REPORT OF THE ANALYSIS OF THE CALPERS/BLUE SHIELD NARROW NETWORK

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Report of the Analysis of the CalPERS/Blue Shield Narrow Network

EXECUTIVE SUMMARY

This report documents the process of review undertaken by the California Department of Managed Health Care (DMHC) of the proposal filed by Blue Shield on June 30, 2004 to eliminate a number of high cost hospitals from its CalPERS HMO network as a cost savings mechanism. CalPERS is the largest employer-sponsored health benefits purchaser in the United States. This report discusses the basis for each finding regarding Blue Shield's compliance with the applicable accessibility standards under the Knox-Keene Health Care Service Plan Act of 1975, as amended ("Knox-Keene Act").

The Blue Shield proposal was significant because it offered a vastly different approach to cost savings. Usually employers utilize increased co-payments, deductibles or cost sharing as the mechanism to control premium increases. In this case, CalPERS and Blue Shield developed a narrower network as the cost savings mechanism for their membership, an approach not previously presented to DMHC. CalPERS has adopted a different vehicle than other large employers by requiring a health plan to exclude high cost hospitals and their affiliated medical groups from its provider network to provide the desired premium savings. If this proposal succeeds in practice it may provide individual employers with alternative mechanisms for the control of rising health care premiums that do not involve greater cost sharing on the part of their employees. DMHC intends to monitor this process closely during 2005 to determine whether narrower networks achieve the goal of cost containment without inappropriately restricting access.

This new network structure required prior regulatory approval by DMHC before it could be implemented in January 2005. The Knox-Keene Act regulates Health Care Service Plans operating in California and mandates, among other things, that minimal standards of access and continuity of care are maintained for all plan enrollees. DMHC was primarily concerned with verifying that the narrower 2005 network would adequately serve Blue Shield's enrollees. The Knox-Keene Act does not, however, require prior regulatory review of the underlying proposed cost savings to employers. Thus, DMHC's role was limited to accepting or rejecting the proposal based solely on the adequacy of the network, rather than in verifying whether the cost-savings to employers would ultimately be realized.

DMHC both approved and denied portions of Blue Shield's proposed network changes – and in approving certain portions, imposed specific performance conditions (undertakings) on Blue Shield concerning continued access to

providers. In this way, DMHC allowed Blue Shield and CalPERS to implement this cost-saving mechanism while ensuring that enrollees' access to services would not be adversely affected.

Some important outcomes of the narrow network implementation include:

- During Open Enrollment, more than one-third of the 58,000 enrollees chose another health plan, allowing for more than adequate access for remaining members.
- Approximately 44 percent of the CalPERS enrollees who were disrupted from their provider in the Sacramento Area did not remain with Blue Shield in open enrollment.
- In the Sacramento area, approximately 15 percent of the CalPERS enrollees elected to pay a higher premium to keep their provider.
- Approximately 17 percent of CalPERS enrollees chose another plan with a lower premium, leaving their current provider.
- Blue Shield estimated that approximately 6,100 affected enrollees would be eligible for continuity of care benefits because they met one or more of the six eligible conditions under §1373.96. For various reasons, including the significant number of enrollees who dropped Blue Shield during open enrollment, as of early February only approximately 2,000 enrollees had qualified for the benefit (34%).
- Of 1,600 enrollees estimated to be eligible to receive continuity of care for children 36 months or younger, only 10 percent actually applied for the benefit. In contrast 78 percent of all closed cases were from enrollees with serious, chronic conditions.

This report also provides useful insights to other employers and health plans considering similar approaches, and includes a template for similar future filings with DMHC.

Section I

INTRODUCTION

The Narrow Network Proposal

In May of 2004, CalPERS and Blue Shield decided to narrow the 2005 provider network serving the CalPERS-HMO in an effort to reduce premium costs. It was believed that this approach would enable Blue Shield to restrict its network to less-costly hospitals and affiliated medical groups of comparable quality. This led to the Blue Shield proposal, filed on June 30, 2004, to discontinue 38 hospitals and 16 medical groups, affecting over 64,000 enrollees statewide. Prior to final action by DMHC, Blue Shield reduced the number of proposed hospital exclusions to 28, and the number of medical group exclusions to 11. It was determined that 58,400 enrollees in 15 counties would be affected by the proposed network changes.

DMHC's role was to determine whether the proposal complied with the Knox-Keene Act; i.e., to determine that access to health care would continue to be sufficient for enrollees affected by the narrowing of the network. Under current law, DMHC's review of the proposal is limited to access determinations. CalPERS' chief rationale for the network changes was cost savings to counter the continuing double-digit premium increases that it had faced for the past few years. The magnitude or reliability of the estimated savings, including the access-cost trade-off, if any, could not be considered by DMHC in its review.

Filing Requirements

The specific filing requirements and complexities of the filing process are discussed separately in Appendix A to this report. The Knox-Keene Act requires very narrow time frames for the review of such proposed network changes – typically 20 business days. In this case, the decision was issued in 27 days as a result of a request by Blue Shield to extend the deadline in order to file additional material requested by the Department. Blue Shield filed over 2,000 pages of information with the DMHC, and ultimately ended up making 25 supplemental filings to the original submittal. A key purpose of this report is to provide the public and other health plans information about the lessons learned during the review process.

Definitions of Key Terms

Under the Knox-Keene Act a health plan submits a license application that is hundreds of pages in length, comprised of the Plan's proposed operations, the benefit structures of its products for consumers, its organizational structure, its provider networks, and enrollee disclosure materials. Under Knox-Keene, a plan's license application is a living document, constantly modified by the Plan during its life span. Therefore:

Material Modification

- A specific kind of amendment to the health plan's original license. It must be reviewed within 20 business days after the filing by DMHC.
- A prospective filing that must be approved or denied before the proposed change takes effect. Other types of amendments of the Plan's original license do not require prospective review and may be submitted on a "use and file" basis.
- There are no specific, pre-determined forms for a material modification because it is not so much a type of change as it is a change with *greater potential impact* upon enrollees. Health Plans frequently discuss the format of these filings in pre-filing conferences with DMHC. The filing format is determined at that time.

Block Transfer

- A more limited type of filing concerning a change to a Plan's provider network. It must be reviewed within seven calendar days after the filing by DMHC.
- Concerns the movement of large "blocks" of enrollees by a plan when it terminates a provider group or hospital, or is terminated by them. This is a relatively new phenomenon and the law surrounding this procedure just went into effect on January 1, 2004.
- Is Filed under a specific filing form. DMHC has reviewed more than 800 block transfers to date.

Provider Network

- The group of physicians and hospitals in a health plan's service area that deliver health care services on behalf of the plan to its enrollees who live or work in that area.

Service Area

- A geographic area, usually a county, where a health plan delivers services. It is usually based on zip codes. Some areas are geographically

distinct, like a rural northern California county. Others, such as large metropolitan areas with extensive transportation networks, tend to be more interrelated. Good examples of the latter include the Los Angeles basin, or the four-county Sacramento region. The filing included all types of service areas.

The Role of the Consultants

In view of the magnitude and complexity of the proposed network changes DMHC secured the assistance of pmpm® Consulting Group, Incorporated, who included Henry W. Zaretsky & Associates, Inc. in establishing a review methodology and conducting the review. This filing was given a high priority by the Department in order to ensure accessibility to services for CalPERS members. This report is written primarily using data from the consultant's viewpoint. Where the term "we" is used, it usually refers to the working group comprised of both consultants and the DMHC licensing team assigned to this project. The consultants' objectives were to:

- Review the initial Blue Shield proposal and subsequent filings;
- Assist DMHC staff in determining additional data needed;
- Define and evaluate alternative methodologies for determining available hospital and physician-services capacity and access to care;
- Determine the proposal's consistency with statutory and other reasonable access standards; and
- Recommend approval, denial or approval with undertakings for each proposed network change.

The review progressed through daily work group meetings of a team of both consultants and DMHC personnel. We found this workgroup method efficient, in that decisions could be made quickly by DMHC staff as the consultants analyzed or verified information about the provider network.

The Dynamic Market Place

In evaluating our review and analysis, it is important to recognize that health-care markets are in a state of constant flux. Our analysis was based on a snapshot in time (i.e., historical data available in July 2004). Providers are constantly entering and exiting individual markets. Competing health plans' market shares change. Residents of various geographic areas come and go. Health care utilization varies with random events, seasons, cycles, long-term

trends, and changes in public policy. Some recent examples of the dynamic nature of this process relating specifically to the Blue Shield proposal include:

- A recent report that the anesthesiology group at Washington Hospital (one of the excluded hospitals) shifted to a different hospital[1]; and
- Recently released data by Blue Shield that in the Sacramento area alone, 18,000 covered lives will shift from Blue Shield to other health plans effective January 1, 2005. Therefore, assuming the departing enrollees were all those who were impacted by the narrow network, only approximately 15,000 of the potentially impacted enrollees transitioned to new Blue Shield providers, or 65 percent fewer than potential maximum that were planned for. Statewide, Blue Shield estimates a net loss of 29,263 covered lives, a 53-percent drop in enrollment from the total enrollees statewide that were projected to be impacted by this network change.
- In performing our analysis, we assumed there would be no net loss in the number of Blue Shield CalPERS enrollees. Thus, we performed our analysis to assure sufficient capacity to accommodate a larger population than will, in fact, transition. While it is not possible to anticipate market changes that will occur between the time of the approval and its effective date (five months), DMHC has mechanisms in place to monitor access and take corrective action as appropriate. DMHC's 24-hour/7 day a week HMO Help Center, is available to answer calls from enrollees with questions regarding their coverage and assist with their complaints. Consumer complaints are tracked and categorized by the Help Center, providing an important feedback mechanism to DMHC. Complaints forwarded to Blue Shield prior to the deployment of the 2005 network led to operational changes such as call routing for CalPERS members and corrections to its website.

Data Deficiencies

It is also important to recognize that the timeliness, comprehensiveness, and quality of the data we relied upon were far from perfect. For example:

- Our primary data source for hospital capacity, Office of Statewide Health Planning and Development (OSHPD) Annual Hospital Financial Disclosure Reports, is subject to inaccuracies, incompleteness, and on average, refers to a period two-years prior to the 2005 calendar year for which the new network is to be effective. We supplemented the

[1] "Hospital Replaces Anesthesiology Group After Health Insurance Contract Dispute", *California Healthline*, California Healthcare Foundation, November 24, 2004

information by using publicly available data on a case-by-case basis by drawing on other sources, including contacts with Blue Shield and hospital systems.

- Data on medical groups and individual physicians were also incomplete or unreliable. We supplemented incomplete data provided by Blue Shield, with data provided by individual medical groups. Well known problems with physician data include:
    - No uniform definition of full-time-equivalent physician
    - Difficulty in obtaining necessary information from physicians to enable estimation of capacity
    - Lack of data to apportion physician workloads to the CalPERS population
    - Overlap of individual physicians among various medical groups and the failure of Blue Shield to provide unique identifiers for each physician

In the Conclusion section to this report, recommendations are advanced to attempt to minimize some of these problems in future filings.

To fill the gaps in hospital and physician data, individuals at the following organizations were contacted:

- AllCare
- Blue Shield
- Brown & Toland Medical Group
- California Pacific Medical Center
- Catholic Healthcare West
- Hill Physicians Medical Group Sutter Health
- Hospital Council of Northern and Central California
- MedClinic
- Mercy San Juan Hospital
- Presbyterian Intercommunity Hospital
- Sierra Sacramento Valley Medical Society
- University of California Systemwide Administration
- University of California Davis Medical Center
- Washington Hospital
- Woodland Medical Clinic

Framework for Analysis

A separate analysis was performed for each of the proposed block transfers of enrollees. Each block was aggregated to the county level and, for presentation purposes; the affected counties were grouped into the following broad geographic areas:

- Greater San Francisco Bay Area
- Los Angeles and Orange County
- Central Valley
- Greater Sacramento Area

The hospital-services capacity analysis focused on estimating available general-acute-care ("GAC") bed capacity in receiving hospitals in each bed service category according to geographic area, and comparing that capacity to expected demand on the part of Blue Shield CalPERS members.

