,633,122	1,716,940	83,818	10.34	0.53
Lab Capitation	23,895	23,895	0	169,724	169,724	0	1.07	-
Vision Capitation	24,782	24,782	0	167,005	167,005	0	1.06	-
Physician FFS	552,724	598,476	45,752	3,389,011	4,010,573	621,562	21.45	3.93
Pharmacy	1,026,810	1,198,030	171,220	7,757,471	7,625,755	(131,716)	49.09	(0.83)
Hospital Inpatient	1,241,770	1,253,975	12,205	6,652,757	7,272,781	620,024	42.10	3.92
Hospital Outpatient	89,899	188,366	98,467	1,089,698	967,513	(122,185)	6.90	(0.77)
Long Term Care	1,274,032	1,502,815	228,783	10,590,961	10,678,805	87,844	67.02	0.56
Other Medical	259,502	310,358	50,857	1,975,168	2,126,680	151,511	12.50	0.96
Lab FFS	10,129	10,129	0	87,061	87,061	0	0.55	-
Risk Share			0	0		0	-	-
Total Health Care Expense	**4,719,546**	**5,373,128**	**653,582**	**33,511,979**	**34,822,836**	**1,310,857**	**212.08**	**8.30**
Revenue less Health Care Exp.	**768,665**	**191,256**	**577,409**	**4,142,603**	**3,432,535**	**710,068**		

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The Notes to the Financial Statements are an integral part of the statements.

Central Coast Alliance for Health

Income Statement: Monterey
for the month ending July 31, 2001
unaudited

	Current Month			Year to Date			Actual	VARIANCE
	Actual	Budget	Variance	Actual	Budget	Variance	PMPM	PMPM
State Capitation	9,147,623	9,246,329	(98,706)	62,536,549	63,368,052	(831,503)	188.71	2.51
Total Revenue	**9,147,623**	**9,246,329**	**(98,706)**	**62,536,549**	**63,368,052**	**(831,503)**	**188.71**	**2.51**
							0.00	-
PCP Capitation	244,492	261,634	17,142	1,879,354	2,134,438	255,084	5.67	0.77
Lab Capitation	46,249	46,249	0	330,425	330,425	0	1.00	-
Vision Capitation	51,236	51,236	0	347,802	347,802	0	1.05	-
Physician FFS	520,805	843,964	323,159	5,873,114	5,489,210	(383,904)	17.72	(1.16)
Pharmacy	2,100,899	1,976,166	(124,733)	12,071,132	12,120,906	49,774	36.43	0.15
Hospital Inpatient	3,006,624	2,947,817	(58,807)	18,816,538	18,776,324	(40,214)	56.78	(0.12)
Hospital Outpatient	429,506	527,337	97,831	3,677,382	3,027,717	(649,665)	11.10	(1.96)
Long Term Care	1,743,749	1,788,003	44,254	12,919,591	13,571,422	651,831	38.99	1.97
Other Medical	308,203	271,812	(36,391)	2,501,007	1,901,905	(599,102)	7.55	(1.81)
Lab FFS	18,475	18,475	0	103,910	103,910	0	0.31	-
Risk Share			0	0	0	0	0.00	-
Total Health Care Expense	**8,470,236**	**8,732,693**	**262,457**	**58,520,253**	**57,804,058**	**(716,195)**	**176.59**	**(2.16)**
Revenue less Health Care Exp.	**677,388**	**513,636**	**163,752**	**4,016,296**	**5,563,994**	**(1,547,698)**		

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Central Coast Alliance for Health

Income Statement: Healthy Families
for the month ending July 31, 2000
unaudited

	Current Month			Year to Date			Actual	VARIANCE
	Actual	Budget	Variance	Actual	Budget	Variance	PMPM	PMPM
Healthy Families Revenue	93,386	89,939	(3,447)	523,760	531,965	8,205	64.16	1.01
Other Revenue			-	-	-	-	0.00	0.00
Interest Income			-	-	-	-	0.00	0.00
Total Revenue	**93,386**	**89,939**	**(3,447)**	**523,760**	**531,965**	**8,205**	**64.16**	**1.01**
Lab Capitation	1,325	1,325	0	6,855	6,855	0	0.84	0.00
Mental Health Capitation	2,858	2,858	0	15,827	15,827	0	1.94	0.00
Physician FFS	11,412	35,390	23,978	91,933	211,201	119,268	11.26	14.61
Pharmacy	5,345	26,593	21,248	45,628	158,702	113,074	5.59	13.85
Hospital Inpatient	5,000	5,276	276	13,558	31,484	17,926	1.66	2.20
Hospital Outpatient	4,659	5,557	898	22,678	33,164	10,486	2.78	1.28
Other Medical	155	1,819	1,665	2,247	12,442	10,195	0.28	1.25
Lab FFS	104	104	0	1,315	1,315	0	0.16	0.00
Risk Share			0	0	0	0	0.00	0.00
Total Health Care Expense	**30,858**	**78,922**	**48,064**	**200,042**	**470,991**	**270,949**	**24.51**	**33.19**
Revenue less Health Care Exp.	**62,528**	**11,017**	**51,511**	**323,718**	**60,974**	**262,744**		

The Notes to the Financial Statements are an integral part of the statements.

