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

June 13,2002 AGENDA: June 25,2002

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

RE: Four-Month Progress Report – Central Coast Alliance for Health

Dear Members of the Board

Attached is the four-month report of the Central Coast Alliance for Health for the period ending May 30th, 2002. These are the highlights of the report for your Board:

1. Membership continued to rise in both Monterey and Santa Cruz Counties for a total membership of 77,623;

2. Quality Improvement programs continued to expand with health outcomes in place for many key variables. The Alliance was in the top 5 plans in the State for health outcomes. The Alliance showed continued improvement in 7 of 8 clinical indicators.

3. Fiscal Performance has continued to be excellent with the Plan meeting its reserve targets. The process of setting funds aside for reserves began in 1995. This is an important achievement and will provide good financial stability for the Plan. The State has frozen, however, rate increases due to budget constraints. With medical inflation, particularly in pharmacy, it is likely that at least 2 million dollars of the reserves will be needed to provide services during this fiscal year.

The Alliance is to be congratulated for its excellent improvement and continued provision of quality care for low income members of the community. The Alliance has also been an active and positive partner in trying to support the public safety net in health care.

It is therefore RECOMMENDED that your Board:

1. Accept and file this four-month report from the Central Coast Alliance for Health.

Respectfully submitted,

Rama K. Khalsa, Ph.D.
Health Services Agency Director

Attachments:
Central Coast Alliance For Health Report,
including attachments A through F

RECOMMENDED:

Susan A. Mauriello
County Administrative Officer

cc: CAO
HSA Administration
Public Health Commission
Central Coast Alliance for Health

CENTRAL COAST ALLIANCE FOR HEALTH
375 Encinal Street ~ Suite A ~ Santa Cruz ~ CA - 95060
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FOUR-MONTH PROGRESS REPORT

TO

THE COUNTY OF SANTA CRUZ

BOARD OF SUPERVISORS

MAY 30,2002

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 January 31, 2002, in its Annual Report to the Board of Supervisors. Following is a summary of the Alliance's activities from February 1, 2002 through May 30, 2002, as requested by the Clerk of the Board.

Member Welfare

The Alliance Commission has continued its focus on member welfare throughout the last four-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. These reports reflect an ongoing commitment by the Alliance to the resolution of member problems in a timely and thorough way. (See Exhibit A for copies of the First Quarter 2002 Complaint and Grievance Report and First Quarter 2002 Wheelchair Timeliness Report.)

The Alliance's membership continues to grow. At the end of April 2002, we had 23,654 Medi-Cal members in Santa Cruz and 52,350 in Monterey; 921 members in Healthy Families in Santa Cruz, with 1619 in Monterey, for a total membership of 77,623.

The Commission has continued to focus on expanded eligibility and outreach to new members. The Commission approved an amendment to the Alliance's contract with the Managed Risk Medical Insurance Board (MRMIB) to implement the expansion of the State's Healthy Families Program to parents of eligible children, a program that will be delayed until 2003 because of insufficient State monies to fund the expansion. An amendment to the Alliance's Knox Keene license was filed with the Department of Managed Health Care (DMHC) in March 2002 and approved on May 23,2002, to facilitate the implementation of this expansion when funding becomes available.

The Commission's Legislative Committee has been tracking bills in the 2002 State Legislature that would make it easier for members to enroll in Medi-Cal and Healthy Families, and watching for ways to enhance payment to our providers and avoid deeper cuts in Medi-Cal rates. The Commission authorized letters of support for key bills that met Alliance priorities in February {See Exhibit B for sample letter of support).

Quality of Care

Every year, the Alliance issues a public report on the results of our Quality Improvement Program (QIP). The purpose of this report is to improve quality care for all our members and to meet the requirements of state and federal agency standards, such as the National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDTS) and Quality Improvement System for Managed Care (QTSMC). The QIP is not just an acronym; it is a comprehensive, systematic and ongoing system of quality review and performance improvement. There are a number of internal and external committees that meet on a regular basis to review data and make recommendations for improvement. There is also an annual member satisfaction survey. The purpose of a performance improvement program is to improve and learn how to sustain that improvement, The Alliance continues to meet its goals for performance improvement as demonstrated by the attached QIP for 2002, which was presented to the Commission in March 2002 [See Exhibit C for QIP report).

HEDIS scores are an important measure of quality outcomes for our members, and the Alliance has improved its HEDIS rates each year, For the most recent data available,' out of nine indicators reported by the State Department of Health Services for both commercial and public plans, the Alliance scored above the Statewide Medi-Cal average on all but one, where the difference between our score and the Medi-Cal average was .5% and statistically insignificant. The Alliance was among the top five plans in the State showing most improvement on 7 of 8 indicators, and on the 8th indicator we had already scored as the fourth best plan.

Provider Satisfaction

In recognition of the work that Monterey providers have done to keep Alliance members healthy and satisfied, staff recommended to the Commission in April 2002 that a 10% enhancement be paid to the Alliance's contracted, non-hospital based specialists for specialty care provided to Monterey County members. Program solvency has been demonstrated in Monterey County, as it was in Santa Cruz County earlier, and this payment will promote a comparable payment structure in the Alliance's two-county service area. These payment enhancements are an important way to encourage referral acceptance and provider satisfaction, particularly considering the State rate reductions proposed for 2002. The Commission board gave final approval to this payment enhancement at its May 22, 2002 meeting.

Fiscal Performance

There is good and bad news in the Alliance's fiscal future. Despite difficult budget times at the State, the Alliance continues to operate efficiently, with an administrative budget as of

[1] "Results of the HEDIS 2000 Performance Measures for Medi-Cal Members," December 2001.

March 31, 2002 that is operating at 5.0% of revenue. As of December 31, 2001, the Alliance's total fund balance was $32,270.844. (See Exhibit D for the Alliance's most recent monthly financial statements and independent audit report.) The Alliance's independent auditor reported to the Commission on May 22,2002 that the Alliance's prudent and conservative approach to fiscal management has resulted in a solid fund balance with which to begin 2002.

The Alliance conducted its semi-annual interim risk settlement in April 2002 and distributed $5.5 M in surplus to local providers in Santa Cruz and Monterey Counties, our largest surplus ever. 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 have been reduced. (See Exhibit E for a report on the Alliance's interim risk settlement for the six month period ending December 31. 2001).

Despite these extraordinary results in 2001, the coming year will be constrained by the State's $24B deficit. The legislature has frozen all Medi-Cal health plan rates, and there will be no new revenue to offset rising medical costs in 2002. There are rumors of even deeper cuts in provider rates, and the Alliance faces possible deficit performance this year. With our strong reserves, we believe we can weather this downturn, but there is a very real prospect of little or no surplus in 2002, since medical inflation could overtake our local efficiencies. In February, recognizing the difficult fiscal situation we face in 2002 and 2003, the Commission approved a strong letter to our legislators and the Department of Health Services regarding potential cutbacks (See Exhibit F for rate freeze letter).

Community Participation

The Alliance Commission and staff continue to participate in local community activities related to the health and welfare of our members. The Commission represents the key health care leaders in both counties, and their participation on the Commission provides an important way to feed critical issues into the policy-making process. Alliance staff participate on a variety of local agencies and commissions, and the Alliance is a key partner in the upcoming Summit on the Uninsured, along with the Community Foundation of Santa Cruz County and the Santa Cruz County Health Services Agency.

In summary, the Alliance faces the remainder of 2002 optimistic about our ability to continue to serve our members and provide timely and efficient payment to our providers.

CENTRAL COAST ALLIANCE FOR HEALTH 0280

2002 - First Quarter Member Complaint and Grievance Report

1. Complaints

For the period of January 2002 through March 2002, the Alliance documented 17 member complaints. The followin 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	Private PCP	Clinic PCP	Pharmacy	Allied	Spec ialist	LTC	Hosp ital	Lab
North County	3	1	1	1	0	1	1	0	0	0	0	0	1
South County	2	1	0	1	0	1	0	0	0	0	0	0	0
Mid County	0	0	0	0	0	0	1	0	0	0	0	0	0
Out of County	1	0	0	0	0	0	0	1	0	0	0	0	0
Totals	**6**	**2**	**1**	**2**	**1**	**2**	**2**	**2**	**0**	**0**	**0**	**0**	**1**

Monterey County	Total Complaints	Access	Accept-ability	Quality of Care	Billing	Private PCP	Clinic PCP	Pharmacy	Allied	Spec ialist	LTC	Hosp ital	Lab
Greater Salinas Area	8	4	2	3	0	2	5	0	0	0	0	1	0
South Monterey County	1	0	0	1	0	0	1	0	0	0	0	0	0
Monterey Peninsula	2	1	0	1	0	1	1	0	0	0	0	0	0
Totals	**11**	**5**	**2**	**5**	**0**	**3**	**7**	**0**	**0**	**0**	**0**	**1**	**0**
Santa Cruz & Monterey County Totals	**17**	**7**	**3**	**7**	**1**	**5**	**9**	**1**	**0**	**0**	**0**	**1**	**1**

Access *complaints are characterized by complaints about an ability to access.an appointment* ***in*** *a timely manner, office hours, teiephone 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 involve more than one complaint category; therefore, the total number of complaints by category may be greater than the total number of documented complaints.)*

2. Santa Cruz County Grievances (2) and State Fair Hearings (2).

here were two (2) formal grievances filed by members during the first quarter of the year 2002. Both of these grievances involved quality of care issues. One (1) of the grievances was resolved within thirty **(30)** days. The member who filed the other grievance has granted an extension of time to resolve her grievance because she was unable to return a signed Release of Information (ROI) form in a timely manner.

During the first quarter, the Alliance received two (2) requests a request for State Fair Hearing. One involved the medical appropriateness of a wheelchair purchased by the Alliance for a member. The hearing was held on 2/28/02 and the administrative law judge upheld the Alliance's proposed resolution. The other request was in response to a TAR denial for an experimental drug, and has been withdrawn by the member.

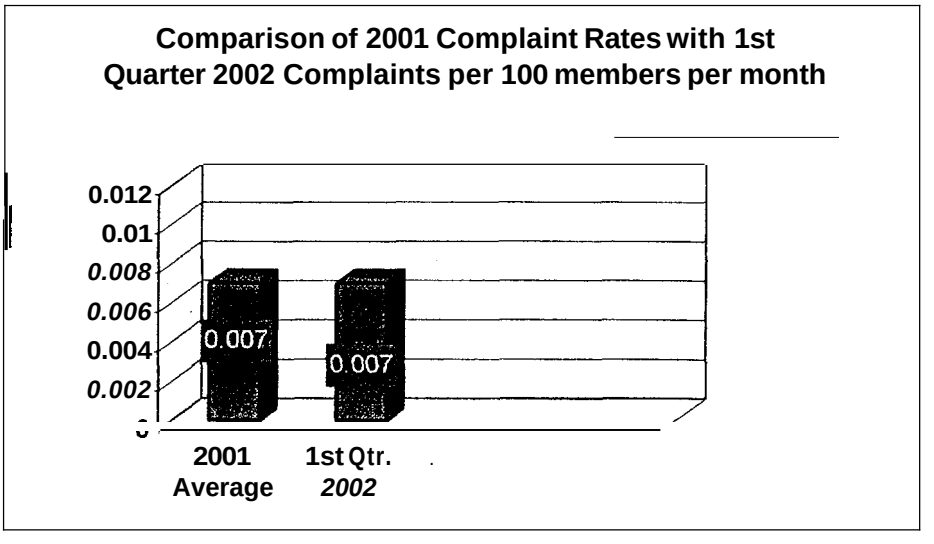
3. Monterey County Grievances (4) and State Fair Hearings – (0).