- First, receiving and discontinuing hospitals in each geographic area were arrayed in terms of GAC services capacity and volume;

- Second, for each GAC category, occupancy rates were calculated in terms of "available" beds (i.e., beds that are existing and actually available for use, as opposed to total licensed beds, some of which may not currently exist); and

- Third, GAC capacity requirements for Blue Shield CalPERS members in each area were determined, and compared to excess capacity among the receiving hospitals. As indicated above, the primary data source for hospital capacity was OSHPD Annual Hospital Financial Disclosure Reports. In individual cases where these data were not sufficient, we drew on other publicly available data sources or contacted Blue Shield and individual hospital systems.

An important problem in the narrow network proposal is that hospital exclusions often translate into medical-group exclusions. This is because some medical groups' physicians only admit their patients to the excluded hospitals. In such cases, there are two categories of medical-group disruption that have to be considered. The first is when the hospital owns or operates an independent practice association (IPA) as a captive, or has an exclusive relationship with physicians employed by a hospital-owned foundation. In these circumstances, if a hospital is excluded from the Blue Shield provider network, the affiliated physicians are also excluded. The second scenario involves all other circumstances where physicians admit only to one hospital. In this second scenario, even if an individual physician wishes to become a member of another IPA, the latter may already have sufficient capacity, and

thus may not take new members. Therefore the individual provider would become excluded from the new network.

The Physician-services capacity in receiving medical groups was estimated according to geographic area and specialty and compared to expected demand on the part of Blue Shield CalPERS members in the following manner:

- First, the data provided by Blue Shield in support of its proposal were inventoried and reviewed;
- Second, receiving and discontinuing medical groups in each geographic area were compared in terms of projected CalPERS-enrollee membership and numbers of physicians in each specialty;
- Third, statutory and industry accessibility standards, including primary care and total physicians per 1,000 population, were reviewed to select standards for medical practice capacity and to identify additional information and data that would be needed to complete the capacity determination;
- Fourth, additional data were requested of Blue Shield and receiving medical groups; and
- Fifth, given what data we were able to obtain, our capacity estimates were generated and assessments made for each proposed block transfer.

In our analysis of both hospital and physician access, we relied on the Rule 1300.51 guideline, that enrollees have access to primary medical services within 30 minutes or 15 miles of an enrollee's residence or workplace.[2] We applied this rule in terms of distance/travel time between the discontinuing hospitals and the receiving hospitals. Based on our analysis of physician-services and hospital- services capacity, recommendations were made for each proposed block transfer in terms of approve, deny, or approve with undertakings. "Undertakings" are a stipulated agreement made between DMHC and a health plan and are a consideration for an order of approval by DMHC. They usually impose additional performance conditions and reporting requirements on the Plan in exchange for the proposed change to be implemented as represented in the filing under consideration.

[2] The guidelines in this rule are broadened outside of urban areas to account for existing patterns of practice.

Format of Report

This report is organized as follows:

- Section II describes the approach used in the hospital-services capacity assessment;

- Section III describes the physician-services capacity assessment methodology;

- In Section IV, the assessment for both physician and hospital services is presented according to geographic area and proposed block transfer; and

- In the concluding section, we discuss the lessons learned and provide recommendations for future assessments based on this experience.

- The tables referred to in the text are provided in the appendices.

Section II

HOSPITAL CAPACITY OVERVIEW

General Approach

The objective of this task was to assess available general-acute-care (GAC) bed capacity in receiving hospitals in each bed service category, and compare that capacity to expected demand on the part of Blue Shield CalPERS members. There were three main steps to the analysis:

- First, receiving and discontinuing hospitals in each geographic area were arrayed in terms of GAC services capacity and volume;

- Second, for each GAC category, occupancy rates were calculated in terms of "available" beds (i.e., beds that are existing and actually available for use, as opposed to total licensed beds, some of which may not currently exist); and

- Third, GAC capacity requirements for Blue Shield CalPERS members in each area were estimated, and compared to excess capacity among the receiving hospitals.

In our analysis of both hospital and physician access, we relied on the Rule 1300.51 guideline, that enrollees have access to primary medical services within 30 minutes or 15 miles of an enrollee's residence or workplace. We applied this rule in terms of distance/travel time between the discontinuing hospitals and the receiving hospitals. This information was provided in the Blue Shield filing.

The only data source containing information on available beds according to category is the Annual Hospital Financial Disclosure Report, administered by the Office of Statewide Health Planning and Development (OSHPD). The bed categories used in that report are not totally consistent with those used for licensing purposes, which are reported in the OSHPD Annual Hospital Report (AHR). The categories are sufficient, however, to enable a reliable profile of each hospital's mix of GAC services in terms of available capacity and utilization. The bed categories used in this analysis are set forth in the following table:

General – Acute – Care Bed Classifications

GAC Bed Classification
Medical/Surgical Intensive Care
Coronary Care
Pediatric Intensive Care
Neonatal Intensive Care
Burn Care
Other Intensive Care
Definitive Observation
Medical/Surgical Acute
Pediatric Acute
Obstetrics Acute
Alternate Birthing Center
Physical Rehabilitation Care
Other Acute Care

Source: Office of Statewide Health Planning and Development, Annual Hospital Financial Disclosure Report.

A request was made to Blue Shield for data on each receiving hospital, as follows:

- For the first quarter of 2004 and for the 12-month period ending March 31, 2004, licensed, available, and staffed beds and patient days according to licensed bed categories;
- For any bed category with 85-percent or greater occupancy, justification that the service is available and accessible to enrollees;
- For each proposed hospital exclusion, for calendar-year 2003, patient days on behalf of CalPERS members according to bed category;
- Licensed-nurse staffing ratios according to bed type; and
- For each proposed hospital exclusion:
    - The number and percentage of affected enrollees who live within a 15-mile radius of each of the proposed alternate hospital(s);
    - Highlight those hospitals where the number of enrollees within the 15-mile radius does not equal the total number of affected enrollees; and

- For the following counties, for each proposed hospital exclusion, provision of the above information as well as the number, and percentage, of affected enrollees who live within a 30-mile radius of each proposed alternate hospital:
- Fresno, Madera, Merced, San Joaquin, Sonoma, Stanislaus, Tulare, and Yolo.

These data were not supplied by Blue Shield, necessitating our reliance on the OSHPD data.

Optimal occupancy for each hospital was assumed to be 80-percent of total available GAC beds. This is a widely used hospital-planning standard. “Excess” beds for each hospital were calculated as the difference between occupied beds and 80-percent of available beds. In a few cases, there were hospitals that had a shortage (i.e., a negative excess) of total available beds using this definition. Excess beds were then summed across all receiving hospitals in each geographic area. In each geographic area, there was an aggregate surplus of available GAC beds.

Blue Shield provided data on calendar year 2003 GAC patient days on behalf of its CalPERS members in each excluded hospital. Aggregate “bed need” for the Blue Shield CalPERS population in each geographic area was calculated as the CalPERS average daily census divided by 0.8 (i.e., beds required by CalPERS members at 80-percent occupancy). The CalPERS bed requirements in each geographic area were then compared to total excess beds. In all geographic areas, there were sufficient beds in the receiving hospitals to accommodate the Blue Shield-CalPERS population in terms of total GAC beds. In a few geographic areas, however, there were shortages in some bed services (e.g., high occupancy in the receiving hospitals having the service in question, or not having the service at all). In such cases, further inquiries were made before recommending denial of the Blue Shield request.

During the assessment, questions arose regarding individual hospital’s data reported to OSHPD. Some examples are as follows:

- A hospital is known to have an extensive heart program but reports zero cardiac care unit beds
- A major hospital reports zero neonatal intensive care beds
- The only receiving hospital reports zero pediatrics beds

As indicated above, the data source we relied upon uses bed categories that do not fully correspond to licensure definitions. Moreover, the primary purpose of this OSHPD reporting system is to provide financial data; thus, the quality-control emphasis on the part of OSHPD staff relates to the latter data, not utilization, and capacity data. It is also believed that the reporting hospitals place higher priority on providing accurate financial data, which is subject to audit. As data questions arose, they were dealt with in two ways. First, the hospital in question was checked against data it reported through the AHR system, which is based on licensed beds. If further questions remained, contacts were made with Blue Shield or the affected hospital.

Table 1 below provides summary data illustrating this process for Sacramento and Roseville. The discontinuing hospitals are in **boldface**. Each receiving hospital has excess capacity in terms of available beds. For Sacramento, there are 192 excess beds in the receiving hospitals, while 21 are required for the CalPERS population from Sutter General and Sutter Memorial.

TABLE 1
Summary Data on Available Capacity - Sacramento and Roseville Areas - and Requirements for PERS Population 2002-2003

HOSPITAL NAME	GAC Avail Beds	GAC PD	ADC	Avail Occ	ADC @ 80% Occ	Excess Beds	PERS PD	PERS ADC	Beds Needed @ 80%
SUTTER GENERAL & SUTTER MEMORIAL HOSPITALS	**483**	**133,360**	**365**	**75.6%**	**386.4**	**21.0**	**6,185**	**16.95**	**21.18**
MERCY GENERAL HOSPITAL	291	65,225	179	61.4%	232.8	54.1			
MERCY SAN JUAN HOSPITAL	247	65,491	179	72.6%	197.6	18.2			
METHODIST HOSPITAL-SACRAMENTO	162	30,049	82	50.8%	129.6	47.3			
UNIVERSITY OF CALIFORNIA, DAVIS MEDICAL CENTER	528	142,937	392	74.2%	422.4	30.8			
MERCY HOSPITAL OF FOLSOM	95	12,666	35	36.5%	76.0	41.3			
EXCESS BEDS AT RECEIVING HOSPITALS						191.6			
SUTTER ROSEVILLE MEDICAL CENTER	**172**	**48,843**	**134**	**77.8%**	**137.6**	**3.8**	**1,733**	**4.75**	**5.93**
MERCY SAN JUAN HOSPITAL	247	65,491	179	72.6%	197.6	18.2			
UNIVERSITY OF CALIFORNIA, DAVIS MEDICAL CENTER	528	142,937	392	74.2%	422.4	30.8			
MERCY HOSPITAL OF FOLSOM	95	12,666	35	36.5%	76.0	41.3			
EXCESS BEDS AT RECEIVING HOSPITALS						90.3			

* Discontinuing hospitals in **boldface**.

Source: Office of Statewide Health Planning and Development, Annual Hospital Financial Disclosure Report, fiscal-year endings between June 30, 2002 and June 29, 2003.

Section III

PHYSICIAN NETWORK CAPACITY OVERVIEW

General Approach

Hospital exclusions often translate into medical-group exclusions because some medical groups' physicians only admit their patients to the excluded hospitals. Two categories of medical-group disruption have to be considered. The first is when the hospital owns or operates an IPA as a captive, or has an exclusive relationship with physicians employed by a hospital-owned foundation. In these circumstances, if a hospital is excluded, the affiliated physicians are also excluded. The second scenario involves all other circumstances where physicians admit only to one hospital. In this second scenario, even if an individual physician wishes to become a member of another IPA, the latter may already have sufficient capacity, and thus may not take new members.

The objective of this task was to assess available medical service capacity by specialty in receiving medical networks, and compare that capacity to expected demand on the part of Blue Shield CalPERS members. First, the data provided by Blue Shield in support of its application was inventoried and reviewed. These data included:

- Provider rosters of receiving networks, including provider name, specialty, network affiliation, and current hospital privileges;
- Counts, according to specialty, of providers open to accepting additional patients;
- Counts of providers continuing to be available to current patients; and
- In each geographic area, the number of members proposed to be transferred to each receiving medical group.

Both receiving hospitals and medical groups in each geographic area were compared to the existing network. We prioritized the scope of the analysis based on the magnitude of the anticipated disruption to the plan's enrollees. We reviewed statutory and industry accessibility standards, including primary care and total physicians per 1,000 population, in order to select standards for medical practice capacity and to identify additional information and data that would be needed to complete the capacity determination. We conferred with DMHC staff to develop a letter to Blue Shield requesting detailed county/provider information. A copy of this letter is set forth in Appendix B.

The following is a summary of the data elements requested to complete the physician services capacity determination:

- The contractual commitments of all medical groups to recruit additional primary care physicians (PCPs) and specialists (SCPs) to demonstrate capacity to serve the enrollee population;
- The age and sex demographics of the CalPERS population;
- Blue Shield's confirmation that no major contract renewals would occur in 2005 to any of the proposed alternate provider networks;
- Updated rosters that identify medical license number and listing of hospitals where current admitting privileges exist for every replacement medical group; and
- For every enrollee block, continuing and replacement hospital and medical group, provision of the following:
    - Geographic plotting of enrollee residence;
    - Geographic plotting of hospitals and medical providers (making distinction between PCP and SCP providers);
    - Calculations of average travel times for enrollees to hospitals and center point of PCP and SCP locations; and
    - For each enrollee block, percentage of enrollees who will fall outside the 15 mile / 30 minute access standard for hospital and center point of medical network.