Central Coast Alliance for Health
Statement of Cash Flows
for the month ending July 31, 2001

Cash flows from Operating Activities:	
Net Income	203,793
Addition$to Health Care Reserve	506,333
Items not requiring the use of cash: depreciation	47,590
Adjustments to reconcile net income to net cash provided by operating activities:	
Change in Receivables	(461,680)
Change in Prepaid Expenses	(808,581)
Change in Other Current Assets	-
Change in Accounts Payable	(10,268)
Change in IBNR	(513,690)
Change in Accrued Expenses	6,840
Change in Interest Payable	-
Change in Current Notes Payable	-
Change in Risk Share Payable	-
Change in Other Current Liabilities	432,786
Change in Lease Payable	-
Change in Note Payable	-
Net Cash Provided by Operating Activities	(1,354,593)
Change in Investments	(64,356)
Investment to Expand Operations (Monterey)	-
Equipment Acquisitions	(39,194)
Net Cash Used in Investing Activities	(103,550)
Payment of Long-term Pebt	
Net Cash Provided by Financing Activities	
Net Increase/(Decrease) in Cash	(700,427)
Cash at June 30,2001	33,507,539
Cash at July 31, 2001	32,807,112

The Notes to the Financial Statements are an integral part of the statements.

Central Coast Alliance for Health

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Notes to Financial Statement

for month ending July 31, 2001

unaudited

- The Santa Cruz-Monterey County Managed Care Commission d.b.a. Central Coast Alliance for Health (the Alliance) is a managed healthcare system serving Medi-Cal eligibles and Healthy Families participants in Santa Cruz County. The Alliance is a local public agency separate and distinct from the County government. Pursuant to the California Welfare and Institutions Code, the Alliance was created by the County Board of Supervisors through the adoption of an ordinance on April 27, 1993.

- In 1998, the Alliance entered into an agreement with Monterey County to expand the Alliance's services into Monterey County beginning October 1, 1999. The Regional County Organized Health System (RCOHS) was approved by the Monterey County Board of Supervisors July 14, 1998 and by the Santa Cruz County Board of Supervisors August 25, 1998

- Restricted cash include healthcare reserve funds.

- Investments consist of U.S. government securities, Local Agency Investment Fund (L.A.I.F.) and mutual funds and are carried at fair value, which approximates cost

- Property and equipment are stated at cost. The costs of normal maintenance, repairs and minor replacements are charged to operations when incurred. Depreciation is calculated on a straight-line method using a three year estimated useful life.

- Premium revenue is received from California Department of Health Services (CDHS) monthly based on estimated membership and premium rates as provided for in the contract. Premium revenue is subject to retrospective adjustments by CDHS when actual membership becomes known. The Alliance records estimated amounts receivable from or payable to CDHS for these retrospective adjustments

- The Alliance maintains a reinsurance policy through CDHS to limif its losses on individual claims. Under the terms of the agreement, CDHS will reimburse the Alliance for each member's annual hospital services in excess of $75,000. The cost of reinsurance is deducted from the Alliance's monthly capitation payment from CDHS, and the recoveries are reported as recoveries revenue.

- Under the terms of its provider agreements, the Alliance has agreed to risk-sharing arrangements. To the extent that actual medical costs fall below established targets, the Alliance is required to make risk-sharing payments to the providers. Medical costs include all amounts incurred by the Alliance under these agreements.

- The Alliance is exempt from California franchise taxes and federal income tax pursuant to Section 501(a) of the Internal Revenue Code.

- The Alliance leases office space under a non-cancelable operating lease with minimum annual payments as follows;

Year Ending December 31	
2001	$ 380,350
2002	391,760
2003	403,513
2004	415,619
2005	99.240
	$1,690,482

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Central Coast Alliance for Health
Notes to Financial Statement
for month ending July 37, 2007
unaudited

- On January 1, 1907, the Alliance established a 401(a) Money Purchase Plan and Trust, which is an elective plan covering all employees after one year of employment. Under the terms of the plan, the Alliance will contribute 5 percent of salaries and wages on behalf of each participant for the plan year. In September 2000, the Alliance's commissioners voted to raise the Alliance's contribution to 10%.

- The Alliance's board established a policy for increasing the organization's capital reserves by establishing a healthcare reserve fund equal to two month's premium, or approximately $28 million. The Alliance intends to reach this target by the year 2004.

EXHIBIT D

CENTRAL COAST ALLIANCE FORHEALTH

September 26,2001

Interim Risk Settlement: Interim Period ending June 30, 2001

Background

The Alliance operates a shared risk payment system in which primary care physicians, hospitals and pharmacists share deficit and surplus risk, and specialty care physicians share surplus, to encourage and reward effective access and case management. Medical budget surplus is earned when members' health care needs are met more effectively than in the prior Medi-Cal **FFS** system. Since the Alliance's inception in 1996, over $14M in surplus has been shared among local contracted providers as avoidable cost and suffering has been reduced.