The Alliance received four **(4)** formal member grievances during the first quarter. Three (3) involved quality of care and access issues, and one (1) involved an access issue. One grievance was resolved after the member granted an extension of time because she was unable to return a signed ROI' in a timely manner. One member withdrew his grievance, and two members failed to return the ROIs and/or respond to attempts to contact them regarding their grievances.

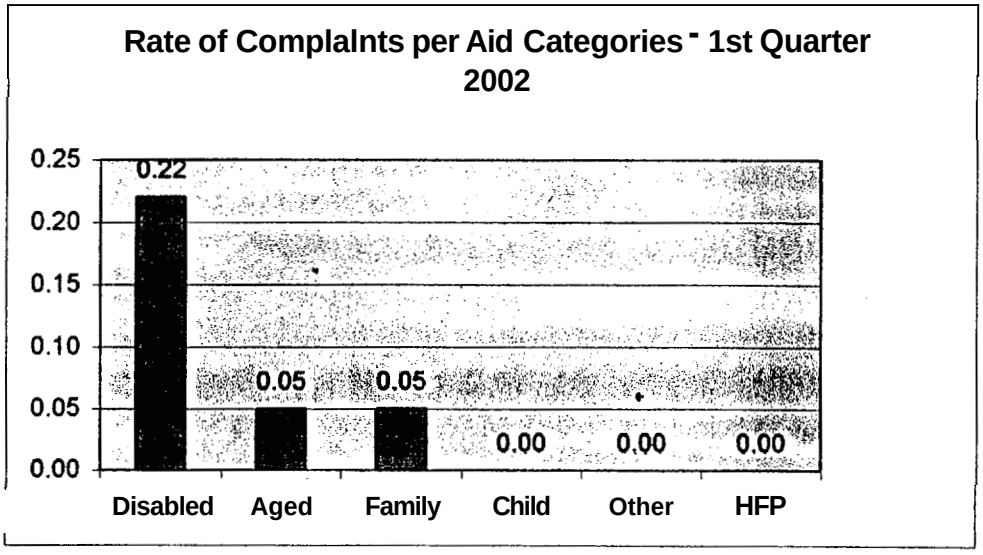
There were no State Fair Hearing requests during the first quarter.

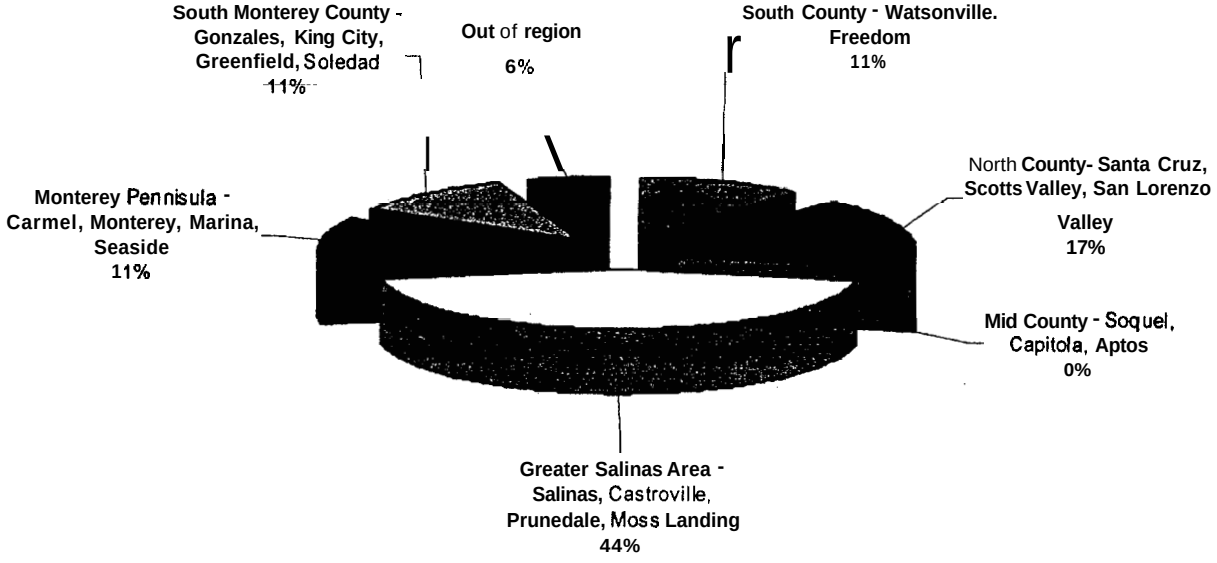
4. Complaint Rates Regional Membership

A comparison of rates per 100 members per month, presenting the annual average rates for 2001 and the 1st quarter rates for 2002. The rate for the first quarter of 2002 was **one complaint for every 12,864 members.**



5. CENTRAL COAST ALLIANCE FOR HEALTH





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Health Services Department

Timeliness Report

1st Quarter 2002 Authorized TARs for Purchase of Wheelchairs with accessories, by the Alliance

Summary of Wheelchair Purchases:

*Santa **Cruz** County members:* **15** wheelchairs: 12 manuals & **3** power

Monterey County members: 17 wheelchairs: **8** manuals & 9 power

Out of Area Members: None

Denials: 3:

#1- Power wheelchair request by member. Initial medical documentation submitted included an assessment by a Physiatrist (Rehabilitation Physician) stating that the patient did not meet the criteria for medical necessity for this equipment. The member disagreed with this evaluation and requested a second opinion. A second evaluation by a different Physiatrist was authorized and completed. This evaluation also clearly documented that there was no indication of any medical need for this equipment. The second opinion Physiatrist recommended a physical therapy program. The member's primary care physician was notified of this assessment and therapy recommendation. The Alliance Medical Social Worker has offered assistance to the member for follow-up of this program.

2, # 3- Both requests for purchase of manual wheelchairs, for members residing in a Skilled Nursing Facility. Per State Medical Policy statement guidelines, the facility is responsible for providing patients with this type of equipment.

The Alliance internal review processing time 1–11 business days, the average number of days was 6.0 days.

68% completed within 1-6 business days
78% completed within 1-8 business days
100% completed in 1-11 business days

Note:

- Internal review process includes member eligibility verification, review for completeness of TAR submission, review of procedure coding, pricing review, and review of previous equipment authorizations, 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.
- A wheelchair at times is authorized for rental rather than purchase when a TAR is initially submitted. The decision for a rental is made when it is not clearly evident there is a prolonged need for the wheelchair. If there is a question after a period of rental for several months, and it is determined there is continued medical need for the wheelchair, the wheelchair will be purchased. The amount paid in rental reimbursement is applied to the purchase amount. This rental -paid to purchase calculation must be accomplished as part of the TAR review authorization process.
- Rental requests are also reviewed for possible future member needs. **A** case discussion between the UR Nurse and the Medical Social Worker is initiated when **a** diagnosis or other care factor appears to indicate or raise questions about the need of the wheelchair for an indefinite period of time. This discussion also includes evaluation of the need for the member.to have knowledge, access, or a referral to community agency resources.

Santa Cruz County Members

Provider B: 4 Manual chairs, authorized in 3-9 days, 3 were previous rentals, the 4th was delivered in 8 business days.

Provider C: 4 manual chairs, authorized in 4 -7 days, 2 delivered in 23 and 33 days, the other 2 have not been delivered as yet. *
3 Power chairs authorized in 6 to 8 days, 1 chair delivered in 16, the other 2 chairs have not been delivered as yet*.

Provider D: 2 manual chairs, authorized in 4 and 8 days, both previous rentals.

Provider M: 2 manual chairs, authorized in 4 and 5 days, 1 delivered in 9 days the other not delivered as yet*.

Monterey County Members

Provider B: 4 manual wheelchairs, authorized in 3-5 days, 3 previous rentals, 1 not delivered as yet*, 1 power chair, authorized in 5 business days and delivered in 5 days.

Provider C: **4** Manual chairs, authorized in 5-9 days, 1 delivered in **18** business days, 1 in **48** days and 2 were previous rentals. 8 power chairs, authorized in 4 to 9 business days, 7 delivered in 5 to **48** days with an average of 21 days, 1 chair not delivered as yet*.

* Due to authorization dates and this report date, delivery 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 Manual chair, TAR received to approval date: 6 business days, replace rim covers.

Provider C: 29 Wheelchairs: 6 manuals and 21 power chairs, authorized in 1-8 days, with an average of 4.4 business days, 89% authorized within 6 days, 96% in 1-7 days.
Major repairs listed on individual TAR's as follows: 13 tires (usually pairs of tires), 7 wheels, 3 wheel assemblies, 2 wheel locks/hub, 5 hangers, 7 batteries, 1 battery box/strap, 4 arm rests, 4 arm pad desks/tubes, 2 thoracic supports, 2 hip belts, 3 chargers, 1 charger box, 3 cushions, 6 foot plates, 8 elevated leg rest assemblies, 1 joystick, 2 motor/gear boxes, 1 motor brush, 1 mount, 1 power recline system, 2 extension tubes, 3 seat sling, 1 seat depth, 1 back slings, 2 backs, 1 side guard, 1 frog leg, 1 caster plate/fork, 4 caster housing, 1 fork and stem assembly, 2 remote boxes, 2 control assemblies, 1 ramp, and 20 miscellaneous small parts, labor hours total 57.5.

Provider H: 2 Power chairs, authorized in 6 and 7 days.
Repairs as follows: 1 motor coupling, 1 actuator cover, 2 batteries, 2 motor gear boxes, 3 misc. small parts, and 7 hours of labor.

Provider O: 1 Power chair, and 1 manual chair, authorized in 3, and 6 days.
Repairs as follows: 1 set of batteries, 1 wheel lock, 1 pair of hand grips, 1 arm pad channel, 1 upper arm desk, and 1 ½ hours of labor.

Note: All above repairs also include labor charges.

Monterey County Members:

Provider C: 25 Wheelchairs: 6 manual and 19 power chairs, authorized in 1-13 days with an average of 5 business days. 88% approved within 7 days, and 72% within 1-5 days.
Major repairs for listed on individual TARs as follows: 1 arm rests, 2 arm pad desks, 3 arm rest channels, 1 headrest, 3 thoracic supports, 1 hip belt, 1 heel pad, 1 horn, 1 custom seating system, 2 wheel assemblies, 2 belts, 1 fork and stem assembly, 3 remote boxes, 1 wheel lock, 1 wheels, 3 seats, 2 vent trays, 7 tires (usually pairs of tires), 3 batteries, 1 battery box, 2 motor/gear box, 3 foot/leg rests, 7 cushions, 3 extension tubes, 3 caster plates, 1 caster housing, 4 hangers, 1 elevated leg rest assembly, 1 ankle hugger, 2 chargers, 1 control assembly, 1 interconnect box, 2 power tilt'systems, 2 chargers, 1 lighting package, 1 ramp, and 11 miscellaneous small parts. Labor hours total 33.5.