In view of the short time table dictated by the statutory 20-business day review period, it was decided that receiving medical groups in the counties most heavily impacted by plan modifications would be reviewed first. Blue Shield provided the following counts of members impacted by proposed medical group exclusions:

Medical Group	Affected Enrollees
Cedars Sinai Health Associates	621
Cedars Sinai Medical Group	447
Delano Regional Medical Group	448
Greater Newport Physicians	2,509
Physicians of Greater Long Beach	220
Presbyterian Health Physicians	2190
SDPMG East County	255
Sharp Community Medical Group	731
Sharp Community Medical Group	1120
Sharp Community Medical Group	778
Sharp Mission Park Coronado	48
Sutter Gould Medical Foundation	9,310
Sutter Independent Physicians	10,039
Sutter Medical Group of the Redwoods	2,817
Sutter Medical Group	25,368
Sutter West Medical Group	5,004
Total Affected Enrollees	**64,896**

The Greater Sacramento Area, comprising the counties of Sacramento, Yolo, Placer, and El Dorado, was identified as subject to the greatest potential for disruption of the provider/enrollee relationship because of the extent of the proposed changes in comparison to all other service areas in the proposal.

Estimates of over and under capacity were generated for the Greater Sacramento area according to physician specialty and medical group affiliation. One of the chief problems with the existing data available for our review was that no reliable public source exists to determine: (1) the total number of physicians in a medical group; (2) the cross-affiliation of specialists among various medical groups; and (3) the full-time equivalency of physicians within each group. This makes an apples-to-apples evaluation of the access and capacity of excluded and replacement medical groups very difficult.

Key indicators affecting demand and supply, and the data used in their measurement, are as follows:

Indicators	Data Elements
Enrollee populations transitioning from excluded medical groups to continuing and replacement medical groups.	Counts of transitioning enrollees provided by Blue Shield, allocated among continuing and replacement medical groups
Patient demand by specialty by medical group	Counts of enrollees transitioning from excluded medical groups to continuing and replacement medical groups multiplied by annualized actual Blue Shield CalPERS HMO service utilization per enrollee by specialty for the 2003 plan year
Medical group capacity according to specialty*	Specialty capacity estimated by multiplying full time equivalent (FTE) physicians in each specialty in continuing and replacement medical groups by patient-visits- per-FTE benchmarks obtained from consultants' proprietary data on IPAs.
Surplus /(Shortage) for primary care physicians	Subtraction of estimated visit demand from estimated visit capacity.

* This approach could not be used for estimating specialist capacity available to transferring members since we did not have estimates of effort (current workload) for individual physicians or groups.

The lack of uniform data on numbers of full-time-equivalent physicians according to specialty available to CalPERS members necessitated the use of physician-population ratios for the entire region according to specialty. These ratios are based on total physicians within each specialty and total population in the region.

Supply standards used for the Greater Sacramento Area were based on national averages for prepaid group practice, and are discussed in Appendix C. The national averages were obtained from Jonathan P. Weiner, "Prepaid Group Practice Staffing and U.S. Physician Supply: Lessons for Workforce Policy", Health Affairs – Web Exclusive, February 2004.

During our independent verification of specialty access in this area, we became concerned about the ability of U.C. Davis to offer specialty appointments in a timely manner, particularly for some sub-specialty physicians. For that reason we created the Sacramento area undertakings to ensure that there was adequate and appropriate specialty access for CalPERS enrollees. These undertakings, imposed upon Blue Shield, can be found in Appendix D.

Section IV

AREA-BY-AREA ANALYSIS

Appendix E contains all of the Tables referenced in this section. These tables include the supporting data used in the analysis for each proposed hospital exclusion.

Greater Sacramento Area

Placer County – Sutter Roseville Hospital

Table 1 provides data on the Sutter Roseville Hospital area. CalPERS members are expected to require six beds out of the 90 excess beds calculated for the receiving hospitals. Our analysis did not find shortages in any of the bed categories. Although University of California Davis Medical Center is 20.5 miles from Sutter Roseville, it is no further than Sutter General or Sutter Memorial, which currently serve as the tertiary backup for Sutter Roseville.

Placer County – Sutter Medical Group / Sutter Independent Physicians

The analysis for medical network capacity in this geographic area is included with the analysis for Sacramento County.

Sacramento County – Sutter Memorial/Sutter General Hospital

Data on available beds and occupancy for each service for the Sacramento area is provided in Table 2. Also included are distance and travel time from the excluded hospital to each receiving hospital (data provided by Blue Shield). We found a total GAC-bed excess of 192, and a CalPERS demand for 21 beds. On a service-specific basis, we did not find a shortage in the receiving hospitals collectively. Mercy San Juan Hospital and UC Davis are the only receiving hospitals with cardiac care unit (CCU) beds and both have high occupancy. Mercy General Hospital, however, has a high volume heart program and uses intensive care unit (ICU) beds for this purpose, with sufficient capacity in that service (ICU). That Mercy General treats cardiac patients in ICU beds was determined through review of its OSHPD AHR data. Four of the five receiving hospitals are within acceptable distances/travel times from the excluded hospital. The most-distant receiving hospital, Mercy Folsom Hospital, is a relatively small, limited-service hospital. We did not find an access problem regarding GAC services in the Sacramento area.

Sacramento County – Sutter Medical Group / Sutter Independent Physicians / Sutter West Medical Group

Due to exclusive admitting relationships by these medical groups, the proposed exclusion of the Sutter Hospitals resulted in a need for enrollees assigned to these groups to find new primary care physicians (PCPs). The data provided by Blue Shield in the filing indicated that for these three medical groups approximately 40,000 members would be affected, with about 7,000 who would be able to retain their PCP due to crossover affiliations with Golden State IPA and Hill Physicians. Our access analysis for the Greater Sacramento Area was focused on ensuring that adequate capacity existed for these members for both primary and specialty services in the proposed receiving medical groups.

Based on PCP capacity calculations for Hill Physicians, MedClinic, UCDMG, and Woodland Clinic, we found that excess capacity existed with respect to primary care. The methodology for making this determination was as follows:

- Demand for outpatient visits for primary-care specialties was calculated as follows: Number of transitioning members (spread among the receiving networks as forecast by Blue Shield) multiplied by average annual physician office visits estimated to be utilized by CalPERS enrollees (based on the consultant's proprietary data base).
- Capacity in the receiving primary-care network for outpatient visit was calculated as follows: Full-time equivalent physician capacity available (as reported by the following medical groups: MedClinic, Woodland Clinic, Hill Physicians, UCD Medical Group, Sierra Nevada Medical Associates and Golden State IPA) multiplied by 2.1 (which is the average number of visits per patient per year reported by MedClinic as the PCP utilization rate).
- Over/under-capacity was then calculated by subtracting the aggregate demand from the aggregate capacity of all reporting network primary-care physicians.

After the consultant's initial calculations were provided to DMHC, the above organizations also provided their own PCP capacity estimates, which also showed surpluses. Thus, PCP capacity was verified independent of estimates provided by the medical groups. Given a demand for office visits of 139,793 and additional office visit capacity for 225,926, we calculated a 62 percent excess capacity among PCP's.

Of the three discontinuing Sutter groups, only Sutter West is 100-percent comprised of physicians that are not affiliated with any of the proposed receiving provider groups. The other two Sutter groups included significant numbers of physicians who are also affiliated with at least one of the receiving medical groups. It was thus essential to develop an inclusive list of physicians,

by name, with their group affiliations. This involved creating an unduplicated list of all potentially available physicians.

This process resulted in a final unduplicated count of 1,009 receiving specialists and 481 excluded specialists. The latter includes all Sutter physicians that are not affiliated with any of the receiving networks. These 1,009 specialists will be available to the CalPERS population in the Sacramento area. The lists we developed only identify practicing physicians available to the entire population and are not indicative of FTE equivalency.

To assess adequacy of specialist supply, we could only evaluate the total number of physicians (receiving and excluded) in each specialty in relation to the total four-county population. The resulting counts are estimates of the aggregate specialist physician supply in the four-county area, with two exceptions: (1) independent physicians not affiliated with any group; and (2) Kaiser-Permanente physicians. This assessment is an aggregate one – i.e., total physicians according to specialty relative to total population.

Our estimates suggest, as expected, some specialties are in abundant supply and some are in shortage, relative to the national average. Relative to this standard, within the Sacramento region there are only two specialties with substantial shortages on a percentage basis -- general surgery and plastic surgery. It is possible the national average for the former includes some subspecialties not otherwise specified.

While aggregate supply shortages or surpluses do not necessarily imply plan-specific deficiencies, such data are useful in assessing plan capacity. Our estimates, for example, should alert any plan to the possibility of some network problems in general surgery and plastic surgery.

DMHC staff met with representatives of Sutter Health prior to submission of the filing. During that meeting Sutter staff explained that their facilities and medical groups were integrated into a total system and that key services are distributed throughout the Sacramento region. For example, Davis and Roseville residents are routinely referred to downtown Sacramento facilities for specialized treatment. This demonstrated a pattern-of-practice that did not technically meet the established geographic guidelines followed by DMHC, but is used as a mechanism by Sutter to promote efficiency and effectiveness. This was a key reason given by Sutter not to allow selected hospitals (such as Roseville or Davis) to be retained in the network without their referral facilities. Retention of one of these smaller hospitals would have required establishing new referral patterns contrary, to their Sutter systems model.

Yolo County – Sutter Davis Hospital

The excluded hospital (Sutter Davis Hospital) is to be replaced by Woodland Memorial Hospital (see Table 3). The former is half the size of the receiving hospital, and does not have pediatric beds, which the latter does. We determined that the two beds required by CalPERS members could be accommodated within Woodland Memorial's 52 excess beds.

Yolo County – Sutter Medical Group/Sutter Independent Physicians/Sutter West Medical Group

The analysis of medical network capacity in this geographic area is included with the analysis for Sacramento County.

Summary actions for the Greater Sacramento Area are as follows:

Hospital	County	Approve	Deny	Withdrawn
Sutter Davis Hospital	Yolo	With Undertakings		
Sutter General Hospital	Sacramento	With Undertakings		
Sutter Memorial Hospital	Sacramento	With Undertakings		
Sutter Roseville Hospital	Placer	With Undertakings		

Greater Bay Area

Alameda County – Eden Medical Center

There are six receiving hospitals designated for Eden Medical Center, and all meet the time/distance standards (Table 4). We found sufficient capacity in each bed service among the receiving hospitals to meet the CalPERS demand for less than 1.5 beds.

The elimination of this hospital would not result in a disruption to a medical group, and as a result a more narrowly focused review of the capacity was performed. Clarification was received that the Hill Physicians, who admit to Eden, could use a hospitalist group at Alta-Bates Summit for admissions when necessary.

Alameda County – Washington Hospital

Of the three receiving hospitals for Washington Hospital, only one, St. Rose Hospital, meets the time/distance standards (Table 5). With less than two CalPERS beds needed, St. Rose has sufficient excess capacity. From a hospital-capacity perspective, there do not appear to be access problems.

We found that Palo Alto Medical Foundation admitted 100 percent of its obstetrics cases to this facility. Elimination of this hospital would have required that obstetrics patients travel across the San Mateo Bridge into San Mateo County, an unacceptable distance. The alternate hospital, St. Rose, was not a comparable replacement. The pattern of practice for the Hill Physicians was to admit primarily to Alta Bates, and few physicians had admitting privileges to St. Rose. Historically, the groups had used Washington Hospital for obstetrics and emergent admissions. Thus, DMHC allowed the exclusion of the hospital only with an undertaking that permitted continued access to this hospital for obstetrics (OB) services.

Contra Costa County – Sutter Delta Medical Center

As shown in Table 6, while the excluded hospital (Sutter Delta Medical Center) is a relatively small-limited-service hospital, the closest of the three receiving hospitals (Mt. Diablo Medical Center), is 16 miles away (22-minutes travel time under ideal conditions). The closest receiving hospital with obstetrics beds is John Muir Medical Center (18.5 miles/28 minutes), with 98-percent occupancy in that service. While there is sufficient obstetrics capacity at San Ramon Regional Medical Center, that hospital is relatively distant (33.6 miles/40 minutes). CalPERS members will require one bed for all services. Recommended approval was contingent on an undertaking allowing access to Sutter Delta for medically necessary admissions.