In June 2000, the Alliance's board authorized staff to conduct mid-year, interim risk settlements in addition to the annual settlement, in order to improve provider satisfaction and increase fiscal performance monitoring. Interim risk settlements are conducted by subtracting the cost of authorized claims from members' medical budgets, with an adjustment for incurred-but-not-yet-reported (IBNR) claims. Budgets for each PCP risk group are separately settled; the Alliance's network includes forty-four PCP risk groups. The Alliance withholds a portion of any interim risk settlement surplus payment, in order to minimize the risk of debits to the annual reconciled risk settlement. Interim risk settlements are followed by annual reconciled risk settlements done at fiscal year end.

During the fiscal year, the Alliance reports utilization data to providers for assessment of practice patterns. Alliance staff are also developing measures of providers' net financial performance to effectively communicate the value of Alliance surplus and **FFS** enhancements (e.g. Alliance payments above Medi-Cal **FFS** rates).

This interim risk settlement report is for Medi-CaI and Healthy Families membership in Santa Cruz County and in Monterey County (separately) from 1/1/01 - 6/30/01. Regionally, the interim risk settlement includes 39 PCP risk groups with 100 or more member months. PCP risk groups with less than 100 member months during the interim settlement period (typically less than 10 linked members) were excluded from the interim risk settlement due to high variability within their small membership, but will be included in the annual settlement.

SO

Review of the Interim Risk Settlement

Santa Cruz Membership:

Medi-Cal surplus is lower in the first six months of 2001 compared to 2000. Total interim **PMPM** surplus earned is $8.99, which is less than the $15.51 PMPM surplus earned in **FY** 2000. There are primarily two reasons for the decline: more conservative **IBNR** estimates, and increased "upfront" fee for service payments.

1. Staff have used more conservative estimates of "incurred but not reported" **(IBNR)** claims for the first six months of 2001, so that less money is available for interim surplus distribution. Use of more conservative IBNR estimates is justified by uncertainties caused by a slowing of Alliance claims payments during the interim period, related to claims staff turnover and ramping up new processing technology (optical character recognition for e-claims). In other words, more money has been "held back" for **IBNR** to ensure that potential late-coming claims costs are fully funded. Staff recognize that "under-reserving for **IBNR**" is the most common reason for health plan fiscal difficulties, and so have used conservative estimates. Notably, by the time the 2001 annual risk settlement is done in early 2002, the actual effect of late-coming claims will be better known, and so the annual settlement will likely not require such conservative **IBNR** estimates.

2. The board's newer payment policies have increased "up front" fee for service (FFS) payments to providers, with the result that "back end" surplus payments are lower. **A** combination of board policy and legislative fee changes increased primary care capitation by about 25%, and specialty care payments by about 19% in the first half of 2001. In dollars, Alliance **PCPs** and specialists were paid about $3.2M more in the first half of 2001 than in 2000, and skilled nursing facilities were paid an additional $2.7M. These FFS payment increases improve provider satisfaction, and reduce provider risk, albeit with reduced surplus sharing as medical budgets are impacted by higher payments.

Healthy Families performance is strong with substantial surplus return. This interim settlement reflects a shift from the Alliance's prior Healthy Families program FFS payment policy (which placed substantial fiscal reward in the settlement), to policies adopted by the board in June 2000 and again in May 2001 to increase "upfront" FFS payments. Relatively small membership (812 at 7/1/01 in Santa **Cruz** County) means that annual performance can vary substantially from year to year, albeit with relatively small total dollar impact. In May 2001, the board also adopted a new physician payment policy for Healthy Families that will provide contracting physicians a choice between risk sharing, or fee-for-service payments without risk, beginning October 1, 2001.

Monterey Membership:

Medi-Cal performance in the interim settlement period is the third measure of the fiscal viability of the Alliance in Monterey County, preceded by one interim and one annual settlement. The interim surplus earning of $329,226 is consistent with prior positive performance.

There are several important factors in the interim settlement for Monterey County, particularly when compared with experience with Santa Cruz County membership:

- "Learning curve" mode. The Alliance has about a two year history of Medi-Cal reform in Monterey County. Physicians are as yet relatively unfamiliar and unpracticed with the Alliance's case management model.

- Member mix. Aid code mix differences between Monterey and Santa **Cruz** counties influence fiscal performance. Disabled and SNF members (who have higher revenues and medical costs) are a higher percentage of membership in Santa Cruz than in Monterey, where less costly and lower revenue TANF members are more prevalent.

- **ER** access. Federal rules on emergency service access have become increasingly permissive, and have eliminated prior opportunities for re-direction of access from the **ER** to primary care offices. While members in Santa **Cruz** County were case managed in the ER in prior years, the current regulatory environment requires retrospective education of members.

With these factors in mind, this first interim settlement in Monterey County indicates solid, initial viability in the program. With the additional security of the Alliance's retention of $30,800,000 for IBNR for the interim period, 10% of the interim settlement surplus withheld for protection of the annual settlement, and $23 million in regional health care reserves, the Alliance's and its provider network have a strong platform on which to build in Monterey County. Specific ongoing challenges include promotion of case management, pharmacy cost management, and member education regarding appropriate access to care.