Provider F: 2 manual chairs, authorized in 4 and 5 days.
Repairs as follows: 2 footplates, 3 extension tubes, 2 hangers and 2-¼ hours labor.

Note: All above repairs also include labor charges.

Out of Area Members: None

Worksheets attached

Respectfully submitted,

Teresa Wahala, RN
Utilization Review Nurse
April 3,2002

1st Q 2002 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
RG	P	1-7	1-11	4	3-20	48	C
EE	P	2-22	2-27	4	3-20	16	C
MC	P	12-31	1-14	9	1-24	9	C
JW	P	2-25	3 8	9	3-25	19	C
PM	P	2-22	2 28	5	3-29	29	C
SD	P	3-5	3 8	4	*	*	C
DC	P	2-28	3 6	5	3-12	5	B
TE	P	12 31	1 14	9	2-12	21	C
DD	P	12-26	1 2	4	3-15	53	C
AD	M	3-8	3 21	9	**	**	C
FG	M	1-7	1-18	9	2-13	18	C
VR	M	1-7	1-14	5	3-20	48	C
RG	M	3-5	3-8	4	*	*	B
JB	M	2-22	2-26	3	**	**	B
RR	M	1-16	1-18	3	**	**	B
IL	M	1-16	1-18	3	**	**	B
RG	M	2-20	2-27	6	**	**	C

* Due to authorization dates and this report date, delivery cannot be reflected on this report.
** Previously rented, already in members possession

CENTRAL COAST ALLIANCE FORHEALTH
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March **27,2002**

Assembly Member Keith Richman (38th District)
State Capitol, Room **5128**
Sacramento, CA 95814

RE: Support for AB1806 – Richman- Medi-Cal Eligibility, Income and Resources

Dear Assembly Member Richman:

The Governing Board of the Central Coast Alliance for Health ("the Alliance"), which is the County Organized Health System serving approximately 74,000 Medi-Cal and Healthy Families beneficiaries in Santa Cruz and Monterey Counties, wishes to be on record in support of AB **1806** regarding expanded eligibility for Medi-Cal recipients.

AB1806, as currently written, would require the Department of Health Services to expand eligibility for Medi-Cal for medically needy members in our region, by deleting the asset test and allowing members to maximize income and resources they can retain, as well as increasing county responsibility for eligibility determination to extent that federal financial participation is available.

The expansion of eligibility and increased outreach to the uninsured and underinsured in Santa Cruz and Monterey Counties is one of our Board's major priorities for this year. This bill would substantially facilitate local efforts to enroll additional eligible members in the Medi-Cal program.

The Alliance board thanks you for your support of our efforts to provide access to quality health care for all members of our community.

Sincerely,

Edith Johnsen

Edith Johnsen
Chair, Santa Cruz-Monterey Managed Medical Care Commission

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QUALITY IMPROVEMENT PROGRAM: 2002

March 27,2002

INTRODUCTION

Central Coast Alliance for Health is a public agency established to enter into a contract with the Department of Health Services (DHS) to serve the Medi-Cal enrollees in Santa **Cruz** and Monterey Counties. Subsequently, the Alliance has also contracted with the California Managed **Risk** Medical Insurance Board (MRMIB) to serve enrollees in the Healthy Families Program.

The Alliance is dedicated to improving the health and well being of the residents of our region. Our mission is:

- To ensure appropriate access to health care services for local members enrolled in the Medi-Cal and Healthy Families programs.
- To improve medical outcomes, minimize unnecessary suffering and cost, and improve and promote self-care and wellness.
- To increase provider satisfaction and participation in serving members needs.

Working in partnership with select providers, the Alliance acts as a bridge between the health care system and those who need health coverage.

It is essential that the Alliance have a comprehensive Quality Improvement Program to systematically monitor and continually improve the quality of health care to its beneficiaries, to identify over and under utilization and substandard care and to take corrective action when indicated.

PURPOSE AND SCOPE

The purpose of the 2002 Quality Improvement/Assurance Program (QIP) is to improve the quality of care for all members within the limits of the resources available to the Alliance and its Participating Providers. Additionally, the QIP was designed to meet the requirements of state and federal agencies and standards, such as the National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS) and Quality Improvement System for Managed Care (QISMC). The QI plan was designed to provide a structured and organized activity schedule for the QI Program and outlines the proposed aspects of care that are reviewed throughout the year.

The QIP is comprehensive, systematic and ongoing, and includes a review of the quality of important aspects of the delivery of health care services and encompasses all services and physicians who have direct and indirect impact on the medical care of Alliance members. It includes the review of services and physicians/vendors in inpatient, outpatient, skilled nursing, ancillary, care management and pharmacy settings. It also includes development of clinical protocols and standards.

Our data systems are set-up to separately identify and track different lines of business, namely Healthy Families and Medi-Cal for each county. Although these programs are monitored separately, they are held to the same quality standards.

PROGRAM OBJECTIVES

The 2002 Quality Improvement Program addresses both internal Alliance operational issues as well as external provider/vendor services. The following program objectives guide the program:

- Monitoring the medical care provided to Alliance members for quality and medical appropriateness through prospective, concurrent and retrospective reviews of ambulatory, inpatient and ancillary services.
- Ensuring input of practicing healthcare providers in both primary care and various specialties in developing policies and standards through committee participation, and establishing performance standards to determine if care provided to members meets the requirements of good medical practice and is satisfactory to members.
- Identification of potential quality of care issues through a systematic review of clinical indicators.
- Identification and establishment of mechanisms to evaluate and improve patient care outcomes both internally and externally, including monitoring of corrective actions taken and the evaluation of their impact on the quality of care.
- Monitoring and ensuring compliance with the requirements of state, federal and other regulatory agencies

- Accurately recording and reporting results of Quality Improvement (QI) activities, including analysis of trends/patterns to the Quality Management (QM) Committee and Board.
- Annually evaluating and reviewing the Quality Improvement Program.

QUALITY IMPROVEMENT ACTIVITIES –ONGOING AND NEW

A. Quality Improvement Program Description
The QIP has been revised according to new activities required, personnel changes, and ongoing review by the QM Committee.

B. Quality Committees

- Quality Management Committee (QMC) is comprised of plan physicians throughout the service region representing various specialties. QMC meets biannually and as needed and assists with the oversight of the medical and operational systems as they affect health care services provided to the members. Specifically they review problem cases elevated by Medical Director for consultation, review QI studies at various stages, review external review reports, meet with community physicians involved in the quality assurance peer review process, and provide other consultation on quality, utilization management and authorization. QMC reports directly to the Physicians Advisory Committee **(PAG),** which includes representation from local physicians and is an advisory committee to the Board.

- Alliance Quality Team (AQT) is the internal quality team responsible for carrying out the QI program and work plan. AQT meets bi-weekly and includes the Medical Director, Health Services Director, Health Services Operations Manager,. Quality Improvement Manager, Quality Improvement Coordinator, Health Data Analyst, Senior Health Educator, Information Technology Department Director, Director of Provider and Member Services, Provider Relations Manager, Member Services Manager, and Claims Manager and Supervisor.

- The Physician Peer Review/Credentialing Committee meets quarterly, and more often depending on need. The PPR/C Committee reviews provider credentials and recommends actions to the Board. The Peer Review function is responsible for the review of all available information regarding the physician/vendor under review and, based on that information, reaches a determination that is impartial and fair.

- Utilization Review (UR) Team is comprised of the Medical Director and the plan's Utilization Review Nurses. UR meets **3** or more times each week to ensure the delivery of quality medical healthcare at the most appropriate level of care, in a timely, effective and efficient manner for Alliance members.

- The Pharmacy and Therapeutics ,Committeeis comprised of local physicians and pharmacists, meets biannually and as needed, and reports to the PAG. Their primary responsibility has been to develop, maintain and monitor a dynamic clinical formulary that ensures effective and efficient drug management for Alliance members. The Alliance formulary is reviewed annually by all network physicians and revisions are approved by the P & T Committee.

- The Staff Grievance Review Team is comprised of the Grievance Coordinator, Executive Director, Medical Director, Health Services Director, Director of Member and Provider Services, Provider Services Manager, and Member Services Manager and meets bi-weekly to review and resolve pending grievances.

C. Member Satisfaction

In the year 2001, DHS contracted with Health Services Advisory Group, Inc. (HSAG) to perform the Member Satisfaction Survey: HEDIS/CAHPS 2.0H, Adult and Child Surveys. HSAG in turn contracted with the Center for the Study of Services (CSS) to administer the CAHPS' mail and phone surveys in English and Spanish to randomly selected Alliance members. This member satisfaction survey was performed in collaboration with the other DHS Medi-Cal Managed Care Division (MMCD) contracted Health Plans. Results will be analyzed and addressed once received.

MRMIB completed the CAHPS 2.0 member satisfaction survey for Health Families members during CY 2000. A decision was made by MRMIB not to perform a member satisfaction survey for CY 2002.

D. Physician/Vendor Credentialing/Recredentialing

The Alliance Credentialing/Recredentialing process meets NCQA standards, including the recently added credentialing of mid-level practitioners. Recredentialing occurs every 2 years and includes a site review by a plan Utilization/Onsite Review Nurse.

E. Information Management (Medical Records)

Each newly credentialed and recredentialed Alliance primary care provider has ten (10) of their Alliance medical records reviewed as part of the facility review and credentialing process. Depending on the scope of their practice, records are reviewed for five (5) adults and five (5) children or all ten (10) are adults or children. Medical records are reviewed for documentation, organization; and completeness of the medical record in relation to medical history, current treatment and preventive measures. Confidentiality of medical records is always a prime consideration. All medical records reviewed on-site (Alliance) or at a provider facility are maintained according to regulations of strict confidentiality.

F. Risk Management

1. External Monitoring: In 2002, the Alliance will undergo the annual validation audit by HSAG for external validation of the Alliance data systems.
2. Severity of Illness/Disease Trends/Patterns: The Alliance Health Services/Utilization Management department tracks the in-member hospital length of stay (LOS) for all Alliance members.
3. Wheelchair Timeliness Report: The Alliance Health Services/Utilization Management department tracks the timeliness of all wheelchair purchases and repairs and reports this quarterly to the Board.

G. Health and Disease Management

During 2002, the Alliance Health Services department will continue to implement components of important health and disease management programs for members with diabetes and asthma. These programs will be expanded to all areas of the Alliance service region, and will be reviewed for access, quality, and outcomes.

H. Statistical Measures/HEDIS

The Alliance HEDIS 2002 measures are drawn from the following HEDIS domains: *Effectiveness of Care, Access/Availability of Care, and Use of Services.* Reporting these measures provides the Alliance an opportunity to improve its preventive health care delivery practices through analysis of study results and implementation of appropriate quality improvement interventions. These measures integrate contractual obligations under the Department of Health Services (DHS) and the California Managed Risk Medical Insurance Board (MRMIB).