The elimination of this hospital would not result in a disruption to a medical group, and as a result, a more narrowly focused review of the capacity was performed. The undertaking assured that access to the hospital would continue to be available for medically necessary admissions for both emergent and non-emergent services.

San Francisco – California Pacific Medical Center and St. Luke's Hospital

There are two excluded hospitals in San Francisco – California Pacific Medical Center and St. Luke's Hospital (Table 7). Distance to receiving hospitals is not an issue in San Francisco. Of the three receiving hospitals, only UC San Francisco has pediatrics, obstetrics, neonatal intensive care or pediatric intensive care, and its occupancy rates in the last two services are above 80 percent. Blue Shield erroneously stated in the filing that it expected UC Mt. Zion to open an obstetrics service (that hospital ceased its GAC services several years ago). The other two replacement hospitals (St. Mary's Medical Center and St. Francis Memorial Hospital) have adequate capacity in all other services. Recommended approval was contingent on access to UCSF and California Pacific Medical Center as needed. Under these conditions, excess capacity was found to be sufficient to accommodate the CalPERS demand for six beds.

The receiving medical network's capacity determination was as made as follows:

- Brown & Toland Medical Group represented to DMHC that its physicians have alternate admitting privileges through the faculty at UCSF for OB; and arrangements for community physicians at UCSF and California Pacific would be made as necessary to mitigate OB access concerns.
- Brown & Toland asserted the CalPERS population could be absorbed at alternate hospitals in other specialty areas.

San Mateo County – Seton Medical Center/Seton Medical Center Coastside

Both receiving hospitals, as shown in Table 8 (Mills Peninsula Medical Center and Sequoia Health Services), are larger and provide more services than the excluded hospitals (Seton Medical Center/Seton Coastside). Both were found to have sufficient excess capacity. Sequoia Health Services, however, is 22 miles from Seton. Even without Sequoia, there is sufficient capacity and service capability in Mills-Peninsula to accommodate the CalPERS demand for 1.2 beds.

The elimination of this hospital did not result in a disruption to a medical group, and as a result a more narrowly focused review of the capacity was performed. We found that the directly contracted physicians admit patients through a hospitalist group.

Santa Clara County – O'Connor Hospital

As shown in Table 9, O'Connor Hospital's exclusion is not expected to result in access problems. All but one of the five receiving hospitals meets the time/distance standards. Adequate capacity was found in these four receiving hospitals in each service to accommodate the CalPERS demand of 1.2 beds.

The elimination of this hospital did not result in a disruption to a medical group, and as a result, a more narrowly focused review of the capacity was performed. We verified 100 percent alternate admitting privileges with the existing medical group.

Sonoma County – Sutter Medical Center of Santa Rosa/Sutter Warrack Hospital

Two hospitals in this area will be excluded – Sutter Medical Center of Santa Rosa and Sutter Warrack Hospital (Table 10). Both are located in Santa Rosa, as is the major receiving hospital-Santa Rosa Memorial Hospital, located less than three miles from each of the excluded hospitals. This hospital was found to have more available GAC beds than both excluded hospitals combined. In all bed categories except ICU, we found manageable occupancy rates with 59 excess GAC beds, while CalPERS requirements are for two beds. Both Petaluma Valley Hospital and Palm Drive Hospital were found to have excess ICU beds.

The elimination of this hospital resulted in a disruption to the Sutter Medical Group of the Redwoods affecting approximately 2,600 members. A more narrowly focused review of the capacity was performed and access to the directly contracted network and Sonoma Primary Care was found to be sufficient.

Summary actions for Greater Bay Area are as follows:

Hospital	County	Approve	Deny	Withdrawn
California Pacific	San Francisco	X		
Eden Medical Center	Alameda	X		
O'Connor Hospital	Santa Clara	X		
St. Luke's	San Francisco	X		
Seton Medical Center/Seton Medical Center Coastside	San Mateo	X		
Sutter Delta Medical Center	Contra Costa	With Undertakings		
Sutter Medical Center of Santa Rosa/Sutter Warrack Hospital	Sonoma	X		
Washington Hospital	Alameda	With Undertakings		

Central Valley

Fresno County – Selma Community Hospital

As shown in Table 11, of the two receiving hospitals -- Community Medical Center Clovis, and Community Medical Center Fresno – the latter is most accessible to this rural community (17.7 miles/23 minutes). It is much larger than the excluded hospital, has a far broader service mix, and was found to have sufficient excess capacity in all services to meet the CalPERS demand for less than 0.2 beds.

The elimination of this hospital will not result in a disruption to a medical group, and as a result, a more narrowly focused review of the capacity was performed. We found no significant pattern of practice to admit to the excluded hospital as opposed to the receiving hospitals.

Kern County – Delano Regional Medical Center

The excluded hospital, Delano Regional Medical Center, was withdrawn from the filing and will remain in the network for 2005.

Madera County – Madera Community Hospital

The excluded hospital, Madera Community Hospital, was withdrawn from the filing and will remain in the network for 2005.

Merced County – Memorial Hospital of Los Banos

The excluded hospital, Memorial Hospital of Los Banos, is smaller and has fewer services than either of the two receiving hospitals (Table 12). Although both receiving hospitals are relatively distant from Los Banos, this is a rural area and broader time/distance standards apply. CalPERS members require less than 0.3 beds. Recommended approval was contingent on an undertaking permitting admissions to Memorial Los Banos for radiological procedures and non-emergent conditions through local physicians as medically necessary.

The elimination of this hospital will not result in a disruption to a medical group, and as a result, a more narrowly focused review of the capacity was performed. The undertaking assured that access to the hospital would continue to be available for medically necessary admissions for both emergent and non-emergent services as previously defined.

San Joaquin County – Sutter Tracy Community Hospital and St. Dominic's Hospital

Two hospitals are being excluded in this area – Sutter Tracy Community Hospital and St. Dominic's Hospital (see Table 13). Both are small-limited service hospitals. The two closest receiving hospitals (San Joaquin General Hospital and Doctor's Hospital of Manteca) have sufficient service capabilities and excess capacity to accommodate the single bed that would be required by CalPERS members. Additionally, St. Dominic's Hospital was in the process of being acquired by Kaiser Permanente, and this transaction was completed in November of 2004.

The elimination of this hospital will result in the disruption of enrollees with Sutter Gould physicians and with some of the Delta IPA physicians in Tracy who only admitted to Sutter Tracy Hospital. Approximately 1,800 enrollees would be affected, and adequate capacity was found for the enrollees with Delta IPA PCPs in the Manteca area.

Stanislaus County – Memorial Medical Center

Data for the Modesto area are shown in Table 14. Three issues emerged from the data:

- One of the receiving hospitals, Oak Valley Hospital, is a small, limited service facility;
- Another receiving hospital, Emanuel Medical Center, is relatively distant from the excluded hospital; and

- The major receiving hospital, Doctor's Medical Center, has limited medical/surgical capacity.

In this county, broader geographic access standards apply under the Act due to it's rural location. DMHC was assured by AllCare, the major admitting group to Doctor's Medical Center, that the latter has sufficient medical/surgical capacity. Of 60 excess beds among the receiving hospitals, CalPERS is expected to require eight. With assurances that the primary receiving hospital has adequate capacity, it was recommended that the Blue Shield request be approved.

The exclusion of Memorial Medical Center would result in the disruption of approximately 7,500 enrollees with Sutter Gould Medical Foundation. Approximately 1,300 enrollees were expected to be able to retain their PCP through crossover relationships with AllCare IPA. Capacity for PCP and specialty services was verified with AllCare IPA.

Tulare County – Sierra View District Hospital

The single receiving hospital (Kaweah Delta) does not meet the time/distance standards (Table 15). Therefore, denial was recommended.

Summary actions for the Central Valley are as follows:

Hospital	**County**	**Approve**	**Deny**	**Withdrawn**
Delano Regional Medical Center	Kern			X
Madera Community Hospital	Madera			X
Memorial Medical Center	Stanislaus	X		
Memorial Hospital-Los Banos	Merced	With Undertakings		
St. Dominic's Hospital	San Joaquin	X		
Selma Community Hospital	Fresno	X		
Sierra View District Hospital	Tulare		X	
Sutter Tracy Community	San Joaquin	X		

Southern California

Los Angeles County – Cedars Sinai Medical Center

The five receiving hospitals meet the time/distance standards, and collectively were found to have the excess bed capacity and service mix to accommodate the two-bed CalPERS need (See Table 16).

The elimination of this hospital would result in a disruption to Cedars Sinai Health Associates and Cedars Sinai Medical Group, resulting in the need for approximately 1,000 enrollees to change their medical group affiliation. A more narrowly focused review of the capacity was performed and adequate capacity was found given the "open" primary and specialty care capacity of the receiving groups, Bay Area, UCLA and St. Vincent IPA.

Los Angeles County – City of Hope

The excluded hospital, City of Hope, was withdrawn from the filing and will remain in the network for 2005.

Los Angeles County – St. Mary Medical Center

The two receiving hospitals meet the time/distance standards (Table 17). Long Beach Memorial Medical Center has a Children's Hospital campus, the data on which are not reported in the OSHPD Financial Disclosure database. It thus has sufficient pediatrics, pediatric intensive care unit (PICU) and neonatal intensive care unit (NICU) capacity to substitute for St. Mary Medical Center, and accommodate the one-half bed required by CalPERS.

The elimination of this hospital would result in an exclusion of Physicians of Greater Long Beach Medical Group, affecting approximately 200 enrollees. As a result, a more narrowly focused review of the capacity was performed and we found that more-than-adequate capacity existed with numerous alternate medical groups in the area.

Los Angeles County – Presbyterian Intercommunity Hospital

As shown in Table 18, the receiving hospitals designated to replace Presbyterian Intercommunity Hospital are poor substitutes for three primary reasons:

- The two large, full-service receiving hospitals located in Long Beach and Lakewood do not meet distance/travel time standards;
- The only hospital that meets the travel standards, Whittier Medical Center, is a smaller, limited-service facility that was involved in a sales transaction at the time of review; and
- Blue Shield did not demonstrate a pattern-of-practice in Whittier of admissions to the Long Beach and Lakewood hospitals.

The exclusion of this hospital would also have resulted in the exclusion of Presbyterian Health Physicians and the reassignment of over 2,100 members to new physicians in other medical groups, because this captive medical group was solely affiliated with this hospital. The members would have been reassigned to alternative medical groups that did not routinely admit to the proposed receiving hospitals in Long Beach and Lakewood.

When compared to the other proposed hospital exclusions in the 2005 network, this specific proposal did not seem logical or consistent with access standards.

Los Angeles County – West Hills Hospital and Medical Center

The two receiving hospitals meet the time/distance standards (Table 19). While they have high occupancy rates in some services (i.e., ICU, pediatrics, and obstetrics), the CalPERS bed need is estimated to be only 0.21 beds. Thus, there is sufficient capacity among the receiving hospitals.

The elimination of this hospital will not result in a disruption to a medical group, and as a result, a more narrowly focused review of the capacity was performed.

Los Angeles County – USC University Hospital

Two of the three receiving hospitals, St. Vincent Medical Center and Good Samaritan Hospital, meet the time/distance standard and have sufficient excess capacity and service mix to meet the CalPERS need for two beds (Table 20).

The elimination of this hospital will not result in a disruption to a medical group, and as a result, a more narrowly focused review of the capacity was performed.

Los Angeles County – St. Francis Medical Center and St. Vincent Medical Center

These hospitals proposed for exclusion were withdrawn from the filing and will remain in the network for 2005.

Orange County – Hoag Memorial Hospital Presbyterian

The excluded hospital, Hoag Memorial Hospital Presbyterian, has adequate substitutes among the three receiving hospitals in terms of bed capacity, service capability, and distance to accommodate the 1.5 beds required by CalPERS members (Table 21).

The elimination of this hospital will not result in a disruption to a medical group, and as a result, a more narrowly focused review of the capacity was performed given the number of "open" primary and specialty care providers in the receiving network as reported by Blue Shield.