Healthy Families via the Alliance began operating in Monterey County 7/1/00, and was included in the 2000 annual risk settlement in March 2001. The Year 2000 PMPM surplus earnings for PCPs was $11.89 on a very small base of 277 members. The Alliance's Healthy Families membership in Monterey County grew to 505 by the end of this interim period, and PMPM surplus for **PCPs** is a commendable $15.32.

Interim Risk Settlement Report for Board Acceptance

The interim settlement is reported in the attached exhibits, which separately report the results with Santa Cruz and Monterey County membership. In summary, staff recommend the board accept and file the report of the following results:

	Santa Cruz Membership		Monterey Membership		**Combined**	
	W/hold	Surplus	W/hold	Surplus	W/hold	Surplus
PCP:						
Mcal	**285,988**	**463,476**	**337,134**	**220,537**	**623,122**	**684,013**
HF	**6,834**	**44,989**	**4,164**	**37,844**	**10.998**	**82,833**
Total					**$634,120**	**$766,846**
Hospital:						
Mcal	**946,836**	**265,484**	**1,468,407**	**91,202**	**2,415,243**	**356,686**
HF	**450**	**12,935**	*0*	**7,498**	**450**	**20.433**
Total					**$2,415,693**	**$377,119**
Specialist:						
Mcal	n/a	**92,165**	n/a	**31,886**	n/a	**124,051**
HF	n/a	**8,972**	n/a	**7,554**	n/a	**16.526**
Total						**$140,577**
Pharmacy:						
Mcal	**29,845**	**10,930**	**39,578**	**9,109**	**69,423**	**20,039**
HF	**260**	**6,557**	**21**	**4,835**	**281**	**11,392**
Total					**$69,704**	**$31,431**

Following the board's acceptance of this report, staff will distribute withholds and surplus to participating providers according to their individual contract performance.

CENTRAL COAST ALLIANCE FOR HEALTH

July 25, 2001

Background information on Board Retreat Topics

The following staff reports are provided on strategic options selected by the board for discussion at its retreat on August 22, 2001. After the board determines the strategic priorities for the Alliance, staff will proceed with business planning and reports back to the board on its selected priorities.

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1. Expand eligibility outreach.
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Quality of Care:

Improving members' health status and medical outcomes.

1. Expand health education and disease management programs.

Definition and Scope:

Health education and disease management programs provide support services to members that "wrap around" their physician's care, promote members' self care, and ensure optimal use of available health care resources. Programs are typically focused on members with prevalent or complex medical conditions (see potential "Target Populations" below). Activities can include:

- Identify high risk members and serve their needs. By analyzing and reporting on claims data, the Alliance could "find" high risk members, monitor members' access to the services expected for their condition, and provide a "services delivered and needed" profile for those members to attending physicians.
- Case coordination and referrals. Acting as a resource for members and physicians, the Alliance could facilitate referrals to medical and social support programs for members with targeted conditions, and assist in coordinating services.
- Targeted health education. The Alliance could identify members to receive targeted health education outreach, and provide support in accessing self-care programs in the community.
- Expansion of community resources. The Alliance could work with local health programs to expand or tailor services to better meet the needs of members.

Using these methods, the Alliance could add value working with local physicians to focus information and services on the needs of high risk members.

The Alliance currently promotes programs for: perinatal care, childhood immunization (grant funded position- Santa Cruz County only at present), breastfeeding promotion, diabetes education, asthma education, smoking cessation, and pediatric "warm line". The Alliance has current or impending case management positions focused on the needs of disabled persons, special needs children, and long term care recipients.

Staff envision that this strategic option could involve strengthening the Alliance's current efforts by organizing a new unit within the Health Services Department, with increased depth of staffing and management. With board direction, staff would also build new capacity to support members' self care and physician management of disease.

Connection to Alliance mission:

- Promotion of members' health via quality medical care and self care is a core value of the Alliance's mission.
- This strategic option advances the Alliance's role in promoting clinical support services and coordinated care for the regions' most medically-vulnerable residents.

Opportunities:

This strategic option would leverage the Alliance's opportunities to:

- Improve health status and quality of life for members while reducing avoidable medical costs.
- Conduct population based needs assessments to focus resources.
- Develop health promotion and disease management programs based on local needs, using physician and member advice.
- Use claims data analyses to "case find" and promote access to appropriate services.
- Promote self-care and disease management practices among members.
- Assist in coordinating care for medically fragile and at-risk members.
- Participate in expanding accessible programs for Alliance members.
- Add value by brokering information, support services and referrals.
- Conduct evaluation studies and adopt "best practices".
- Realize medical budget savings through effective disease prevention and management.

Risks:

- Must avoid duplicating existing services, and avoid any unwelcome intervention in doctor/patient relationship.
- Must be mindful of role of Alliance as health plan, not direct medical service provider.