The external accountability set for 2002 **DHS** requirements consists of the following HEDIS 3.0 measures:

- Childhood Immunizations Status (for 2 year olds)
- Well Child Visits in the First 15 Months of Life
- Annual Adolescent Well Care Visits
- Chlamydia Screening
- Perinatal Care
- Annual Diabetic Eye Exam
- Appropriateness of Asthma Medication

For MRMIB 2002 reporting, the clinical quality measures consists of the following HEDIS 3.0 measures:

- Childhood Immunizations Status (for 2 year olds)
- Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
- Adolescent Well Care Visits
- Children's Access to Primary Care Providers
- Follow-up after hospitalization for Selected Mental Illness
- 120 days Initial Health Assessment (Non-HEDIS).

Both DHS and MRMIB require that all results be audited by an approved NCQA licensed organization that will perform the HEDIS audit according to NCQA guidelines.

I. Quality Profiling
During CY 2001 the Alliance developed and distributed quality profiles for individual providers based on their performance in selected HEDIS measures. The profiles were distributed to providers in a confidential manner. The information presented included the overall health plan mean, the nationwide NCQA mean for Medicaid managed care plans, and the individual provider's compliance rate for each measure. These profiled will now be distributed to providers on an annual basis.

J. Potential Quality Issues
QI staff maintains a tracking and trending report designed for use in evaluating providers' performance over a designated period of time.

K. Delegated Review
The Alliance provides for an external independent review according to the regulations set forth by DHS and DMHC, for the purpose of impartial review of appeals and disputed level of care decisions.

L. Internal Quality Improvement Pro-iects (IQIPs)
On behalf of DHS, HSAG has approved four IQIP focus studies: breastfeeding promotion, breast cancer screening, cervical cancer screening, and promotion of perinatal care. Activities in these areas are ongoing as we work with members and providers to increase access to and compliance with these services.

M. Quality-based Incentives for Providers
~~The Alliance will continue to explore and develop this project as appropriate.~~

N. Revised Site Review Tool
The Alliance will continue to give feedback to Department of Health Services, and MRMIB as appropriate regarding the Site Review Tool used in the credentialing and recredentialing of Primary Care Providers.

O. Clinical Practice Guidelines
Adult and child preventive health screening guidelines have been approved and distributed to providers. Guidelines for asthma and diabetes care are being developed.

P. Perinatal Outreach and Case Management Program
The Health Educator has implemented phone outreach, tracking, and follow-up with provider-identified high-risk pregnant members. Physicians, clinics, and the Comprehensive Perinatal Program have been involved in the program development. A Health Educator also provides phone follow-up with all new mothers to encourage compliance with the recommended post partum visit, breastfeeding, immunization of the newborn, and enrollment of the newborn.

Q. Quality Improvement Activities related to HEDIS
The Alliance developed and implemented interventions and data capture activities to address issues identified by HEDIS and IQIP studies:

- Childhood Immunizations
- Well Child Care
- Annual Adolescent Well-Care Visits
- Timely Prenatal Care
- Check-Ups after delivery
- Chlamydia Screening
- Cervical Cancer Screening
- Breast Cancer Screening
- Annual Diabetic Eye Exams
- Appropriateness of Asthma Medication

Q. CRMS data system
The Alliance uses the CRMS data system to capture, analyze, and report data related to quality measures. In CY 2002, the Alliance will also use the CRMS database to produce quarterly utilization reports for individual providers

S. Initial Health Assessments
The Alliance continues to identify new members on provider eligibility lists and to provide ongoing feedback to providers regarding their compliance with the 120-Day Health Assessment mandate. We have implemented the Individual Behavior **Risk** Assessment requirement as part of the initial health assessment and ongoing preventive health visits. Compliance with the 120 day Health Assessment requirement is tracked and analyzed as part of the annual HEDIS audit.

T. Regulatory requirements
The Alliance will continue to meet regulatory requirements and strive toward meeting NCQA standards.

U. Medical Director Meetings
The Alliance Medical Director continues to attend the statewide meetings to discuss quality improvement initiatives and activities.

V. MOUs
The Alliance continues to work with health departments and local agencies and coalitions on the delivery and coordination of quality health care to Alliance members, and ongoing review and education of network providers.

W. Health Education and Cultural and Linguistic Needs Assessment
During CY 2001, the Alliance completed an initial Needs Assessment report for DHS and MRMIB. The report included findings and recommendations for improvement of services in these areas.

PROGRAM ACCOUNTABILITY

An annual evaluation of the QIP is conducted to assess the overall effectiveness of The Alliance's quality improvement process. This evaluation examines and reports on all aspects of the program.

A. The QI Plan will be revised and updated annually for the coming year by the Medical Director and Health Services Director, and will then be reviewed and approved by the QMC. The **QI** Plan will outline the proposed aspects of care to be reviewed, and the related Health Services QI activities for the year. The minutes of the QMC will reflect this QI Plan progress at least quarterly. The Quality Management Committee (QMC) will initially, and annually thereafter, review and recommend the Alliance's Quality Improvement Program (QIP) to the Commission for approval. The Commission review and approval will be documented in the minutes of the Governing Board. The QMC may also make recommendations for revision of the program at any time deemed necessary.

B. A year-end evaluation of the QI Program will be prepared annually by the Medical Director and the Health Services Director for review and approval by the QMC, and will be forwarded to the Commission for approval. This report will summarize the activities for the year and will identify areas where actual improvement in quality and outcomes of care has been accomplished through the efforts of the QM Program. The report will provide any deficiencies with suggested actions for improvements for the following year.

Reviewed and Approved by:

Barbara Palla MD
Medical Director

Barbara Flynn RN
Health Services Director

Date

Central Coast Alliance for Health

Quality Improvement: Report of the Medical Director 3/27/02
2001 Statistical Measures for Quality Assessment and Improvement

The following 2001 statistical measures were calculated by Central Coast Alliance for Health to assess quality and identify areas of improvement. These measures were modified as necessary based on the demographics, ethnicity, age and sex of the enrolled population. The statistical measures were divided into three areas:

1. External Accountability Set (Measuring Clinical Quality – HEDIS Reporting)
2. Quality Improvement Collaborative Initiative
3. Internal Quality Improvement Projects (IQIPs)

These measures were developed using HEDIS 3.0, as well as integrating contractual obligations under the Department of Health Services (DHS), Department of Corporations ***(DOC),*** and California Managed risk Medical Insurance Board (MRMIB). Requirements for statistical studies were incorporated into the Alliance Quality Improvement Plan for the first year of operation and each year thereafter for continued review of outcomes in a managed care environment.

EXTERNAL ACCOUNTABILITY SET

The Alliance was required to report audited results on **six** specific Health Plan Employer Data and Information Sets (HEDIS) measures selected by the Department of Health Services (DHS) as the External Accountability Set. In addition to the DHS reportable measures, the Alliance reported selected HEDIS **3.0** measures to MRMIB. Both DHS and MRMIB required that all results be audited by an approved NCQA licensed organization that performed the HEDIS audit according to NCQA's guidelines.

The external accountability set reported for 2000 DHS requirements consisted of the following HEDIS 3.0 measures:

- Childhood Immunizations Status (for 2 year olds)
- Well Child Visits in the First 15 Months of Life
- Annual Adolescent Well Care Visits
- Prenatal Care in the First Trimester/ Initiation of Prenatal Care
- Check-Ups after Delivery
- Annual Diabetic Eye Exam

For MRMIB 2000 reporting, the clinical quality measures consisted of the following HEDIS **3.0** measures:

- Childhood Immunizations Status (for 2 year olds)
- Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
- Annual Adolescent Well Care Visits
- Children's Access to Primary Care Providers
- Follow-up after hospitalization for Selected Mental Illness
- 120 days Initial Health Assessment (Non-HEDIS)

CENTRAL COAST ALLIANCE FOR HEALTH
2001 QUALITY IMPROVEMENT STATISTICAL MEASURES: Attachment 1

HEDIS 3.0 Measures

The Alliance HEDIS 2001 measures were drawn from the following HEDIS domains: *Effectiveness of Care, Access/Availability of Care,* and *Use of Services.* Reporting these measures provided the Alliance an opportunity to improve its preventive health care delivery practices through analysis of study results and implementation of appropriate quality improvement interventions.

A. HEDIS Measures: Medicaid (i.e., Medi-Cal)

1. Childhood Immunization Status (for 2 year olds) – Effectiveness of Care Measure

- Description/Indicators:
  The percentage of Medicaid enrolled children who turned two years of age during the measurement year, who were continuously enrolled for 12 months immediately preceding their second birthday, and who were identified as receiving the following immunizations within the time periods specified and by the member's second birthday:

- Results:

Data Element	DTP (4)	IPV (1)	OPV (3)	Hib (3)	Hep. B (3)	VZV (1)	Combo 1	Combo 2
2001 Alliance Rate: Medicaid	77.6%	88.1%	82.0%	82.0%	75.7%	79.1%	64.0%	58.6%
2000 NCQA Nat'l Medicaid Mean	65.5%	78.6%	74.0%	71.2%	69.2%	55.3%	51.3%	38.1%

2. Well-Child Visits in the First 15 Months of Life – Use of Services Measure

- Description/Indicators:
  The percentage of Medicaid enrolled members who turned 15 months of age during the measurement year, who were continuously enrolled in the plan from 31 days of age, and who received either zero, one, two, three, four, five, six or more well-child visits with a primary care practitioner during their first 15 months of life.

- Results:

Data Element	0 Visits	1 Visit Only	2 Visits Only	3 Visits Only	4 Visits Only	5 Visit Only	6 or More Visits
2001 Alliance Rate: Medicaid	2.4%	1.2%	2.7%	4.1%	9.7%	23.1%	56.7%
2000 NCQA Nat'l Medicaid Mean	13.9%	7.7%	8.7%	10.7%	13.9%	16.3%	30.2%

* Note: 89.5% of Alliance members had four or more well-child visits by 15 months of age.

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3. Adolescent Well-Care Visits – Use of Service Measure

- Description/Indicators:
  The percentage **of** Medicaid enrolled members who were age **12** through 21 years during the measurement year, who were continuously enrolled during the measurement year, and who received at least one comprehensive well-care visit with a primary care provider or an OB/GYN provider during the measurement year.

- Results

	Alliance Rate: Medicaid	2000 NCQA Nat'l Medicaid Mean
Reported Rate	**23.0%**	**27.9%**

4. Timely Prenatal Care – Access/Availability of Care Measure

- Description/Indicators:
  The percentage of women who delivered a live birth between November 6th of the year prior to the measurement year and November 5th of the measurement year, who were continuously enrolled at least **43** days prior to delivery through 56 days after delivery. For these women, the measure assesses the percentage of women in the denominator who received prenatal care in the first trimester OR within **42** days of enrollment in the Plan.