Riverside County – Desert Regional Hospital

The Blue Shield included this hospital as an excluded facility for 2005, yet it provided additional explanation in a subsequent amendment to the original filing explaining that it would utilize the contract between its network medical group, Heritage Provider Network and the Desert Regional hospital. Thus, Blue Shield's CalPERS members would continue to access this hospital in 2005 under their medical group's direct contract with the hospital, rather than accessing it through the Blue Shield contract. Blue Shield explained that this change provided it a cost savings due to the lower rate in the Heritage Provider Network contract. The proposal was approved by DMHC based upon this explanation.

Ventura County – St. John's Regional Medical Center/St. John's Pleasant Valley Hospital

The single receiving hospital (Community Memorial Hospital of San Buenaventura) does not provide rehabilitation, and has high occupancy in CCU, NICU and obstetrics, with occupancy rates of 100-percent or greater in CCU and NICU (Table 22). Denial was recommended.

The elimination of this hospital will not result in a disruption to a medical group, and as a result, a more narrowly focused review of the capacity was performed.

Summary actions for Southern California are as follows:

Hospital	County	Approve	Deny	Withdrawn
Cedars Sinai Medical Center	Los Angeles	X		
City of Hope	Los Angeles			X
Hoag Memorial Hospital	Orange	X		
Presbyterian Intercommunity Hospital	Los Angeles		X	
Desert Regional	Riverside	X		
St. Mary Medical Center	Los Angeles	X		
St. John's Regional Medical Center/St. John's Pleasant Valley Hospital	Ventura		X	
USC University Hospital	Los Angeles	X		
West Hills Hospital and Medical Center	Los Angeles	X		
St. Francis Medical Center and St. Vincent Medical Center	Los Angeles			**X**

San Diego County

The excluded Sharp Hospitals were all withdrawn from the filing and will remain in the network for 2005.

Hospital	County	Approve	Deny	Withdrawn
Grossmont Hospital	San Diego			X
Sharp Chula Vista Medical Center	San Diego			X
Sharp Coronado Hospital & Healthcare Center	San Diego			X
Sharp Mary Birch Hospital for Women	San Diego			X
Sharp Memorial Hospital	San Diego			X

A network capacity determination was deferred when Blue Shield withdrew its proposal to terminate providers in this county.

Section V

CONCLUSION AND RECOMMENDATIONS

This review was complex, performed within a tight time frame, and constrained by incomplete, inconsistent data. Nevertheless, we believe the approved requests for the narrowing of provider networks will not result in unacceptably compromised access for Blue Shield CalPERS enrollees during 2005, notwithstanding the constantly changing health care market place. In assessing all proposed changes, we erred on the conservative side by basing the analysis on the total number of Blue Shield CalPERS members who would be impacted by the proposed changes. It would have been reasonable, however, to assume that some members would switch to other health plans during the open enrollment period in order to maintain continued access to their established physicians and hospitals. As a result more than 18,000 CalPERS members chose to move to other health plans in 2005 during open enrollment. As a result of this large percentage of members transitioning out of the new network (approximately one-third), a greater capacity in the narrow network resulted than we projected.

In our assessment, we were constrained by three shortcomings in the process:

- The 20-business day review period;
- The lack of complete and uniform data; and
- The inability to consider the economic consequences of the proposal.

These problems should be corrected for future filings. Our recommendations follow:

Review Period

Assessing proposals for narrowing of provider networks can be a complex and time consuming process as was the CalPERS/Blue Shield filing. Requiring such assessments to be performed in an unrealistic time frame could lead to less thorough findings, in either direction. The time allowed for review should be extended in one of two ways. It could simply be extended to a more reasonable period (e.g., 45-60 days). Or, a requirement be implemented that a proposal be declared complete before the review clock commences. A filing would be declared complete once DMHC determines the applicant has submitted sufficient data and clarifications to enable a thorough review within the mandatory review period.

Complete and Uniform Data

It has been previously noted that this was the first filing of its type received by DMHC. DMHC and Blue Shield determined during the pre-filing conference that the material modification should be filed as 53 separate "block transfers" to include each affected hospital and medical group. It became apparent upon review of the original submittal that this filing format was inadequate because critical data was not included in the block transfer filing forms. As a result, a 120-comment deficiency letter by the DMHC was issued to Blue Shield, resulting in the filing of 25 subsequent amendments comprising over a thousand additional pages of material (see Appendix B). The knowledge gained from this process provides DMHC with guidance in establishing future uniform data requirements for all similar filings.

In addition to establishing uniform data requirements, extensive pre-filing conferences should be held, ensuring that the plans provide adequate data on access and capacity with their filing. Such data requirements would incorporate specific definitions, specified data elements and uniform time periods. Moreover, all data should be provided on Excel spreadsheets according to a specified format. It is also recommended that plans be obligated to submit written attestations from each receiving hospital and medical group along with sufficient documentation from each entity to demonstrate capacity for the proposed number of transferring members.

Data to be included with such submissions should include:

- Updated occupancy levels from each receiving hospital (to supplement older OSHPD data);
- Require all time/distance data to be calculated and provided under two scenarios, e.g. "Map quest" (drive time and distance) and similar calculations at peak driving times;
- Written attestations from PCPs who are actually open and available and which clearly identify the number of transferring members each PCP is willing to accept;
- Specialist provider referral data and supporting analysis to justify that the receiving network specialists have enough excess capacity to handle the additional referral utilization; and
- Proposed undertakings when it is clear that hospital or physician capacity is likely in question.

1. Hospital Data

We recommend that data for hospital bed capacity be submitted as follows. For each major bed classification, data should be submitted in an Excel spreadsheet for licensed and available beds, total patient days and plan patient days for the most recent calendar year.

The bed classifications are as follows:

Medical/Surgical
Perinatal
Pediatrics
ICU
CCU
Burn
Neonatal Intensive Care
Rehabilitation
Total General Acute Care

The following is an example of the format for Medical/Surgical Beds

Hospital Name	OSHPD I.D.	Plan Status		Medical/Surgical			
		Discontinuing	Receiving	Licensed Beds	Available Beds	Total Patient Days	Plan Patient Days
Hospital A							
Hospital B							

In addition, all time/distance data between discontinued and receiving hospitals would be required to be calculated under two scenarios: Non-peak and peak driving times.

2. Physician Data

The existing fixed-ratio (1/2000 and 1/1200) access-capacity standards for physicians defined under the Knox-Keene Act are not useful in this kind of analysis because of physician overlaps between medical groups. There is no practical way to verify the composition of a physician practice between HMO and fee-for-service patients and it is therefore nearly impossible to accurately project the number of new patients receiving physicians can serve. In this filing Blue Shield did not provide adequate physician data. This required the time-consuming task of contacting receiving medical groups in an attempt to obtain essential data.

To assure future filings to DMHC provide the necessary physician detail to accurately assess IPA/medical group and individual PCP/specialty capacity, plans must confirm and attest to the validity of the information they obtain from receiving IPA/medical groups and their contracted PCP/specialty physicians. Such detailed information should include, but is not necessarily limited to the following:

Primary Care Physicians:

- Total count of PCPs, by specialty, in the receiving IPA/medical group
- Total count of PCPs, by specialty, accepting new HMO members
- Name and unique identifier of each PCP accepting new HMO members
- Number of HMO patients currently assigned to each PCP
- Confirmed number of new HMO patients each PCP has agreed to accept
- Name(s) of other IPA/medical group affiliation(s), if applicable
- Primary and secondary hospital affiliation, as applicable

Specialist Physicians/Ancillary Providers:

- Total count of physicians, by specialty, contracted to IPA/medical group
- Total count of physicians, by specialty, accepting new (HMO) patients
- Board certification(s) of those specialists accepting new (HMO) patients
- Confirmed number of new (HMO) patients each specialist can accept
- Name(s) of other IPA/medical group affiliation(s), if applicable
- Primary and secondary hospital affiliation(s), as applicable

In order to assure that each plan provides the necessary physician access data in a structured and consistent format, we recommend using the format set forth in Appendix F for all future health plan filings:

3. Economic Considerations

DMHC lacks the legislative authority to review the economics of the proposed network change in terms of financial viability and the cost-access tradeoff. The financial viability of the health plan and network are crucial considerations in making access determinations, especially regarding network stability. The access-cost trade-off is also an important consideration. We thus recommend that DMHC be given the authority to review the underlying financial rationale and calculations used by the health plan in proposing a narrowing of its provider network to achieve significant cost savings. The Blue Shield proposal will provide useful data to show how consumers respond when faced with an alternative between a narrow network and higher out-of-pocket costs.

Appendices

APPENDIX A – DESCRIPTION OF SPECIFIC FILING REQUIREMENTS

Department of Managed Health Care: Authority and Background

Under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), the Department has broad power to regulate health plans and to ensure that the interests of enrollees are protected (Health and Safety Code sections 1341(a) and 1346(b)). The Director of the Department may exercise all powers necessary or convenient to administer or enforce such laws (Health and Safety Code sections 1341(c) and 1346(b)). The provisions of the Knox-Keene Act include the following: promoting the effective representation of enrollees; ensuring the financial stability of plans; and ensuring that enrollees receive readily available health care in a manner providing continuity of care (Health and Safety Code sections 1342(e), (f), and (g)).

In addition, Health and Safety Code sections 1367(d) and (e) require a plan to provide timely access to care and continuity of care to its enrollees. Rule 1300.51 provides a guideline for health plans to provide enrollees' access to primary care doctors within 30 minutes or 15 miles of an enrollee's residence or workplace.[3] New legislation, effective January 1, 2004, (SB 244 (Stats 2003, ch. 590) and AB 1286 (Stats 2003, ch. 591)), provides enhanced continuity of care for enrollees in block transfer settings. These statutes provide for the completion of covered services for conditions such as a serious chronic condition, pregnancy, terminal illness and care for a newborn child.

The materiality of a change proposed by a plan determines whether the plan must file an Amendment or a Notice of Material Modification with the Department. Because Blue Shield's filing contained a significant narrowing of its provider network, it was filed as a Material Modification. A Material Modification requires approval by the Department prior to its implementation.[4] The Material Modification may be approved or denied, in whole or in part, by order of the Director of the Department.

The DMHC convenes a pre-filing conference with the health plan in the majority of material modification filings. The chief purpose of this meeting is to establish the form and content of each filing, since many of the filings present unique issues or business transactions not seen by the Department. This industry is competitive, dynamic, changing direction frequently, and new business concepts are often proposed by our licensees.

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[3] Title 28 of the California Code of Regulations, section 1300.51
[4] Health and Safety Code section 1352(b)

During this pre-filing conference, the DMHC and Blue Shield discussed how such a large volume of information could be presented in the filing. We mutually chose the commonly used block transfer filing forms. They present information concerning access to care in a familiar form to both the Department and to Blue Shield. While the form is not completely on point for this transaction, it provided an efficient means to organize the information. This circumstance was unique; in that the filing was composed of an application for a narrow network and 53 block transfer forms. The Department has not previously been presented with this type of "hybrid" filing, and had to devise a new review methodology.

DMHC realized that the size and complexity of this narrow network proposal would raise novel policy issues that would need to be addressed in a very short time frame. Accordingly, we determined that more staff would be required than was normally the case. It is typical for a single attorney to review a material modification filing. In this instance, we assigned 4 staff from the licensing division. The Department also resolved to retain industry consultants to review the filing and present their independent analysis of the filing. In all, 5 independent consultants reviewed and commented on the proposal. The DMHC staff and the consultants worked full-time on the filing together for 5 weeks.

There are many different types of material modification filings. A general review process encompasses the following points:

- Plans are expected to contact designated Licensing Counsel prior to a filing, including a Material Modification or Amendment.

- A pre-filing conference, by telephone or in-person, is initiated by the plan when it is ready to discuss a proposed change in its licensure application.

- If preliminary discussions indicate that the scope of the filing is extensive, the Department requests that the licensee provide, in advance of the pre-filing conference, an agenda that includes an outline of the proposed change(s).

- Each of the plan's designated Department staff (Licensing Counsel, Plan Surveys Analyst, Financial Examiner and Help Center Counsel) will attend if the scope of the anticipated filing will include a topic or document within the scope of review of the staff.

- The discussions during the pre-filing conference could include a presentation by the plan to explain the proposed change and discussion of questions. The discussion includes an explanation from Department staff regarding the nature and extent of information necessary to the Department's review and evaluation and guidance on common mistakes and errors.