Target population:

Approximate regional counts (note that a member may be counted in more than one category) of Alliance members in clinical categories of potential focus:

• Members with disabilities	12,000
• Aged members	6,000
• Diagnosis of hypertension	4,500
• Children w/ special needs	3,000
• Diagnosis of asthma	3,000
• Diagnosis of diabetes	2,000
• LTC residents in SNFs	1,000
• Diagnosis of obesity	1,000

Preliminary cost estimate:

A preliminary estimate of the annual administrative cost for this strategic option ranges from *$650,000* to $1,630,000. The "high end" of the estimate includes a need to lease and configure additional office space, and add service and support staff (approximately 13 FTEs) to capably manage services for a broad target population. The "low end" estimate assumes a smaller increase in service capacity (approximately 6 FTEs), possibly contained within existing Alliance office space, and serving a narrower target population.

Quality of Care:

Improving members' health status and medical outcomes.

2. Design and implement quality-based incentive payment policy.

Definition and scope:

Background. The Alliance's risk payment policy currently rewards physicians for "cost effective case management", as measured by medical budget surplus shared back with providers. The guiding principle is that effective case management will minimize unnecessary cost and suffering by providing timely and appropriate access to needed services. This model is "utilization based": for each primary care physician (PCP), the cost of medical services utilized by his/her members is deducted from members' medical budgets to determine surplus rewards.

Concept of OBI. The Alliance's "utilization based" incentive system could evolve further to use quality-related factors to distribute some portion surplus. *An* example of such quality based incentives (QBI) would be to assign 25% of all **PCP** earned surplus to a pool, which would then be distributed based on quality-related factors, while the remaining 75% of surplus was distributed based on utilization. The ratio of quality to utilization based distribution could be changed over time. There are several ways this could be constructed, and numerous factors that could be used to distribute surplus. For example, some health plans have implemented QBI factors related to physician performance in HEDIS quality studies. With QBI, a physician's surplus earnings depend not only on savings from medical budgets, but also on performance on specific quality-related measures.

Connection to Alliance mission:

- The Alliance uses progressive provider payment systems to increase provider satisfaction in order to improve members' access to health care.
- This strategic option would create new rewards and incentives for quality-related performance among providers. Optimal quality of care for members is a key goal for the Alliance.

Opportunities:

This strategic option would leverage the Alliance's opportunities to:

- For the benefit of members, further promote and reward providers' quality of care.
- Further realize the cost savings that are inherent in quality services.
- Provide incentives for collaboration in the Alliance's quality studies and initiatives.
- Tie providers' fiscal incentives and rewards to quality measures that are required by regulation or contract.
- Respond to general public concerns that managed care health plans constrain, rather than promote, quality of care.

Risks:

- QBI design must not lose sight of the need to 'learn budget surplus before it is spent". The Alliance must maintain fundamental practices of fiscal solvency, including an effective utilization management program.
- QBI design can be "politicized" if providers attempt to influence selection of criteria that are simply favorable to their practice.

Target population:

- Staff envision that **QBI** would be applied first to physician incentive arrangements on a regional basis.

Preliminary **cost** estimate:

QBI design would require extensive staff planning, including analysis of options, physician advisory input, financial modeling, and board presentations. Implementation would require contract language development and signing of amendments throughout the network, and modification of the Alliance's risk settlement procedures. Most of these activities would simply become assigned priorities of existing Alliance staff, although about $5,000 in consulting and contract design fees are estimated. While not expected to require new staff resources, **QBI** does demand considerable staff time and energy to achieve success in design and implementation.

Integration of Care:

Integrate care to reduce fragmentation and inefficiency.

1. Better coordinate or even "carve in" excluded services.

Definition and scope:

The Alliance promotes its case management model using a broad range of Medi-Cal benefit responsibilities, however dental, mental health, and California Children Services (CCS) are significant programs that are "carved out" of the Alliance, primarily due to State-wide political issues. The "carve out" concept has strong proponents who attest that managed care plans are not well suited to arranging access for specialized needs (e.g. mental health), or that existing programs are already in place and well established (e.g. CCS). However, most also agree that "carve outs" can fragment both the financing and delivery of care, and require time-consuming "border management". Most problematic are the bifurcated billing requirements for providers, and occasional disputes between programs over responsibility for payments.

Coordination between the Alliance and "carve out" programs has been in process since inception, via Memorandums of Understanding that clarify coordination procedures, and frequent ongoing communications between programs. For example, about **30%** of the Alliance's utilization management program is focused on coordinating the CCS carve out.

Integration of "carve out" programs is in various stages in other COHS. The CCS program is fiscally integrated in Santa Barbara, San Mateo and Solano counties, where the CCS program continues its independent operations but financing is consolidated within the COHS to minimize billing confusion and benefit payment disputes. Mental health services are also fiscally integrated in Solano County, and a "carve in" is under consideration in Santa Barbara County. Notably, these "carve in" arrangements typically integrate revenue and payments, but maintain the important and necessary operations of the CCS and County mental health programs. Dental services are not yet integrated in any COHS, but the State has indicated in interest in exploring dental integration with local health plans.