- Results

	Alliance Rate: Medicaid	2000 NCQA Nat'l Medicaid Mean
Reported Rate	**76.0%**	**Not Available**

6. Check-Ups After Delivery – Effectiveness of Care Measure

- Description/Indicators:
  The percentage of Medicaid enrolled women who delivered a live birth between November 6th of the year prior to the measurement year and November 5th of the measurement year, who were continuously enrolled at least **43** days prior to delivery through 56 days after delivery, and who had a postpartum visit on or between 21 days and 56 days after delivery.

- Results

	Alliance Rate: Medicaid	2000 NCQA Nat'l Medicaid Mean
Reported Rate	**57.0%**	**Not Available**

7. Diabetic Eye Exam

- Description /Indicators
  The percentage of Medicaid enrolled members with diabetes (Type I and Type **2)** age 18 through **75** years, who were continuously enrolled during the measurement year, and who had an eye exam with an eye care professional during the measurement year.

- Results

	Alliance Rate: Medicaid	2000 NCQA Nat'l Medicaid Mean
Reported Rate	**54.5%**	**41.0%**

B. HEDIS Measures: Healthy Families

1. Childhood Immunizations

- Description/Indicators:
  The percentage **of** Healthy Families enrolled children who turned *two* years **of** age during the reporting year, who were continuously enrolled for **12** months immediately preceding their second birthday, and who were identified as receiving the following immunizations within the time periods specified and by the member's second birthday:

- Results

	Central Coast Alliance for Health	
	Combo1	**Comb02**
Reported Rate:	**Sample too small to report**	

2. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life – Use of Services Measure (Healthy Family Members Only)

- Description/Indicators:
  The percentage of Healthy Families enrolled members who were three, four, five or six years **of** age during the measurement year, who were continuously enrolled during the measurement year, and who received one or more well-child visit(s) with a primary care provider during the measurement year.

- Results

	Central Coast Alliance for Health
Reported Rate:	**70.4%**

3. Adolescent Well-Care

- Description/Indicator
  The percentage of Healthy Families members who were 12 through **21** years of age during the measurement year, who were continuously enrolled during the measurement year, and who had at least one comprehensive well-care visit with a primary care provider or an OB/GYN provider during the measurement year.

- Results

	Central Coast Alliance for Health
Reported Rate:	**16.3%**

4. Children's Access to PCP – Access/Availability of Care Measure

- Description/Indicators:
  The percentage of Healthy Families enrollees who were:

  1. Children age 12 through **24** months, and 25 months through **6** years, who were continuously enrolled in Healthy Families during the measurement year, and who had a visit with a primary care provider during the measurement year.
  2. Children age 7 years through 11 years who were continuously enrolled during the measurement year and the calendar year preceding the measurement year, and who have had a visit with a health plan primary care provider during the measurement year or the calendar year preceding the measurement year.

- Results

	Central Coast Alliance for Health		
Data Elements	**Age 12-24 Months**	**Age 25 Months - 6 Years**	**Age 7 - 11 Years**
Reported Rate	**N/A***	**92.2%**	**N/A***

* No members met denominator

5. Follow-up After Hospitalization for Mental Illness – Effectiveness of Care Measure (Healthy Families)

- Description/Indicators:
  The percentage of Healthy Families members age six years and older who were hospitalized for treatment of selected mental health disorders, who were continuously enrolled for 30 days after discharge, and who were seen for an ambulatory mental health visit or were in a day/night treatment with a mental health provider.

- Results

Reported Rate	The Alliance has no record of any Healthy Family members who were six years and older and who were hospitalized **for** the treatment **of** mental health disorders during **CY** 2000. The information was administratively queried through the **Plan's** medical utilization management database.

6. Initial 120-Day Health Assessment – Non-HEDIS Access/Availability of Care Measure

- Description/Indicators:
  The percentage of Healthy Families members age 2 years and older, who were continuously enrolled in the Health Plan for at least 120 days during the measurement year, and who had an initial health assessment (IHA) with a primary care provider within 120 days of enrollment.

- Results

	Central Coast Alliance for Health
Reported Rate:	**33.3%**

QUALITY IMPROVEMENT COLLABORATIVE INITIATIVE

Health Plans in the Medi-Cal Managed Care Division Two Plan Model, Sacramento GMC Mode, and the County Organized Health Systems are required to undertake a joint quality improvement collaborative initiative addressing a common topic among all the Plans as of the 2000-reporting year. In 2001 the Quality Improvement Collaborative Initiative selected was Effectiveness of Care Measure: Chlamydia Screening in Women.

1. Chlamydia Screening in Women – Effectiveness of Care Measure

- Description/Indicators
  The percentage of Medicaid women age 16 through 26 years who were identified as sexually active, who were continuously enrolled during the measurement year, and who had at least one test for chlamydia during the measurement year.

- Results

Reported Results	Central Coast Alliance for Health
Age 16-20 years	42.0%
Age 21-26 years	39.0%

INTERNAL QUALITY IMPROVEMENT PROJECTS

In accordance with the QISMC standards, DHS and MRMIB requirements, the Alliance performed Internal Quality Improvement Projects (IQIPs) to measure its own performance in important focus areas, undertake systemic interventions to improve performance, and follow-up on the effectiveness of the interventions.

In 2001, the Alliance implemented IQIP interventions for four topics:

Clinical focus areas:
- Cervical Cancer Screening
- Breast Cancer Screening

Non-Clinical focus areas:
- Breast Feeding Program
- Promotion of Prenatal Care

1. Cervical Cancer Screening – Effectiveness of Care Measure

- Description/ Indicators
  The percentage of Medicaid enrolled women age 21 through 64 years, who were continuously enrolled during the measurement year and who received one or more cervical cancer screening tests (i.e., Pap smears) during the measurement year or the two years prior to the measurement year.

- Results

	Central Coast Alliance for Health
Reported Rate:	57.0%

2. Breast Cancer Screening – Effectiveness of Care Measure

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- Description/ Indicators
  The percentage of Medicaid enrolled women age 52 through 69 years, who were continuously enrolled during the measurement year, and the preceding year, and who had a mammogram during the measurement year or the preceding year.

- Results

	Central Coast Alliance for Health
Reported Rate:	**55.0%**

3. Breast Feeding Promotion

- Description/ Indicators
  The percentage of infants born during the measurement year, who were continuously enrolled at the time of their birth though age six months, and who were breastfeeding at hospital discharge, and at 1, **3,** and 6 months of age.

- Results

1. Intent re: infant feeding (at 1 week prior to birth):

Central Coast Alliance for Health			
	Breastfeed only	**Combination breast and formula**	**Formula only**
Total	69%	**96%**	**4%**
Hispanic/Latina	60%	97%	**3%**
White	89%	**89%**	**11%**

2. Initiation of breastfeeding (at hospital discharge):

Central Coast Alliance for Health				
	Total Breastfeeding	**Breastfeed only**	**Combination breast and formula**	**Formula only**
Total	93%	69%	24%	**7%**
Hispanic/Latina	92%	69%	23%	9%
White	**89%**	89%	*0*	**11%**

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3. Duration of breastfeeding (at 1, 3, and *6* months post-parturn):

Central Coast Alliance for Health				
	Total breastfeeding	Breastfeed only	Combination breast and formula	Formula only
1 month total	84%	44%	40%	16%
Hispanic/Latina	83%	37%	46%	17%
White	89%	67%	22%	11%
3 month total	Data Collection and Analysis in Progress			
Hispanic/Latina				
White				
6 month total	Data Collection and Analysis in Progress			
Hispanic/Latina				
White				

4. Promotion of Perinatal Care

The Perinatal IQIP uses the perinatal HEDIS studies as described previously in this report under **"HEDIS** 3.0 Measures."

Central Coast Alliance for Health

Balance Sheet

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for the month ending March 31, 2002

unaudited

Assets			
	Cash	29,712,482	
	Restricted Cash	19,728,230	
	Short Term Investments	5,966,768	
	Receivables	17,482,724	
	Prepaid Expenses	39,930	
	Other Current Assets	15,586	
	Total Current Assets		72,945,720
	Furniture, Fixtures and Equipment - Santa Cruz	2,115,740	
	Furniture, Fixtures and Equipment - Monterey	928,313	
	Vehicles	24,295	
	Accumulated Depreciation	(2,501,549)	
	Other Non-Current Assets		
	Total Non-Current Assets		566,798
	Total Assets		73,512,518
Liabilities			
	Accounts Payable	37,482	
	Incurred But Not Reported Claims/Claims Payable	33,196,742	
	Accrued Expenses	546,021	
	Lease Payable - Current	-	
	Note Payable - Current		
	Interest Payable		
	Estimated Risk Share Payable	5,433,743	
	Other Current Liabilities	1,935,375	
	Total Current Liabilities		41,149,362
	Long Term Debt		
	Lease Payable - Non-Current	-	
	Notes Payable - Non-Current		
	Total Non-Current Liabilities		-
Fund Balance			
	Health Care Expense Reserve	19,728,230	
	Fund Balance - Prior Years	13,602,614	
	Retained Earnings - Current Year	(967,689)	
	Total Fund Balance		32,363,155
	Total Liabilities and Fund Balance		73,512,518

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

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Central Coast Alliance for Health

Consolidated Income Statement
for the month ending March 31, 2002
unaudited

	Current Month			Year to Date			Actual	VARIANCE
	Actual	Budget	Variance	Actual	Budget	Variance	PMPM	PMPM
State Capitation	15,857,718	16,189,753	(332,035)	47,399,324	47,722,311	(322,987)	204.16	1.39
Healthy Families Revenue	105,906	107,302	(1,396)	312,465	321,906	(9,441)	1.35	0.04
Other Revenue	0	0	0	0	0	0	0.00	0.00
Interest Income	82,205	88,577	(6,372)	261,893	269,833	(7,940)	1.13	0.03
Total Revenue	**16,045,829**	**16,385,632**	**(339,803)**	**47,973,682**	**48,314,050**	**(340,368)**	**206.64**	**1.47**
PCP Capitation	495,701	576,718	81,017	1,450,976	1,693,168	242,192	6.25	1.04
Lab Capitation	76,021	76,021	0	226,310	226,310	0	0.97	0.00
Vision Capitation	82,249	82,249	0	242,786	242,786	0	1.05	0.00
Physician FFS	1,698,153	1,950,444	252,291	5,460,905	5,684,414	223,509	23.52	0.96
Pharmacy	3,565,143	3,382,027	(183,116)	10,248,973	8,747,381	(1,501,592)	44.15	-6.47
Hospital Inpatient	4,576,818	4,457,112	(119,706)	13,195,756	13,235,976	40,220	56.84	0.17
Hospital Outpatient	766,869	572,647	(194,222)	2,211,718	1,679,803	(531,915)	9.53	-2.29
Long Term Care	3,231,451	3,384,612	153,161	9,784,872	9,928,316	143,444	42.15	0.62
Other Medical	756,084	675,739	(80,346)	2,093,738	1,977,766	(115,972)	9.02	-0.50
Lab FFS	43,653	43,653	0	151,866	151,866	0	0.65	0.00
Reinsurance Expense	140,751	140,751	0	403,922	404,476	553	1.74	0.00
Total Health Care Expense	**15,432,894**	**15,341,973**	**(90,921)**	**45,471,824**	**43,972,262**	**(1,499,562)**	**195.86**	**(6.46)**
Salaries & Fringe Benefits	593,195	625,934	32,739	1,883,619	2,079,804	196,185	8.11	0.85
Contract Services	60,917	55,550	(5,367)	87,400	106,650	19,250	0.38	0.08
Travel & Training	10,900	8,990	(1,910)	22,679	20,290	(2,389)	0.10	-0.01
Office Supplies & Equipment	41,517	55,760	14,243	108,569	167,280	58,711	0.47	0.25
Rent & Occupancy	34,910	36,450	1,540	112,955	120,450	7,495	0.49	0.03
Other Expenses	64,630	68,500	3,870	194,324	205,500	11,176	0.84	0.05
Total Administrative Expenses	**806,069**	**851,184**	**45,115**	**2,409,546**	**2,699,974**	**290,428**	**10.38**	**1.25**
	5.0%			**5.0%**				
Health Care Expense Reserve	**0**			**1,060,000**				
Net Income less Reserve	**(193,134)**			**(967,687)**				
% of Revenue less Expense and Reserve	**-1.20%**			**-2.02%**				
Members Current Month	**78,539**							
Monthly Average	**77,388**							