- The licensee is encouraged to contact designated Department staff with any additional questions that may develop as the anticipated filing is finalized.

- Plans file all Material Modifications electronically through the Department's e-filing web portal.

- The Department staff identifies issues that may potentially impact the delivery of health care services to California enrollees and develop written Undertakings or promises that memorialize the major plan representations offered as part of the Material Modification.

- When the extent of the material changes are fully identified and evaluated and the necessary Undertakings are substantially drafted, the Department determines whether the nature of the changes proposed in the material modification warrants the solicitation of public comment.

- If the Material Modification may potentially result in plan consolidation, structural changes in ownership, conversion to for-profit status or a plan withdrawal of products or market participation, public participation will be solicited as part of the final approval process.

- If the Department determines that it is appropriate to solicit public comment, it will develop an agenda, outlining the Department's review authority and the substance of any Undertakings. The notice of the public meeting will be scheduled to allow the submission of written comments for interested stakeholders prior to the meeting.

APPENDIX B – DMHC DEFICIENCY COMMENT LETTER TO BLUE SHIELD

July 16, 2004

VIA ELECTRONIC MAIL and U.S. MAIL

Lyle Swallow
Associate General Counsel
California Physician's Service
d/b/a Blue Shield of California
50 Beale Street, 22nd Floor
San Francisco, CA 94105

Re: California Physician's Service d/b/a Blue Shield of California
Proposing Changes to Provider Network for CALPERS Enrollees
Filed June 30, 2004; Filing No. 20040557

Dear Mr. Swallow:

The Department of Managed Health Care (the "Department") has reviewed the information submitted in the above-referenced filing (the "Notice") filed by California Physician's Service d/b/a Blue Shield of California (the "Plan") for compliance with the Knox-Keene Health Care Service Plan Act of 1975, as amended[5].

Please review the following comments and feel free to contact me if you would like to discuss any of the issues before filing the Plan's responsive amendment. I recognize the short time frame available to the Plan to respond and will work with you to find the most expeditious way to gather and provide this information.

Exhibit E-1

1. At page 13, the Plan states that UC Davis Medical Group has "committed that, as necessary, additional PCP offices will be opened to new patients and/or new PCPs will be recruited." Please provide more details as to this commitment and whether this commitment is a contractual obligation between the Plan and the group.

2. At page 14, the Plan states, "The Plan has also advised the group [UC Davis Medical Group] that, in the event the Plan receives member

[5] California Health and Safety Code Sections 1340 et seq. (the "Act"). References herein to "Section" are to Sections of the Act. References to "Rule" refer to the regulations promulgated by the Department at Title 28 California Code of Regulations.

complaints regarding specialist access, the Plan will first seek to resolve the matter with UC Davis and will then, if necessary, make alternative arrangements for the affected enrollee(s) to receive necessary specialist services elsewhere." Please explain whether (i) there would be an issue contractually between the Plan and the group to send enrollees elsewhere, if necessary, and (ii) where the Plan would send such affected enrollees (i.e. a Sutter Medical Group specialist?).

3. Starting at page 16, the Plan discusses continuity of care issues. Please address the following:

   a. The Plan states that it cannot trigger the post-termination continuity of care provisions that are in its provider contracts, yet does not foresee reluctance of excluded providers to render continuity of care.

      i. The Plan states it is not modifying its provider contracts in order to facilitate continuity of care, but such is not the case for Sutter Healthcare. Please provide the amended sections of the contracts with Sutter Healthcare providers (hospitals and medical groups/IPAs) that relate to continuity of care.

      ii. Please explain if excluded hospitals, upon a contractual basis, can refuse to provide the level of continuity of care the Plan intends to provide per its filed continuity of care policies. If so, please explain how the Plan intends to fulfill its promise of continuity of care if there is no binding obligation upon excluded hospitals to provide it. Please disclose if any excluded hospitals have stated to the Plan they have issues with, or have stated they will refuse to provide continuity of care.

      iii. The Plan states that excluded medical groups/IPAs remain contractually obligated to provide covered services to any Blue Shield commercial HMO plan member assigned to them, including CALPERS members.

         1. As the CALPERS members will no longer be assigned to the excluded medical groups/IPAs, please explain how the Plan intends to fulfill its promise of continuity of care if there is no binding obligation upon excluded medical groups/IPAs to provide it. Please disclose if any excluded medical groups/IPAs have stated to the Plan they have issues with, or

have stated they will refuse to provide continuity of care.

iv. If it is the case there is no contractual obligation upon an excluded hospital or excluded medical group to provide the level of continuity of care stated in the Plan's policies, and provision of continuity of care will have to be negotiated on a case-by-case basis, please explain what payment rate the Plan will be offering to excluded providers. Please disclose any known issues raised by any of the excluded providers regarding payment for continuity of care.

b. The Plan states at page 18 it will undertake to identify enrollees that are potential continuity of care cases. Please explain if the Plan will automatically grant continuity of care for all enrollees so identified, and found eligible, or the enrollee must still request continuity of care for it to be provided. Please also explain how and when the Plan will be contacting enrollees it identifies as eligible for continuity of care.

c. Please be aware that the Department may request an undertaking from the Plan regarding continuity of care at a later date.

4. The Plan states in the Exhibit E-1 that there will be 64,808 enrollees impacted by the proposed hospital exclusions. This number only includes instances where enrollees are transitioning from one medical group to another, thus the actual total number of affected enrollees is much higher than 64,808. Please provide a revised calculation that incorporates those enrollees who are keeping their medical group, yet will experience a change in hospital.

5. Please provide the following data: The age and sex demographics of the CALPERS population.

Exhibit I-8 Enrollee Transition Plans

6. Please provide the anniversary date for all proposed alternate hospitals for which the Plan has an "evergreen" contract. For all other proposed alternate hospitals, please provide the renewal or expiration date of the contract with the Plan.

7. Please provide the anniversary date for all proposed receiving medical groups for which the Plan has an evergreen contract. For all other proposed receiving groups, please provide the renewal date or expiration date of the contract with the Plan.

8. In the transition plans, the Plan provides bed occupancy rates for proposed alternate hospitals. The Exhibit E-1 states the source of these figures is the Office of Statewide Health Planning and Development ("OSHPD"). In most instances the figures cited differ from what the Department has found for utilization in 2003 on the Automated Licensing Information and Report Tracking System ("ALIRTS") database found on OSHPD's website. Please provide the exact source of the Plan's figures and the time period from which the figures are drawn. Please also clarify whether the Plan is referring to staffed bed or licensed beds when it cites the figures in the transition plans.

9. Please discuss the impact of the new nursing staffing ratio law that went into effect on January 1, 2004 (AB 394) and whether the Plan accounted for this fact in making its capacity determinations for proposed alternate hospitals.

10. Please provide for each proposed alternate hospital, the following:

    a. Number of licensed, available, and staffed beds as well as patient days for the major categories of bed types (i.e., medical, surgical, pediatrics, ICU, etc) for the first quarter of 2004 and for the 12-month period ending 3/31/04. For any bed type with 85% or more occupancy in either time period, please justify the Plan's position that the service is available and accessible to enrollees. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

    b. For each proposed hospital exclusion, for calendar year 2003, provide patient days on behalf of CalPERS members according to bed category.

    c. Licensed nurse staffing ratios by hospital acuity level, e.g. ICU, medical/surgical, pediatric.

11. For each proposed hospital exclusion, please provide the number (and percentage) of affected enrollees who live within a 15-mile radius of each of the proposed alternate hospital(s). If the number of enrollees within the 15-mile radius of the alternate hospital(s) does not equal the total number affected number of enrollees, highlight this fact. For the following counties, for each proposed hospital exclusion within the county, please provide the above information, and in addition, the number, and percentage, of affected enrollees who live within a 30-mile radius of each proposed alternate hospital:

    a. Fresno
    b. Madera
    c. Merced

d. San Joaquin
e. Sonoma
f. Stanislaus
g. Tulare
h. Yolo

Section 1367(d), (e), Rules 1300.51(d)(H)(ii), 1300.67.1, 1300.67.2.

12. For the following proposed hospital exclusions, the Plan is proposing to redirect enrollees to a hospital or hospitals which appear to have issues in terms of geographic accessibility. Please provide additional information regarding the pattern of practice of affected enrollees in the area as to the typical distance and time traveled for hospital services:

a. Alameda County: Enrollees being redirected from Washington Hospital to Alta Bates Summit Medical Center.

b. Contra Costa County: Enrollees redirected to San Ramon Regional Medical Center and Mt. Diablo Medical Center

c. Fresno County: Enrollees redirected to Community Medical Center – Clovis

d. Los Angeles County:
    1. Enrollees redirected from Presbyterian Intercommunity Hospital to St. Joseph's Orange Hospital and Long Beach Memorial Hospital
    2. Enrollees redirected from USC University Hospital to Encino Tarzana Medical Center – Tarzana and UCLA Medical Center

e. Madera County: Enrollees redirected out-of-county to Community Medical Center – Fresno and Community Medical Center – Clovis

f. Merced County: Enrollees redirected to Mercy Hospital and Health Services

g. Orange County: Enrollees redirected to all proposed alternate hospitals.

h. San Mateo County: Enrollees redirected to Sequoia Hospital

i. Tulare County: Enrollees redirected to Kaweah Delta District Hospital

j. Ventura County: Enrollees redirected to Community Memorial Hospital of San Buenaventura

Section 1367(d), (e), Rules 1300.51(d)(H)(ii), 1300.67.1, 1300.67.2.

13. Please define the number of years beyond the 2005 calendar year, Blue Shield intends to offer the continuing and replacement providers as options in this plan.

14. For every instance in the filing where the Plan has stated it will allow affected enrollees to access the excluded facility for a particular service beyond December 31, 2004, please provide an undertaking to that effect. A single undertaking is sufficient.

15. For every hospital, please provide a report listing physician, medical group, specialty, type of admitting privilege, and current status as to accepting new or existing patients.

16. For every continuing and replacement medical network / provider entity, please provide analysis and explanation of the ability of the existing medical network/provider entity to be able to provide the same level of service and access to the proposed new hospitals, including:

    a. Analysis of service and access to new hospitals given location, open/closed status and hospital privileges
    b. Geographic plotting of proposed hospital and medical network providers by PCP and SPC, admitting privileges at the proposed hospital, and open to new patients status.
    c. Analysis and explanation of the capacity of the receiving medical network for open providers relative to the number of enrollees that will need to transfer to a new provider.

17. For every enrollee block transfer, continuing and replacement hospital and medical network / provider entity, please provide the following:

    a. Geographic plottings of enrollee residence
    b. Geographic plottings of hospitals and medical providers (making distinction between PCP and SCP providers)
    c. Geographic plottings of hospitals and medical providers by PCP and SPC who have privileges at proposed hospitals and are open to new patients
    d. Calculations of average travel times for enrollees to hospitals and center point of PCP and SCP locations.
    e. Analysis of the accessibility/capacity of the medical providers relative to the new hospital.

f. For each enrollee block, percentage of enrollees who will fall outside the 15 mile / 30 minute access standard for hospital and center point of medical network.

18. Please provide by specialty category, including primary care, the CALPERS enrollee physician utilization rate per thousand and the general Plan's commercial non-CALPERS enrollee utilization rate per thousand.

19. If the Plan represents in a transition plan that providers of a group can admit to a proposed alternate hospital, is this representation based on all the providers having actual privileges at the alternate hospital, or is it possible some providers only have courtesy privileges. Please provide further explanation on how the Plan made its determination as to whether physicians had privileges at a hospital for purposes of the transition plans and the source of the data – individual providers reporting to the Plan or medical groups on behalf of the physician members.

<u>*Alameda County*</u>

Eden Hospital Medical Center / Hill Physicians / Affinity

20. Please explain why Alta Bates Medical Group is not a provider option at Alta Bates / Summit Hospitals, and whether the receiving hospital(s) is Alta Bates, Summit, or both.

21. Please provide a complete breakout of the percentage of Hill Physicians that can admit to each of the alternate facilities for both specialists and PCPs.

22. Please provide a complete provider roster for Affinity Medical Group (PCP and SCP), and identify the coverage area(s) for Affinity.

23. Please explain which of the receiving facilities will be the primary receiving facility for Affinity Medical Group. In addition, please provide the number of hospitalists at Alameda Hospital. Please also analyze whether the number of hospitalists will be sufficient given their current caseload and the number of transitioned enrollees.