This strategic option would involve staff in:

- Further coordinating services between the Alliance and local programs and agencies, or
- Exploring integration of carved out services into Alliance health plan financing and administration.

Connection to Alliance mission:

- The Alliance's mission principles of improved access and quality of care are promoted by the health plan's case management model. Further coordination, or even integration, of "carve out" services would reduce member and provider confusion and frustration, improve efficiency, and encourage a more seamless and integrated local case management system.

Opportunities:

This strategic option would leverage the Alliance's opportunities to:

- Explore the potential benefits and pitfalls of integration with "carve out" program staff in a local planning process.
- Improve case management for members in a more clinically integrated, regional system that minimizes fiscal fragmentation and disputes.
- Improve access to a broader provider network as program networks are integrated and providers respond to a more "user friendly" system.
- Achieve fiscal integration (of revenue, provider billing, and health plan payments) while maintaining the professional services of any "carved in" programs.
- Simplify billing and program relations for local providers.
- Reduce time and energy now spent on "managing the borders".

Risks:

Successful integration of "carve outs" between the Alliance and other programs would require:

- **A** strong commitment, from all programs involved, to achieve a successful partnership.
- New Alliance systems and procedures to operate in a more integrated manner while sustaining the professional services of "carved in" programs.
- Revenue funding would need to be sufficient to cover new Alliance payment responsibilities. For example, dental funding that is based only on historical Medi-Cal dental cost is certain to under fund new demand if access is assured.

Target population:

There are about two thousand children with complex medical needs that are currently involved in the CCS program in the region. Several thousand Alliance members access County mental health services regionally, and more are treated by Alliance primary care physicians for less acute psychiatric complaints. All Alliance members have dental care needs.

Preliminary cost estimate:

Coordination or integration of "carved out" services would require extensive staff planning and interaction with programs during the "discussion phase". Policy and planning issues would be brought before Advisory Groups and the board. On the regulatory front, State contract modifications, and potentially amendments to State law would be required for implementation. Alliance State contract revenue rates would need to be negotiated for any new benefit cost responsibilities. Most of these planning and development activities would simply become assigned priorities of existing Alliance staff, although about $10,000 in consulting fees are estimated depending on scope.

The planning phase for this topic is not expected to require new staff resources, but would demand considerable staff time and energy. **If** the "political will" to move forward with integration was demonstrated among the program(s) involved, then staff would return to the board with operations plans and budgets.

Integration of Care:

Integrate care to reduce fragmentation and inefficiency.

2. Improve integration of long-term care services.

Definition and scope:

The increasing importance of long term care (LTC) services is well known, particularly in view of our aging population. Less visible to many is the current fragmented funding for long term care services, the "disconnect" and/or duplication among related service programs, and the lack of broad scope case management for long term care needs. In too many cases, patients and families access LTC services on a "hit or miss" basis, find that services require duplicative intake processes, and discover that service choices are unduly constrained by regulation or the rules of provider reimbursement.

In response to this situation, County and community health care professionals in both Santa Cruz and Monterey counties have acquired separate planning grants from the State to explore integration of long term care services at the local level. **A** key principle of these planning efforts has been to develop methods to prevent or delay the need for permanent long term care placement in a nursing home by keeping members at home as long as clinically appropriate. Several stages and techniques of coordination have been defined, and several models of fiscal and organizational integration have been explored.

In brief summary, three LTC integration models have been most prominent to date in local planning:

- Full risk integration. This model requires a risk-bearing organization to accept capitated payment for a broad scope of long term care services, in a manner that would fiscally reward substitution of home and community-based care for SNF care: a key goal of LTC integration. This model consolidates revenue for various long term care programs, and requires substantial new governance and organizational resources. **A** few counties in California are exploring this model, but none are now operational. Important statewide issues of regulatory waivers, capitation development, and other topics remain unresolved at present.

- Hybrid integration, This model could bring some new services into a local risk-bearing system to improve integration. For example, the Alliance might add Adult Day Health Services to its benefit responsibilities, and expand its capacity for LTC case management assistance. Other home and community-based services (e.g. In Home Supportive Services, Multi-Purpose Senior Services) could remain outside the local organization and retain their current fee-for-service revenue. This model focuses on improving integration of services through collaboration among programs without substantial restructuring of LTC financing. Some regulatory waivers may be required to increase local options. Several counties in California are moving in this direction with their LTC integration planning.

- PACE program. PACE stands for "Program of All-inclusive Care for the Elderly", and this model is perhaps best recognized via the "On Lok" Senior Health Services Program that has operated successfully in certain neighborhoods in San Francisco since 1979. PACE programs such as On Lok serve the frail elderly with the goal of optimizing independent living. They receive capitated Medicare and Medicaid funding, and are at full risk for all the care needed by enrollees. They use interdisciplinary clinical teams to provide and case manage the medical and social services needed by enrollees. Through affiliate organizations, other services such as housing and meals assistance are provided. Several counties in California are exploring either a "franchise" arrangement with On Lok, or locally-developed PACE program.