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

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Central Coast A[illegible]nce for Health

Income Statement: Santa Cruz

for the month ending March 31, 2002

unaudited

	Current Month			Year to Date			Actual	VARIANCE
	Actual	Budget	Variance	Actual	Budget	Variance	PMPM	PMPM
State Capitation	5,819,549	5,836,407	(16,858)	17,614,198	17,246,295	367,903	246.54	(5.15)
Other Revenue			-	-	0	-	-	-
Total Revenue	**5,819,549**	**5,836,407**	**(16,858)**	**17,614,198**	**17,246,295**	**367,903**	**246.54**	**(5.15)**
PCP Capitation	226,758	284,176	57,418	666,350	837,892	171,542	1.33	2.40
Lab Capitation	23,253	23,253	0	71,707	71,707	0	[illegible]	-
Vision Capitation	25,674	25,674	0	76,067	76,067	0	1.06	-
Physician FFS	475,242	665,054	189,812	1,706,044	1,943,736	237,692	23.88	3.33
Pharmacy	1,309,576	1,320,584	11,008	3,916,737	3,417,320	(499,417)	54.82	(6.99)
Hospital Inpatient	1,388,632	1,325,505	(63,127)	4,023,347	3,870,125	(153,222)	56.31	(2.14)
Hospital Outpatient	234,281	144,172	(90,109)	723,305	423,586	(299,719)	10.12	(4.19)
Long Term Care	1,288,320	1,462,102	173,782	4,188,235	4,288,184	99,949	58.62	1.40
Other Medical	410,169	310,920	(99,249)	1,072,309	909,300	(163,009)	15.01	(2.28)
Lab FFS	18,323	18,323	0	64,578	64,578	0	0.90	-
Reinsurance Expense	48,707	48,707	0	153,975	153,976	0	2.16	0.00
Total Health Care Expense	**5,448,934**	**5,628,470**	**179,535**	**16,662,654**	**16,056,471**	**(606,184)**	**233.22**	**(8.48)**
Revenue less Health Care Exp.	**370,615**	**207,937**	**162,677**	**951,544**	**1,189,824**	**(238,280)**		

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Central Coast Alliance for Health

Income Statement: Monterey
for the month ending March 31, 2002
unaudited

	Current Month			Year to Date			Actual	VARIANCE
	Actual	Budget	Variance	Actual	Budget	Variance	PMPM	PMPM
State Capitation	10,038,169	10,353,346	(315,177)	29,785,126	30,476,016	(690,890)	190.82	4.43
Total Revenue	**10,038,169**	**10,353,346**	**(315,177)**	**29,785,126**	**30,476,016**	**(690,890)**	**190.82**	**4.43**
								-
PCP Capitation	268,943	292,542	23,599	784,625	855,276	70,651	5.03	0.45
Lab Capitation	51,185	51,185	0	149,981	149,981	0	0.96	-
Vision Capitation	56,576	56,576	0	166,719	166,719	0	1.07	-
Physician FFS	1,198,563	1,248,626	50,063	3,694,169	3,630,386	(63,783)	23.67	(0.41)
Pharmacy	2,248,663	2,033,818	(214,845)	6,315,815	5,247,186	(1,068,629)	40.46	(6.85)
Hospital Inpatient	3,179,786	3,126,126	(53,660)	9,150,918	9,349,408	198,490	58.63	1.27
Hospital Outpatient	524,786	422,702	(102,084)	1,472,029	1,238,898	(233,131)	9.43	(1.49)
Long Term Care	1,943,130	1,922,510	(20,620)	5,596,637	5,640,132	43,495	35.86	0.28
Other Medical	340,272	358,931	18,659	1,008,695	1,053,794	45,099	6.46	0.29
Lab FFS	24,758	24,758	0	85,853	85,853	0	0.55	-
Reinsurance Expense	92,045	92,045	0	249,947	250,500	553	1.60	0.00
Total Health Care Expense	**9,928,705**	**9,629,818**	**(298,888)**	**28,675,387**	**27,668,133**	**(1,007,254)**	**183.71**	**(6.45)**
Revenue less Health Care Exp.	**109,464**	**723,529**	**(614,065)**	**1,109,738**	**2,807,883**	**(1,698,144)**		

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

Central Coast Alliance for Health

Income Statement: Healthy Families
for the month ending March 31, 2002
unaudited

	Current Month			Year to Date			Actual	VARIANCE
	Actual	Budget	Variance	Actual	Budget	Variance	PMPM	PMPM
Healthy Families Revenue	105,906	107,302	1,396	312,465	321,906	9,441	67.50	2.04
Other Revenue			-	-	-	-	0.00	0.00
Interest Income			-	-	-	-	0.00	0.00
Total Revenue	**105,906**	**107,302**	**1,396**	**312,465**	**321,906**	**9,441**	**67.50**	**2.04**
Lab Capitation	1,583	1,583	0	4,623	4,623	0	1.00	0.00
Mental Health Capitation	3,414	3,414	0	9,970	9,970	0	2.15	0.00
Physician FFS	24,348	36,764	12,416	60,692	110,292	49,600	13.11	10.72
Pharmacy	6,904	27,625	20,721	16,422	82,875	66,453	3.55	14.36
Hospital Inpatient	8,400	5,481	(2,919)	21,492	16,443	(5,049)	4.64	(1.09)
Hospital Outpatient	7,803	5,773	(2,030)	16,385	17,319	934	3.54	0.20
Other Medical	2,229	2,473	244	2,765	4,702	1,938	0.60	0.42
Lab FFS	573	573	0	1,434	1,434	0	0.31	0.00
Total Health Care Expense	**55,254**	**83,686**	**28,432**	**133,782**	**247,658**	**113,876**	**28.90**	**24.60**
Revenue less Health Care Exp.	**50,652**	**23,616**	**27,036**	**178,683**	**74,248**	**104,435**		

0311

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

Central Coast Alliance for Health

0312

Statement of Cash Flows

for the month ending March 31, 2002

Cash flows from Operating Activities:	
Net Income	(193,135)
Additions to Health Care Reserve	
Items not requiring the use of cash: depreciation	44,000
Adjustments to reconcile net income to net cash provided by operating activities:	
Change in Receivables	253,906
Change in Prepaid Expenses	5,046
Change in Other Current Assets	
Change in Accounts Payable	(76,758)
Change in IBNR	1,800,000
Change in Accrued Expenses	28,181
Change in Interest Payable	
Change in Current Notes Payable	-
Change in Risk Share Payable	
Change in Other Current Liabilities	(897,295)
Change in Lease Payable	
Change in Note Payable	
Net Cash Provided by Operating Activities	1,113,080
Change in Investments	
Investment to Expand Operations (Monterey)	
Equipment Acquisitions	(17,719)
Net Cash Used in Investing Activities	(17,719)
Payment of Long-term Debt	
Net Cash Provided by Financing Activities	-
Net Increase/(Decrease) in Cash	946,226
Cash at February 28, 2002	48,494,486
Cash at March 31,2002	49,440,712

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

Central Coast Alliance for Health

Notes to Financial Statement

for year ending March 31, 2002

unaudited

- The Santa Cruz-Monterey County Managed Care Commission d.b.a. Central Coast Alliance for Health (the Alliance) is a managed healthcgre 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, 1098 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 Chubb to limit its losses on individual claims. Under the terms of the agreement, Chubb will reimburse the Alliance for each member's annual hospital services in excess of $100,000.

- 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	
2002	$391,760
2003	403,513
2004	415,619
2005	99.240
	$1,690,482

Central Coast Alliance for Health
Notes to Financial Statement
for year ending *March* 31, *2002*
unaudited

- On January 1, 1997, 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 $31 million. The Alliance intends to reach this target by the year 2003.

Report **of** Independent Public Accountants

To the Board **of** Directors of
Santa Cruz-Monterey Managed Medical Care Commission
d.b.a. Central Coast Alliance for Health:

We have audited the accompanying balance sheets of Santa Cruz-Monterey Managed Medical Care Commission d.b.a. Central Coast Alliance for Health (a California local public agency) **as** of December 31, 2001 and 2000, and the related statements of revenues and expenses and changes in fund balance and cash flows for the years then ended. These financial statements and the supplementary information in the exhibit referred to below are the responsibility of the Organization's management. Our responsibility is to express an opinion on these financial statements and exhibit based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. *An* audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. *An* audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Santa Cruz-Monterey Managed Medical Care Commission d.b.a. Central Coast Alliance for Health as of December 31,2001 and 2000, and the results of its operations and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States.

Our audits were made for the purpose of forming an opinion on the financial statements taken **as** a whole. The supplementary information in the exhibit is presented for purposes of additional analysis of the financial statements and is not a required part of the financial statements. This information has been subjected to the auditing procedures applied in our audits of the financial statements and, in our opinion, is fairly stated in all material respects in relation to the financial statements taken **as** a whole.

San Francisco, California
March 22, 2002

Santa Cruz-Monterey Managed Medical Care Commission
d.b.a. Central Coast Alliance for Health

Balance Sheets — December 31, 2001 and 2000

	2001	2000
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$19,459,926	$16,618,121
Investments	12,666,029	5,550,322
Due from California Department of Health Services	18,307,692	18,111,446
Reinsurance receivables	666,095	–
Prepaid expenses and other current assets	159,344	80,579
Total current assets	51,259,086	40,360,468
PROPERTY AND EQUIPMENT:		
Furniture and equipment	2,993,752	2,736,996
Leasehold improvements	41,875	15,153
	3,035,627	2,752,149
Less: Accumulated depreciation	(2,366,675)	(1,815,194)
Net property and equipment	668,952	936,955
ASSETS LIMITED AS TO USE	18,668,230	12,379,251
RESTRICTED CASH	300,000	300,000
Total assets	$70,896,268	$53,976,674
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
Medical claims liability	$31,447,406	$28,728,337
Provider risk-sharing payable	4,191,982	2,729,738
Accounts payable	251,874	166,584
Other accrued liabilities	2,734,162	3,188,297
Total current liabilities	38,625,424	34,812,956
FUND BALANCE:		
Designated	18,668,230	12,379,251
Undesignated	13,602,614	6,784,467
Total fund balance	32,270,844	19,163,718
Total liabilities and fund balance	$70,896,268	$53,976,674

The accompanying notes are an integral part of these statements.