24. The Plan states that 96% of the Hill Specialists have admitting privileges at Alta Bates Summit Medical Center ("Summit") and 100% of the Affinity Medical Group specialists have admitting privileges at Alameda Hospital. What are the hospitals at which Affinity Medical Group physicians have current admitting privileges? Please explain whether other of the alternate hospitals listed will be utilized for specialty care, and if so, how enrollee will be admitted.

25. Please describe the admitting relationships of the continuing and replacement networks with St. Rose and Valley Care.

26. Please address the following regarding very high or extremely high bed occupancy rates for the following hospitals. The data comes from OSHPD's ALIRTS database for occupancy data reported by the respective hospitals for 2003 (the source of the data holds true for any of the other bed occupancy rates cited for the balance of this comment letter). For each figure cited, please provide the Plan's analysis as to the actual capacity of the hospital to deliver the listed service and why redirecting enrollees to this hospital would still constitute reasonable access and availability for the listed service:

    a. Summit's newborn intensive care nursery beds are at 96% capacity.

    b. Please explain why San Ramon Regional Medical Center is considered an alternate facility given that the Plan states it is at 99% occupancy.

    Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

Washington Hospital

27. The Plan states that St. Rose Hospital does not have NICU services, thus enrollees will be redirected to Summit. As noted in a previous comment, such services are at maximum bed occupancy capacity. In addition, Bay Valley Medical Group is not affiliated with Summit. Please explain the Plan's reasoning for redirecting these services to Summit.

28. The Plan states that St. Rose Hospital does not have cardiac services, thus enrollees will be redirected to Summit. Bay Valley Medical Group is not affiliated with Summit. Please explain the Plan's reasoning for redirecting this service to Summit.

29. The Plan states only 55% of Hill Physicians doctors have admitting privileges to alternate hospitals. Please provide a breakout, by PCP and specialist, of what percentage have admitting privileges at each of the alternate facilities. Please provide the number of hospitalists that will be available to admit Hill Physician enrollees to Summit. Please also analyze whether the number of hospitalists will be sufficient given their current caseload and the number of transitioned enrollees. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

30. The Plan has not addressed how it will admit Hill Physician enrollees needing to be admitted to St. Rose Hospital. Please address.

31. Plan states that only 19% of Hill Physician obstetricians have admitting privileges to St. Rose Hospital, as the Plan is excluding the rest of Hill Physician obstetricians from the CALPERS network. Please explain why the Plan is excluding these other obstetricians. Please provide additional data substantiating that the remaining obstetricians will be sufficient to care for the existing and for transitioned enrollees.

32. The Plan states that those affected enrollees with Hill Physicians may be referred to Bay Valley Medical Group for obstetrical care. Please explain how these arrangements will work if the enrollee is not assigned to Bay Valley Medical Group.

Contra Costa County

Sutter Delta Medical Center

33. The Plan states that San Ramon Regional Medical Center and John Muir Medical Center are at approximately at or near 100% capacity. Please explain why the Plan is proposing to redirect CALPERS enrollees to these two facilities. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

34. Please explain which of the proposed alternate facilities would be considered the primary admitting facilities for Hill Physicians.

35. Please provide a breakout, by percentage, of the admitting privileges to each of the alternate facilities for both Hill Physician PCPs and specialists.

36. The Plan states that 86% of Hill Physicians' PCPs admit to the alternate facilities, and to resolve the shortfall in admission privileges that "The Plan's proposed alternate groups have physicians who will admit patients on behalf of those PCPs without privileges." The filing does not indicate the Plan intends to transition enrollees away from Hill Physicians as a part of the CALPERS hospital network exclusion. Please explain this statement.

37. The Plan states that 78% of Hill Physician specialists admit to the alternate facilities, but does not address how the enrollees who see specialists without admitting privileges will be able to get admitted. Please address.

Fresno County

Selma District Community Hospital

38. For each figure cited, please provide the Plan's analysis as to the actual capacity of the hospital to deliver the listed service and why redirecting enrollees to this hospital would still constitute reasonable access and availability for the listed service:

    a. Community Medical Center -- Fresno is at 105% capacity for perinatal beds, 94% capacity for intensive care beds and 87% for intensive care newborn nursery beds.
    b. Community Medical Center – Clovis is at 87% for medical/surgical beds and 91% for perinatal beds.

    Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

39.Please provide the number and percentage of PCPs without admitting privileges to Community Medical Center – Fresno and Clovis and the number of hospitalists who will be available to cover for the shortfall. Please also analyze whether the number of hospitalists will be sufficient taking into account current caseload and the number of enrollees to be transitioned. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

Los Angeles County

USC University Hospital

39. The Plan states that a redirection from USC University Hospital results in only 42 enrollees being affected, yet there were 557 bed days by CALPERS members recorded at the hospital in 2003. Please provide further explanation.

40. The Plan states that Encino Tarzana Medical Center – Tarzana is at 99% bed occupancy capacity. UCLA Medical Center is at 98% bed occupancy capacity for intensive care and 97% for both coronary care and acute repertory care. Please provide the Plan's analysis as to the actual capacity of the hospitals to deliver services and why redirecting enrollees to these hospitals would still constitute reasonable access and availability for services. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2. The distance between USC and UCLA exceeds the 15 mile access standard, and there are several other tertiary hospitals closer to USC. Please explain why other alternative hospitals have not been considered.

St. Mary's Medical Center

41. The Plan proposes that enrollees will access Long Beach Memorial Hospital and Lakewood Regional Medical Center as alternate facilities. The affected enrollees will be the 219 enrollees currently assigned to Physicians of Greater Long Beach. The Plan is transitioning enrollees away from Physicians of Greater Long Beach to other medical groups which, per the Plan, do not admit to Long Beach Memorial Hospital. Please explain why the Plan lists Long Beach Memorial Hospital as an alternate and also why the Plan does not list Los Alamitos Medical Center as an alternate hospital given that Alamitos IPA admits to this facility.

West Hills Hospital Medical Center

42. As noted previously, Encino Tarzana Medical Center –Tarzana is at 99% bed occupancy capacity. Please provide the Plan's analysis as to the actual capacity of the hospital to deliver services and why redirecting enrollees to this hospital would still constitute reasonable access and availability for services. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

Presbyterian Intercommunity Hospital

43. As a result of excluding Presbyterian Intercommunity Hospital, the Plan proposes to exclude Presbyterian Health Physicians. However, the proposed alternate hospitals and the hospitals to which the receiving medical groups admit do not agree. Nuestra Family Medical Group, Physician Healthways, Lakewood Health Plan, and Good Samaritan Medical Group, all proposed receiving groups, do not admit to any of the three proposed alternate hospitals. Please provide further explanation.

44. The Plan states, "Services that are unavailable at Whittier Hospital will be redirected to St. Joseph Orange Hospital and Long Beach Memorial Hospital as necessary." Please specify the services being referenced. In addition, please explain if the Plan intends Whittier Hospital to be the primary admitting hospital, with enrollees to access services at the other two facilities for only those services for which Whittier Hospital cannot provide.

Presbyterian Health Physicians

45. The Plan states that enrollees will be directed to Whittier, St. Joseph's Orange, and Long Beach Memorial and to 7 new medical networks. Please provide further analysis and explanation of the accessibility/capacity of the proposed medical networks to provide

services at these hospitals given facility location, provider/service mix, and provider location, provider hospital privileges and open/closed status.

46. The Physician Healthways Medical Group's only Anatomic and Clinical Pathology specialist is not accepting new enrollees. Please explain how the Plan intends to provide enrollees access to this type of specialist. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

Cedars Sinai Medical Center

47. The Plan does not state that one of the alternate hospitals will be St. Vincent Medical Center, though a receiving provider group for the Cedar Sinai Health Associates, St. Vincent IPA, admits to this facility. Please revise.

48. UCLA Medical Center is at 98% of bed occupancy capacity for intensive care and 97% for both coronary care and acute repertory care. UCLA Medical Center – Santa Monica is at 95% bed occupancy for perinatal. St. John's Hospital and Health Center is at 137% of bed occupancy capacity for intensive care. Please provide the Plan's analysis as to the actual capacity of the hospitals to deliver these services and why redirecting enrollees to these hospitals would still constitute reasonable access and availability for these services. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

49. Of the 3 pediatricians affiliated with UCLA Medical Group, only one pediatrician is accepting new enrollees. Please confirm that only one pediatrician will be sufficient to serve the needs of affected enrollees and will, in addition, be geographically accessible to affected enrollees. Section 1367(d), (e), Rules 1300.51(d)(H), 1300.67.1, 1300.67.2.

Merced County

Memorial Hospital of Los Banos

50. It is not clear which hospital the Plan intends to provide as an alternate to Memorial Hospital Los Banos. Mercy Hospital and Health Services ("Mercy") has two locations, Community Campus and Dominican Campus. Please clarify.

51. The Plan states that enrollees will be directed to hospitals in Merced. Please provide and analysis and explanation of the proposed medical network for Los Banos relative to the admitting privileges for the hospitals and referral patterns for the community, and how the proposed network will meet service and accessibility standards.

52. The Plan states that only 20% of the Blue Shield direct network PCPs have admitting privileges at Mercy Hospital and Health Services. The Plan states that this issue is resolved by the fact that: "The Blue Shield Direct Contracted Network includes a medical group in Merced which is contracted to provide hospitalist services at Mercy Hospital and Health Services." Please explain how many hospitalists will be available to admit enrollees. Please also analyze whether the number of hospitalists will be sufficient given their current caseload and the number of transitioned enrollees. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

53. It is unclear whether any of the specialists in the Blue Shield direct network have admitting privileges at Mercy. If none or few do, please explain how that is congruent with the Plan's assertion that the pattern of practice is for enrollees to go to Merced for specialty care. In addition, the Plan did not adequately explain how enrollees would be admitted into Mercy if their specialist did not have admitting privileges. Section 1367(d), (e), Rules 1300.51(d)(H), 1300.67.1, 1300.67.2.

Madera County

Madera Community Hospital

54. The Plan states that Madera Community Hospital is not listed in the HMO directory and is not currently available to CALPERS members. The Plan also states that despite this fact, "some physicians" have used this facility, and thus the Plan proposes to drop the facility. CALPERS members recorded 214 bed days at the hospital. Also, only 45% of the enrollee's PCPs have admitting privileges at the alternate hospitals, leading to the conclusion that this hospital is one of the primary admitting facilities for area CALPERS members. The alternate facilities are also out-of-county to the enrollees. In addition, both alternate facilities (Community Medical Center – Fresno and Clovis) are at or over occupancy capacity for many bed types. Please provide a clearer explanation of the rationale for redirecting enrollees from Madera Community Hospital such the Department may better understand the situation. Please include in the explanation if this exclusion will require any change of PCPs on the part of enrollees.

Orange County

Hoag Memorial Hospital

55. The Plan states that overall Fountain Valley Regional Hospital is at 100% capacity. Per OSHPD's ALIRTS database, Mission Hospital Regional Hospital Medical Center is at 92% bed occupancy capacity for intensive

care. Please provide the Plan's analysis as to the actual capacity of the hospitals to deliver these services and why redirecting enrollees to these hospitals would still constitute reasonable access and availability for these services.

56. As a result of excluding Hoag Memorial Hospital, the Plan proposes to exclude Greater Newport Physicians. However, the proposed alternate hospitals and the hospitals to which some of the receiving medical groups admit do not agree. Talbert Medical Group and ARTA Health Network, per the Plan, do not have affiliations with any of the alternate hospitals proposed for Hoag Memorial Hospital. Please clarify.

Greater Newport Physicians

57. ARTA Health Network has two psychiatrists, and both are not accepting new enrollees. Please address how enrollees will be able to access this specialty. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

58. The Plan states that enrollees will be directed to St. Joseph's Orange, Mission, and Fountain Valley and that there is no access problem because physicians admit to the proposed hospitals. Aside from hospital capacity noted above, please provide further analysis and explanation of the accessibility/capacity of the proposed medical network to provide services at these hospitals given facility location, provider/service mix, provider location, provider hospital privileges and open/closed status.