Because the Alliance is responsible for SNF, home health, hospice, DME, acute care and medical services for local Medi-Cal recipients, it is positioned to play a key role in new local models of LTC integration affecting Medi-Cal recipients. The Alliance could also offer capabilities in finance and claims, risk management, medical management, and information systems in any new State financing arrangements that would promote local integration and efficiency.

Connection to Alliance mission:

- The Alliance's mission principles of improved access and quality of care are promoted by the health plan's case management model. Further coordination, or even integration, of long term care services would reduce member and provider confusion and frustration, improve efficiency, and encourage a more seamless and integrated local case management system.

Opportunities:

This strategic option would leverage the Alliance's opportunities to:

- Improve "user friendliness" and effectiveness of long term care services for members and families through coordinated case management.
- Consolidate long term care information and resources for referrals.
- Promote independent living with home and community based services as alternatives to institutional care.
- Improve quality oversight of long term care services.
- Potentially, realize savings from effective case management of long term care services in capitated revenue models.

Risks:

- All LTC integration models require collaboration among fragmented LTC providers, with attending "political" uncertainty.
- Full risk integration model is largely untested, and so fiscal risk could represent opportunity or threat.
- Long term care services workers, affordable housing, and residential care facilities are under increasing pressure in California economy, so that alternatives to SNF care may be in short supply.
- Some regulatory waiver requirements are not yet clarified nor tested for federal approval.
- Feasibility and budget savings related to substitution of home and community-based care for SNF care require further study.
- PACE model, if done via On Lok franchise instead of via Alliance-based program, would pull some LTC services and revenue out of the Alliance with a "dis-integrating" effect.

Target population:

To date, local planning efforts in the region have focused on the Medi-Cal disabled and elderly populations, which number 18,000 in the Monterey Bay region.

Preliminary cost estimate:

County and community-based planning costs in both counties have been subsidized by State grants to date. Alliance staff have participated in these planning efforts without marginal costs incurred. This strategic topic presents an array of future options for Alliance participation in local LTC integration. These options represent substantial undertakings by the Alliance and local stakeholders. Depending on the direction of local planning, and on the board's interest in and approval for Alliance participation, staff would return with a conceptual design proposal, and then operations plans and budgets.

Eligibility Outreach and Insurance Options:

Expanding Health Care Access through Insurance

1. **Expand** eligibility outreach.

Definition and scope:

Health officials in many counties in California have placed substantial emphasis on Medi-Cal and Healthy Families eligibility outreach to reduce the number of uninsured. These insurance programs are publicly financed, and thereby address the most basic deficit of the uninsured: money. Health officials have also witnessed declining Medi-Cal enrollment under welfare reform, and slow enrollment in Healthy Families. The conclusion is that many uninsured people are actually eligible for these insurance programs, but lack awareness, and need assistance with enrollment. In response, eligibility outreach efforts have been organized to connect the uninsured with free or low cost Medi-Cal and Healthy Families insurance through informing and enrollment assistance.

The Alliance collaborates with County and community agencies in the Monterey Bay region to increase awareness and enrollment in the Medi-Cal and Healthy Families programs. These efforts take many forms: communications via schools and health fairs, radio spots and flyers distributed in communities, presentations at community/agency meetings, telephone response and referrals regarding enrollment application, and so forth. Through these methods, the Alliance has assisted in promoting access to insurance as an initial step toward access to health care.

The Alliance board could authorize staff to increase its participation in eligibility outreach, with more extensive involvement in media and face-to-face outreach campaigns, to further promote health care access via these publicly finance programs.

Connection to Alliance mission:

- **A** key goal for the Alliance is to improve the health of lower income residents of the region through appropriate access to health care. Medi-Cal or Healthy Families enrollment is a prerequisite to accessing the Alliance's health benefits and provider network. Therefore, a prospective member's enrollment in Medi-Cal or Healthy Families is an important "first step" toward improved health care access.

Opportunities:

This strategic option would leverage the Alliance's opportunities to:

- Reduce the number of uninsured and improve access to health care through the Medi-Cal and Healthy Families programs, which are publicly funded insurance programs that do not require local financing (beyond member co-pays).
- Outreach efforts will target all potential enrollees, including those healthy individuals who may not seek enrollment, or who let enrollment lapse in periods of wellness. Enrollment of such eligibles provides them with access to preventive services during periods of wellness, and has fiscal benefits for the Allliance.
- Statewide data indicate a ***60%*** disenrollment rate in Healthy Families, so there are clearly opportunities to better retain, as well as recruit, enrollees.
- Build upon the collaborative eligibility outreach efforts already under way in the Monterey Bay region.
- Focus Alliance legislative advocacy on expansion of Medi-Cal and Healthy Families eligibility.

Risks:

- Since Healthy Families is a multi-plan program, successful eligibility outreach may increase other health plans' membership. Regardless, access is improved.
- Some local physicians have expressed concern that individuals already insured by employers (in presumably better paying insurance programs) will qualify for and switch to Healthy Families. While data show that employer-sponsored insurance is rare or unaffordable for income-eligible enrollees in Healthy Families, and despite controls OR "crowd out" in Healthy Families (i.e. must have three month period of non-coverage prior to enrollment; employer may not drop insurance without stopping coverage for all employees - even those not eligible for Healthy Families), some physicians may have concerns regarding eligibility outreach efforts for the Healthy Families program.