Santa Cruz-Monterey Managed Medical Care Commission
d.b.a. Central Coast Alliance for Health

Statements of Revenues and Expenses and Changes in Fund Balance
For the Years Ended December **31, 2001** and **2000**

	2001	2000
REVENUES:		
Premiums earned	$189,699,575	$143,215,815
Investment income, including realized and unrealized gains and losses	1,510,974	1,536,160
Total revenues	191,210,549	144,751,975
MEDICAL COSTS:		
Hospital inpatient and long-term care costs	80,938,711	74,162,587
Hospital outpatient, pharmacy, lab and other costs	54,696,597	35,554,059
Physician services	19,562,381	12,420,519
Provider capitation	5,810,443	3,569,148
Provider risk-sharing	5,500,000	4,381,692
Reinsurance premiums, net of recoveries	659,569	(66,8111
Total medical *costs*	167,167,701	130,021,190
ADMINISTRATIVE EXPENSES:		
Salaries, wages and employee benefits	7,272,082	5,413,732
Professional fees	584,826	546,173
Purahased services	165,540	34,176
Supplies, occupancy, insurance and other	2,361,793	1,888,338
Depreciation	551,481	591,742
Total administrative expenses	10,935,722	8,474,161
EXCESSOFREVENUESOVEREXPENSES	13,107,126	6,256,624
FUND BALANCE, beginning of year	19,163,718	12,907,094
FUND BALANCE, end of year	$ 32,270,844	$ 19,163,718

The accompanying notes are an integral part of these statements.

Santa Cruz-Monterey Managed Medical Care Commission
d.b.a. Central Coast Alliance for Health

Statements of Cash Flows
For the Years Ended December 31,2001 and 2000

	2001	2000
CASH FLOWS FROM OPERATING ACTIVITIES:		
Excess of revenues over expenses	$ 13,107,126	$ 6,256,624
Items not requiring use of cash: depreciation	551,481	591,742
Changes in certain assets and liabilities:		
Due from California Department of Health Services	(196,246)	(8,289,699)
Reinsurance receivables	(666,095)	-
Prepaid expenses and other current assets	(78,765)	(62,258)
Medical claims liability	2,719,069	13,746,583
Provider risk-sharing payable	1,462,244	425,346
Accounts payable	85,290	69,147
Other accrued liabilities	(454,135)	(21,207)
Cash provided by operating activities	16,529,969	12,716,278
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of property and equipment, net	(283,478)	(465,601)
Increase in investments	(7,115,707)	(481,212)
Increase in assets limited as to use	(6,288,979)	(5,237,994)
Cash used for investing activities	(13,688,164)	(6,184,807)
Increase in cash and cash equivalents	2,841,805	6,531,471
CASH AND CASH EQUIVALENTS, beginning of year	16,618,121	10,086,650
CASH AND CASH EQUIVALENTS, end of year	$ 19,459,926	$16,618,121

The accompanying notes are an integral part **of** these statements.

Santa Cruz-Monterey Managed Medical Care Commission
d.b.a. Central Coast Alliance For Health

Notes to Financial Statements
December 31,2001 and 2000

1. Oraanization and Basis *Of* Presentation

The Santa Cruz-Monterey Managed Medical Care Commission d.b.a. Central Coast Alliance for Health (the Alliance) is a managed healthcare system serving Medi-Cal-eligible persons in Santa Cruz and Monterey counties, California (the Counties). The Alliance is a local public agency separate and distinct from the respective county governments.

The Alliance began serving enrollees in Santa Cruz County in 1996. In 1998, the Alliance entered into an agreement with Monterey County to expand the Alliance's services into that county beginning October 1, 1999, The Boards of Supervisors of both counties approved the Alliance's status as a Regional County Organized Health System in 1998. Pursuant to the agreement, Monterey County has agreed to share the expansion costs incurred during the Monterey County start-up period, which ends March 31,2001, if the expansion is subsequently discontinued. These start-up costs amounted to $1,907,287.

The Alliance has contracted with the California Department of Health Services (CDHS) to provide healthcare benefits to eligible County residents. In turn, the Alliance has contracted with various healthcare providers to provide or arrange hospital and medical services for its members. The Alliance's contract with CDHS is subject to annual rate redeterminations and extends to December 31, 2002.

The accompanying financial statements have been prepared in accordance with the Standards of the Governmental Accounting Standards Board (GASB). As permitted by GASB No. 20, "Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting," the Alliance has elected to apply all FASB Statements and Interpretations, Accounting Principles Board Opinions and Accounting Research Bulletins issued after November 30, 1989, except for those that conflict with or contradict GASB pronouncements.

2. Summary of Significant Acceuntina Policies-

Use **of** Estimates

The preparation of financial statements in accordance with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets And liabilities and disclosure of contingent assets and liabilities at the date **of** the financial statements. Actual results could differ from those estimates.

Cash and Cash Equivalents

The Alliance considers all highly liquid instruments purchased with an original maturity **of** three months or less to be cash equivalents.

Investments

Investments consist of U.S. government securities and mutual funds and are carried at fair value.

Property and Equipment

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 basis over the estimated lives of the assets, which range from three to five years.

Assets Limited as to Use

Assets limited as to use are designated assets set aside by the Board of Directors (the Board) for future healthcare expenditures.

Premium Revenue

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

Medical Costs

The ***cost*** of contracted healthcare services is accrued in the period in which it is provided to a member based, in part, on estimates, including an accrual for medical services provided but not reported to the Alliance.

Risk Sharing

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.

Reinsurance

In 2001, the Alliance maintained a reinsurance policy with CDHS to limit its losses on individual claims. Under the terms of this agreement, CDHS will reimburse the Altiance for each member's annual hospital services ***costs*** in excess of $75,000.

Reinsurance premiums are reported as medical costs, and the reinsurance recoveries are recorded as a reduction of reinsurance expense.

The Alliance held no reinsurance insurance policy in **2000.**

Income Taxes

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

Reclassifications

Certain 2000 balances have been reclassified to conform to the **2001** presentation.

3. Investments

Cash and cash equivalents and investments are categorized by credit risk as follows:

Category *1* — Insured or collateralized with securities held by the Alliance or by its agent in the Alliance's name.

Category 2 — Collateralized with securities held by the pledging financial institution's trust department or agent in the Alliance's name. Collateralized deposits represent amounts covered by collateral held by the pledging financial institutions; under California laws, depository banks maintain a collateral pool for all public funds deposited.

***Category* 3** — Uncollateralized, including any bank balance that is collateralized with securities held by the pledging financial institution or by its **trust** department or agent but not in the Alliance's name.

The Alliance does not have any deposits in Category 2 or Category 3.

Cash and cash equivalents and investments, including assets limited as to use and restricted cash, consist of the following:

	Fair Value	
	2001	20Q0
Cash and cash equivalents:		
Deposits with financial institutions	$38,428,156	$29,297,372
Investments:		
U.S. government securities	$ 2,721,314	$ 2,731,100
U.S. government pooled investment fund	1,417,969	1,341,210
Certificates of deposit	6,749,798	–
Total categorized	10,889,081	4,072,310
Investments not categorized: equity mutual funds	1,776,948	1,478,012
Total investments	$12,666,029	$ 5,550,322

4. Operating Lease

The Alliance leases office space under noncancelable operating leases with minimum annual payments as follows:

Year Ending December 31	
2002	$ 391,760
2003	403,513
2004	415,619
2005	99,240
	$1,310,132

Rental expense under operating leases was approximately $419,047 and $412,555 during the years ended December 31,2001 and 2000, respectively.

5. Retirement Plan

On January 1, 1997, the Alliance established a 401(a) Money Purchase Plan and Trust (the Plan), which is ah elective plan covering all of its employees. Under the terms of the plan agreement, employees may make voluntary contributions to the Plan and 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 contributions to 10 percent. The Alliance incurred approximately $373,726 and $210,856 of retirement plan expense during the years ended December 31, 2001 and 2000, respectively.

6. Regulatory and Contractual Requirements

As a limited license plan under Knox-Keene Health Care Service Plan Act of 1975 (the Act), the Alliance is required to maintain a minimum level of tangible net equity. The required tangible net equity level was approximately $1,000,000 at December 31, 2001. The Act also requires the Alliance to maintain a $300,000 restricted deposit, which is included in restricted cash in the accompanying balance sheets.

7. Healthcare Expense Reserve

During 1997, the Alliance's Board of Directors established a policy for increasing the organization's capital reserves. This policy calls for accumulating designated fund balance over time to equal two months of premium revenue, or approximately $31.2 million. The Alliance intends to reach this target by the year 2003. As of December 31, 2001 and 2000, the Alliance had accumulated designated reserves of $18,668,230 and $12,379,251, respectively.

EXHIBIT

Santa Cruz-Monterey Managed Medical Care Commission
d.b.a. Central Coast Alliance for Health

0323

Supplementary Departmental Statement of Revenues and Expenses
And Changes in Fund Balance
For the Year Ended December **31,2001**

	Santa Cruz county	Monterey County	Healthy Famllles	Administrative	Total
REVENUES:					
Premlums earned	$70,380,351	$118,298,190	$1,021,034	$ -	$189,699,575
Investment income, including realized and unrealized gains and losses	-	-	-	1,510,974	1,510,974
Total revenues	70,380,351	118,298,190	1,021,034	1,510,974	191,210,549
MEDICAL COSTS:					
Hospital inpatient and long-term care costs	29,514,103	51,308,036	116,572	-	80,938,711
Hospital outpatient, pharmacy, lab and other costs	21,012,902	33,537,834	145,861	-	54,696,597
Physician services	6,790,596	12,615,866	155,919	-	19,562,381
Provider capitation	2,661,622	3,148,821	-	-	5,810,443
Provider risk-sharing	1,938,000	3,112,000	450,000	-	5,500,000
Reinsurance premiums, net of recoveries	422,278	237,291	-	-	659,569
Total medical costs	62,339,501	103,959,848	868,352	-	167,167,701
ADMINISTRATIVE EXPENSES:					
Salaries, wages and employee benefits	-	-	-	7,272,082	7,272,082
Professional fees	-	-	-	584,826	584,826
Purchased services	-	-	-	165,540	165,540
Supplies, occupancy, insurance and other	-	-	-	2,361,793	2,361,793
Depreciation	-	-	-	551,481	551,481
Total administrative expenses	-	-	-	10,935,722	10,935,722
EXCESS OF REVENUES OVER EXPENSES	$ 8,040,850	$ 14,338,342	$ 152,682	$ (9,424,748)	13,107,126
FUND BALANCE, beginning of year					19,163,718
FUND BALANCE, end of year					$ 32,270,844

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

DATE: April 15, 2002

TO: Local Primary Care Physicians

FROM: Alan McKay, Executive Director (ext. 4300; amckay@ccah-alliance.org)

RE: ALLIANCE 2001 RISK SETTLEMENT

First, the (very) good news. The Alliance is now distributing $5.5M in surplus to local providers in Santa Cruz and Monterey Counties...our 2001 surplus is our largest ever. Fiscal performance in Monterey County has improved, and our regional Alliance membership exceeds 74,000 residents. The health plan has reached its reserves target of $30M. Our earnings are high, membership is robust, and our reserves are strong. We are pleased to share back with you the surplus earned in our local, non-profit system of care. The Alliance's governing board and staff truly appreciate the health care services you provided to our members in **2001**.