Target population:

The following data estimates for the Monterey Bay region are drawn from two reports from the UCLA Center for Health Policy Research: 1) Uninsured Californians in Assembly and Senate Districts: Year 2000 and 2) Health Insurance Coverage of Californians Improved in 1999, But **6.8** Million remain Uninsured.

Uninsured in Santa Cruz and Monterey Counties:	116,000: **18%** of regional population
Eligible but not enrolled in Medi-Cal:	*20,500:* 18% of the uninsured
Children eligible but not enrolled in HF:	5,200: 4.5% of the uninsured
Parents likely eligible for HF soon:	8,000: **7%** of the uninsured
Total eligible but not enrolled:	33.700: 29% of the uninsured

Preliminary cost estimate:

If the board prioritized this strategic option, staff would work with both Counties and local agencies involved in eligibility outreach to assess needs and campaign opportunities, and return with a proposed plan to increase Alliance participation. There may be opportunities to access foundation grant funding for these activities, based on prior grants and foundation interest in eligibility outreach.

Eligibility Outreach and Insurance Options:

Expanding Health Care Access through Insurance

1. Create a new Alliance insurance program.

Definition and scope:

In February 2001, the Alliance board received a report from Commissioner Khalsa regarding the uninsured in Santa Cruz County. The board then requested a follow up report from staff summarizing the steps that would be required for the Alliance to implement a new insurance program for publicly financed beneficiaries, potentially for child care workers in Santa Cruz County funded by the Proposition 10 funds administered by the Santa Cruz County Children and Families Commission (SCCCFC). Commissioner Khalsa has indicated that approximately $500,000 in Proposition 10 funding could potentially be available for this project, however a precise count of targeted eligibles is not yet developed. Staff delivered an initial planning report at the May 2001 meeting of the board, and summarized the substantial legal, regulatory and operational tasks that would be required by such a venture.

Opportunities were discussed, including: support for the mission of the SCCCFC, and developing capabilities for other publicly funded health care programs in the future. Other issues were discussed, including: re-contracting the Alliance provider network for a new line of business, expected implementation costs in relation to a program currently envisioned to serve a small target population with modest public funding, and potential convergence of new legislative programs for the uninsured.

Regarding new local public funds to address the needs of the uninsured, Alliance staff are aware only of the potential of funds from the Santa Cruz County Children and Families Commission for insurance for child care workers. However, should the board proceed with this project, it would develop needed legal, regulatory and operational "infrastructure" that could be useful in participating in other publicly funded health insurance projects, should hnding become available.

Connection to Alliance mission:

- A key goal for the Alliance is to improve the health of lower income residents of the region through appropriate access to health care. Insurance coverage is a prerequisite to accessing the Alliance's health benefits and provider network. Therefore, the Alliance could further facilitate access by developing a publicly financed health insurance option for lower-income residents ineligible for Medi-cal or Healthy Families.

Opportunities:

This strategic option would leverage the Alliance's opportunities to:

- Reduce the number of uninsured and improve access to health care through a new, publicly funded Alliance insurance program.
- Develop a community-based planning process that would bring together stakeholders in the problems of (and solutions for) the uninsured. Other counties that are leveraging substantial tobacco tax and settlement funds to address the uninsured rely on such planning processes for consensus, direction and support.
- Provide support for the mission of the Santa Cruz County Children and Families Commission. **A** substantial number of Alliance members are children who benefit from the work of the SCCCFC.
- Develop Alliance infrastructure for other publicly funded insurance programs, should funding become available.

Risks:

- The small target population with modest funding would require substantial commitment of new Alliance administrative resources. The substantial legal, regulatory and operational requirements of this project would be offset by a relatively modest scale of potential revenue and beneficiaries.
- The Alliance must re-contract its provider network for any new line of business. While most providers would likely support and participate in a health insurance program for child care workers, it is possible that some providers may decline to participate. The Alliance must demonstrate to the Department of Managed Health Care that it has sufficient provider capacity to meet the full scope of needs of any new target population.
- It is possible that the Alliance could develop a health insurance program, accessing local public funding (e.g. Proposition 10 funds), that would be made obsolete by new State and federally funded programs.
- Medical cost risk and administrative overhead is relatively high in the individual insurance market, compared to the group market.

Target population:

The population count of uninsured child care workers in Santa Cruz County is not yet determined. However, if approximately $500,000 per year would be made available, and with a very preliminary estimate of a monthly premium of $150, then funding would cover approximately **278** enrollees per year if all available funding were used for premiums.

Preliminary cost estimate:

A very preliminary administrative cost estimate related to this proposal for a new insurance program for child care workers in Santa Cruz County is $1,040,000 per year. This estimate includes a need to lease and configure additional office space, and add service and support staff (approximately 11 FTEs) to capably manage a new insurance program as proposed above.