With your surplus and withhold check, find enclosed a brief analysis of your results in Medi-Cal, and in Healthy Families if applicable. Dr. Barbara Palla, Medical Director, has enclosed some suggested case management methods that can enhance PCP earnings in the risk settlement. If you would like to discuss your results in relation to your practice, or would like to find out more about the Alliance case management support services, please contact Dr. Palla at ext. **4329.** If you would like to see summary data on the 2001 settlement by County, please contact Ms. Anna Berens at ext. **4339.**

Despite our extraordinary results in 2001, the coming year will be constrained by the State's $14B deficit. The legislature has frozen all Medi-Cal health plan rates across the State. There will be no new revenue to offset rising Medi-Cal costs in 2002. **As** a result, all Medi-Cal plans face possible deficit performance this year. The Alliance has strong reserves and can weather this downturn, but not without hardships. There is a very real prospect of little or no Alliance surplus in 2002, since medical inflation could overtake our local efficiencies.

The Alliance **is** responding to this fiscal challenge with low administrative costs, and effective case management support services. Your efficient use of medical resources will be most important. Our governing board has communicated to the State that Medi-Cal inflation should be a funding priority. We ask that you join us in that effort, and email or write the Governor (see enclosure) to express your views. We can work together to sustain the improved health and welfare of our communities.

Congratulations again on our outstanding Alliance 2001 **risk** settlement

6-9

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

March 13, 2002

Senator Bruce McPherson
State Capitol, Room 2054
Sacramento, CA 95814

RE: STATE MEDI-CAL HEALTH PLAN "RATE FREEZE"

Dear Senator McPherson:

I write on behalf of the governing board of the Central Coast Alliance for Health, with the special pleasure of addressing you as a long time friend of the health plan. **As** you know, the State's **FY** 01/02 budget did not provide the Alliance (or other Medi-Cal health plans) with a revenue increase. Recently, the Governor proposed to reduce Medi-Cal payments, and we understand the Medi-Cal health plan "rate fi-eeze" will continue in **FY** 02/03, and possibly even further. While our local medical costs inexorably rise, our State revenue is frozen.

We appreciate that these are difficult decisions being made in response to our troubled State economy. However, our board wants to convey **our** concerns for the impact of these decisions on health care access and quality of care for our 73,000 members in Santa Cruz and Monterey Counties. We ask for your support in ensuring the survival of our regional efforts in Medi-Cal reform in the months to come.

In 2002, the Alliance estimates our medical costs will increase by $10M due to inflation in pharmacy, technology, and other medical services provided to our low-income single-parent, child, aged, blind and disabled members. While the State's Medi-Cal FFS program will have their inflation costs covered, our local Medi-Cal health plan rates are fi-ozen and our inflation is not funded. This is a fundamental and troubling inequity. We anticipate major impacts in 2002 to potentially include:

1. **A** negative bottom line, for the first time in the Alliance's history.
2. Diminished member access if fiscal concerns reduce provider participation.
3. Use of as-yet incomplete Alliance reserves to manage deficits.
4. Possible disqualification from Healthy Families Program related to inadequate reserves.

See Attachment A for a more detailed discussion of these issues.

Our request for your support

The Alliance board's primary concern is that our members' health care access and health status not be damaged by broad scope State budget decisions. We appreciate the seriousness of the State's budget deficit and we intend to be "part of the solution" by providing cost-effective health care to our 73,000 low-income members. However, the Alliance recently tripled in size and fiscal risk in our expansion to Monterey County, and our reserves are not fully funded. Our provider relations that pave the way for our members' access to care depend on fair medical budgets and the assurance of solvency, Our many Medi-Cal safety net providers rely on the Alliance as their main source of .earnings. Our participation in the Healthy Families Program depends on our sustaining proper reserves.

We believe State budget actions should be considered to address our concerns, which differ greatly from those of for-profit HMOs contracted with the State for Medi-Cal services. The Alliance's governing board asks that either one of our two proposals be implemented at the earliest possible date:

1. Alliance revenue parity with Medi-Cal FFS cost inflation. We ask that, as soon as possible, the State budget provide funding for the Alliance's medical cost inflation equal to that in the State's Medi-Cal FFS program. This action would do much to address provider concerns about fairness and solvency, and to prevent an erosion of our members' access to care.

2. Support for Alliance reserves and solvency. We ask that, should we experience a material decline in reserves as a result of the Medi-Cal health plan rate freeze, you will support our need for a emergency revenue allocation so that the Alliance can continue to qualify to participate in the Healthy Families Program, and remain solvent as the sole Medi-Cal health plan serving the Monterey Bay region. We would update you on our fiscal status and needs as we assess the impact of the rate freeze in the months to come.

For perspective on our proposals, the Alliance expects $10M in un-funded medical cost inflation in 2002. This is about a 5.5% cost increase, which we believe will parallel the Medi-Cal FFS program. Regarding reserves, the Alliance currently holds about $25M, which is $5M less than our minimum target of two months' capitation revenue held in reserves. To maintain participation in the Healthy Families Program, we need to maintain a minimum of about $18M in reserves. Un-funded medical cost inflation will undermine our bottom line, and our reserves.

We very much appreciate your attention to our concerns regarding the Medi-Cal health plan rate freeze. The Alliance will participate fully in statewide efforts to maintain public services during this economic downturn. We hope that our letter has clarified the potential impact of State budget decisions on the Alliance's mission, and we look forward to working with you to ensure our continued survival and success in regional Medi-Cal reform.

Sincerely,

Edith Johnsen, Chairperson
Governing Board, Central Coast Alliance for Health

Attachment

cc: Mr. Richard Figueroa, Deputy Legislative Secretary, Governor's Office
Mr. David Maxwell Jolly, Deputy Secretary Health and Human Services Agency
Mr. Byron Chell, Executive Director, California Medical Assistance Commission
Ms. Cheri Rice, Chief, DHS Medi-Cal Managed Care Division
Santa Cruz County Board of Supervisors
Monterey County Board of Supervisors

CENTRAL COAST ALLIANCE FOR HEALTH

March 13,2002

Attachment A: Impact of State Medi-Cal Health Plan "Rate Freeze"

How does the State's "rate freeze" impact the Alliance?

Since our inception in 1996, the Alliance has opened doors of health care access for our members by offering providers improved Medi-Cal services and payment opportunities. Through our locally operated non-profit health plan, our providers share in the financial risk of providing over $180M in medical services each year. Our local physicians offer a "medical home" for each Alliance member, and share in budget savings from care that is timely and well managed. The State previously has provided the Alliance with capitation revenue to match medical cost inflation. Accordingly, our risk-sharing providers have been assured that our medical budgets are fair, so that effective care and prevention can result in surplus earnings. Fair budgets, better access, better outcomes, lower cost, improved earnings. The current State rate freeze upsets that equation, and we fear our hard won gains in Medi-Cal access and quality are in jeopardy.

The impact of the State's rate freeze on the Alliance will be significant. In 2002, the Alliance expects medical costs to increase overall by 5.5% (about $10M) with some sectors such as pharmacy and medical technology increasing by 18%. The rate freeze pre-empts funding of this inflation, so we project a 2002 operating loss of more than $3M: the first deficit in our six-year history. This deficit would prevent our building of reserves, and destabilize our provider risk sharing arrangements.

Our recourse will be to draw upon our $25M fund balance, which our board has accrued toward our goal of $30M, or two month's capitation in reserves. Meanwhile, although the Alliance's rates are frozen, the State's Medi-Cal Fee For Service (FFS) program will pay for Medi-Cal cost inflation in the coming year. Our board faces the unappealing prospect of drawing on its incomplete reserves to offset un-funded medical cost inflation. Meanwhile, the State will pay for such inflation in its unmanaged Medi-Cal FFS program. This lack of parity in State funding of Medi-Cal inflation unduly penalizes our health plan.

The Alliance's credibility can be undermined by even one year's deficit performance, and such fiscal distress can weaken our partnerships with our providers, members and communities. In addition, the Alliance's reserves may drop below the $18M in tangible net equity (TNE) required for participation in the Healthy Families Program (HFP). It would be most unfortunate if the Alliance became disqualified for the HFP due to the Medi-Cal health plan rate freeze. If the State continues the rate freeze in future years, the Alliance's reserves could be depleted to the point of insolvency.

How could the Medi-Cal "rate freeze" affect Alliance member welfare?

We believe the State's rate freeze will negatively effect on our provider relations, which are key to our members' health and well being. We all remember the days when dissatisfied physicians turned away en masse from Medi-Cal, so that it was nearly impossible for beneficiaries to access care except at emergency rooms or safety net clinics. The fundamental principle of the Alliance's work is that provider satisfaction results in better health care access and outcomes for members. Therefore, the interests of providers and members are joined in our health plan. Our concerns regarding the Medi-cal health plan "rate freeze" include:

- Member access diminished by providers' fiscal concerns. Some local providers may reduce or discontinue voluntary services to our members out of concern that the Alliance's budgets and reserves will be undermined by the State rate freeze. Our surplus-sharing opportunities for providers are reduced if our medical budgets lack parity with State Medi-Cal **FFS** program inflation. Also, Monterey County providers are particularly sensitive to reserves, since they have witnessed several health plan insolvencies. Moreover, our many safety net providers (e.g. community clinics, and hospitals with **high** Medi-Cal volume) depend on Medi-cal payments, so the Alliance's solvency is a survival issue for them **as** well.

- Member choice in the Healthy Families Program. The Alliance is the only non-profit health plan option for local children in the *HFP*. We offer a seamless transition between Medi-Cal and HFP enrollment, and the Alliance is the "Community Provider Plan" with the most safety net providers and the lowest co-payments. As noted above, the Alliance would become disqualified to serve HFP eligible families if our tangible net equity drops below $18M due to the rate freeze.

- Local innovation in health services for members. The Alliance operates on less than **7% of** revenue for administration, and is among the most efficient health plans in the State. Even with low administrative overhead, we provide focused case management support for our members **with** disabilities, children with special health care needs, and members needing long-term care services. We conduct **HEDIS** quality studies on preventive services, and have scored among the top health plans in the State. The rate freeze jeopardizes our finding of board priorities for further local innovation, including new disease management programs, and Medi-Cal/HFP eligibility outreach.

For our members' welfare and the viability of our regional Medi-Cal reform, the Alliance's board proposes options of **1)** parity between Alliance revenue and Medi-Cal FFS cost inflation, or 2) revenue support for the Alliance to maintain reasonable reserves.