<u>Riverside County</u>

Desert Regional Medical Center

59. The Plan states that as the two medical groups associated with the hospital are institutionally capitated and have a separate contract with Desert Regional Medical Center, the hospital will not leave the network. However the Plan also states, "CALPERS members will still be able to continue to access this facility under this separate contract, however, it will not be listed in the 2005 CALPERS Network provider directory." It is not clear (i) if the capitated contracts with Desert Regional Medical Center and Heritage (Oasis) have terms beyond the 2005 calendar year, (ii) why the Plan is including this hospital in this filing; (iii) why the hospital will not be listed in the directory; (iv) why other Blue Shield direct contract medical providers in the Palm Springs area are not identified as continuing network providers. Please provide additional information.

Sacramento/Placer Counties

All Proposed Excluded Hospitals

60. Please explain why Auburn Faith Hospital was not included in the excluded hospital group. If included in this group, please provide Hospital Transition Form.

61. Please explain why enrollee access to replacement hospitals is practical given the driving times involved.

62. The Plan states that the Mercy Hospitals (Mercy Hospital of Folsom, Mercy San Juan Hospital, and Mercy General Hospital) do not provide family planning services, pediatric subspecialty, or neonatal services. The Plan references Exhibit E-1 for its response to resolution of these issues. The Exhibit E-1 only address family planning services such as tubal ligation and elective abortions and neglects to discuss access to pediatric subspecialty or neonatal services. Please discuss access to these specialties with specificity. In addition:

    a. The Plan has not adequately explained how it will get enrollees admitted to Methodist Hospital of Sacramento and UC Davis Medical Center in particular if their physician lacks admitting privileges.

    b. When discussing access to pediatric subspecialty and neonatal services, please also explain how the Plan intends to get the enrollee admitted if their physician lacks admitting privileges.

    c. The Plan states for these particular services that on a “case-by-case basis” enrollees will be allowed to access Sutter Memorial Hospital for the services. Please elaborate on when the Plan would allow such access and how enrollees would get access given that they must switch to medical groups not affiliated with Sutter Healthcare.

63. For each figure cited, please provide the Plan’s analysis as to the actual capacity of the hospital to deliver the listed service and why redirecting enrollees to this hospital would still constitute reasonable access and availability for the listed service:

    a. Mercy Hospital of Folsom’s perinatal bed occupancy rate is at approximately 83%.

b. Mercy San Juan Hospital's pediatric bed occupancy rate is at approximately 99% capacity and newborn nursery bed capacity is at approximately 85% capacity.
c. Mercy General Hospital's perinatal bed occupancy rate is at approximately 100% and intensive care bed occupancy rate is at 90%.
d. UC Davis Medical Center's coronary care beds are at 93% capacity, intensive care beds at 92% capacity, and burn care beds at 94% capacity.
e. Sierra Nevada Memorial's intensive care bed occupancy is at approximately 106% of capacity.

Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

64. Please explain why Sierra Memorial Hospital is not listed as an alternate hospital for any of the filed Exhibit I-8 hospital transition plans.

65. The Plan states that Mercy Hospital of Folsom will be used for "community services." Please elaborate as to the meaning of this statement.

66. The Plan has not addressed whether Mercy Hospital of Folsom has the same range of services as Sutter Roseville Medical Center. Please address.

67. The Plan states that for those enrollees redirected from Sutter Roseville Medical Center, UC Davis Medical Center will be used for tertiary admissions. Please:

    a. Specify which services UC Davis Medical Center will be relied upon to provide.

    b. Please explain how the enrollees would be admitted to UC Davis Medical Center given that their physicians will not have admitting privileges at this hospital.

68. The Exhibit I-8 transition plan for Sutter Roseville Medical Center has numerous references to the Sutter Medical Group -- Redwoods. The reason for the references is unclear. Please explain.

Sutter Independent Physicians

69. MedClinic does not have any specialists on staff for the following specialties: Hematology/Oncology, Plastic Surgery, Endocrinology, or Colon/Rectal Surgery. Please explain how enrollees transitioned to this

group will be able to access such services. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

70. Please explain which hospital(s) will be the primary admitting facility for enrollees assigned to MedClinic.

71. Please explain which hospital(s) will be the primary admitting facility for enrollees assigned to Hill Physicians.

72. Please explain which hospital(s) will be the primary admitting facility for enrollees assigned to Golden State IPA.

73. Please demonstrate that Hill Physicians and Golden State IPA have available PCP and SCP capacity to serve 7,000 additional enrollees. Include a current list of open and available PCP and SCP coverage for Mercy Folsom and Mercy San Juan Hospitals.

74. Please clarify where enrollees in the Auburn, Grass Valley and other surrounding areas will access hospital care.

75. Given that some Sutter Independent Physicians admit to other facilities other than solely Sutter hospitals, please explain the necessity of taking out all of the CALPERS membership from the group and transitioning them to new medical groups.

San Diego County

76. The Department has been advised by the Plan that an agreement has almost been reached with Sharp HealthCare, which would bring 5 proposed excluded hospitals back into the network. Given this fact, the Department will reserve comment on the proposed hospital exclusions for a later date if necessary.

San Francisco County

California Pacific Medical Center / Brown and Toland Medical Group

77. UCSF Medical Center is at 93% of bed occupancy capacity for coronary care. Please provide the Plan's analysis as to the actual capacity of the hospital to deliver this service and why redirecting enrollees to this hospital would still constitute reasonable access and availability for this service. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

78. Please define the hospitalist model operating at St. Mary's Medical Center, e.g. post-ER treatment only or ER and post-ER treatment, and explain how hospitalist staffing will be adequate to admit enrollees to

St. Mary's Medical Center on behalf of "community physicians" and the projected number of enrollees who will be transitioned to "community physicians" given their current caseload and the number of transitioned enrollees. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

79. Only 25% of the "community physicians" have admitting privileges to St. Mary's Medical Center. Please explain how enrollees being treated by "community physician" specialists will be admitted to St. Mary's Medical Center if necessary.

80. Please provide a report linking all assigned PERS members to contracted Community Physicians. Include a listing of open and available status for the Community PCPs. Identify which PCPs (28%) have privileges at St. Mary's.

81. Please identify by subspecialty the 25% of Community providers. Please include a plan for accessing subspecialty care when there is no sub-specialist available.

82. As those enrollees assigned to "community physicians" cannot be admitted to UCSF Medical Center for obstetrical services, the Plan states that, "Maternity members will be covered by Continuity of Care for the first nine months of 2005, and the Plan anticipates that an obstetrical program will be operational at either St. Mary's Medical Center or Mt. Zion Medical Center by that time. In the absence of such an arrangement, OB services will be available to Plan members at California Pacific Medical Center at no additional expense." Please provide letters from St. Mary's and Mt. Zion attesting to their plans to add an obstetrics program. Also, please provide further elaboration on this statement, including:

    a. What the Plan specifically means by "Continuity of Care" and

    b. Whether "Continuity of Care" would be automatically granted or would need to be requested. In addition, please provide an undertaking that in the absence of such alternate arrangements referenced above enrollees may access California Pacific Medical Center for obstetrical services at no additional expense.

St. Luke's Hospital

83. The Plan states that one of the two alternative facilities, St. Mary's Medical Center, does not offer obstetrical services. The Plan states that, "Integrated Medical Group St. Luke's will negotiate arrangements with providers who are associated with UCSF to provide access to specialists to admit and treat patients referred for OB care and

treatment." Please provide more explanation and details as to the arrangements, including to how many specialists UCSF is proposing to allow access for Integrated Medical Group St. Luke's ("Integrated") members, and why the referral patterns would be different than those supporting California Pacific medical Center's OB program. Also, please provide a listing of all contracted physicians by subspecialty (PCPs and SCPs) with delineation of hospital-specific medical staff memberships / admitting privileges and explain why Hill Physicians are not an option at St. Luke's.

84. The Plan states only 30% of the Integrated PCPs have admitting privileges with St. Mary's Medical Center, however the medical group is negotiating with the "hospitalist team" at St. Mary's Medical Group. Please provide more details as to the negotiations and the number of hospitalists that will be available if an agreement is reached. Please also analyze whether the number of hospitalists will be sufficient given their current caseload and the number of transitioned enrollees. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

85. The Plan states that 60% of Integrated's specialists have admitting privileges at St. Mary's Medical Center. The Plan states that obstetrics, orthopedics, and gastrointestinal services are the most affected by the shortfall in privileges. The Plan proposes Integrated, "will negotiate arrangements with providers who are associated with UCSF to provide access to specialists to admit and treat patients referred for OB care and treatment." Please describe the practice model of Integrated Medical Group, explain how referrals will work and the status of the negotiations. Please explain why OB referrals from CPMC will be to St. Mary's when OB referrals from Integrated Medical Group (St. Luke's) will be to UCSF. Also, the Plan did not address admission of enrollees who will be with Integrated orthopedists or gastroenterologists. Please address. Finally, please explain if there are any other specialties affected and how enrollees will get admission to an area network hospital.

San Joaquin County

St. Dominic's Hospital/Sutter Tracy Community Hospital

86. The OSHPD's ALIRTS database does not have utilization data for San Joaquin General for 2002 or 2003. Please provide the most current data possible regarding occupancy rates for different bed types at this facility.

87. For each figure cited, please provide the Plan's analysis as to the actual capacity of the hospital to deliver the listed service and why redirecting

enrollees to this hospital would still constitute reasonable access and availability for the listed service:

a. The Plan states that Doctor's Hospital of Manteca is at a 99% bed occupancy rate.

b. Dameron Hospital is at an 89% bed occupancy rate for the following bed types: medical/surgical, perinatal, coronary care and at 92% for intensive care.

c. St. Joseph's Medical Center of Stockton is at 100% bed occupancy rate for perinatal, 89% for intensive care, and 87% rate for acute repertory care.

Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

Delta IPA – Tracy

88. Please explain which facility is the primary admitting facility for Delta IPA –Manteca. In addition, please specify to which hospitals Delta IPA-Manteca physicians can admit. Please note that the Plan states that Delta IPA – Manteca doctors admit to San Joaquin General Hospital, however the Delta IPA website does not list this facility as a contracted facility. Please explain. In addition, the transition plan for Delta IPA states that the facilities to which Delta IPA refers are St. Joseph's Medical Center of Stockton and Lodi Memorial Hospital. This does not appear to agree with the facilities listed in the associated hospital transition plan filing. Please clarify.

89. The transition plan for Delta IPA states that 1,047 enrollees will be transferred from Delta IPA – Tracy to Delta IPA – Manteca due to the exclusion of Sutter Tracy Community Hospital. The transition plan states that there are 7,255 enrollees in Delta IPA affected. It is unclear whether these 7,255 enrollees will also be changing from Delta IPA – Tracy to Delta IPA – Manteca. Please clarify. In addition, please provide the number, and percentage, of enrollees who will be within 15 miles and 30 miles of their assigned Delta IPA – Manteca PCPs. Section 1367(d), (e), Rules 1300.51(d)(H), 1300.67.1, 1300.67.2.

90. The provider list filed under Exhibit I-1-a for Delta IPA does not clearly distinguish between Delta IPA – Manteca and Delta IPA – Tracy physicians. Please provide a more specified list for each location.

San Mateo County

Seton Medical Center

91. The Plan maintains that Mills Peninsula Hospital has the same level of services, with the exception of cardiac care, as Seton Medical Center. Unlike Seton Medical Center, Mills Peninsula Hospital does not offer intensive care or perinatal care beds. Please further address the issue of services at Mills Peninsula Hospital.

92. The Plan states that cardiac surgery admissions will be done at Sequoia Hospital. Per the ALIRTS database of OSHPD, Sequoia Hospital does not have any coronary care beds. Please address what appears to be a discrepancy.

93. As there is a shortfall of admitting privileges for PCPs to both Sequoia Hospital and Mills Peninsula Hospital, the Plan intends to use hospitalists at both facilities for admissions. Please provide the number of hospitalists at each facility to care for enrollees and please also analyze whether the number of hospitalists will be sufficient given their current caseload and the number of enrollees to be transitioned. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

94. Per the Plan, only 32% of specialists in Blue Shield's directly contracted network have admitting privileges to either or both facilities. Please address the following: Will Mills Peninsula Medical Group continue as a Blue Shield contracted medical group. For orthopedist surgeons, the Plan will, "actively recruit Orthopedic Surgeons that admit to either Sequoia Hospital and/or Mills Peninsula Hospital, however, in the event that this effort is not successful, global letters of agreement will be negotiated to ensure that members have access to the redirected hospitals." Please provide more information on the "global letters of agreement" and the significance of these letters to provide access to the hospitals.

95. Given that only approximately one-third of the specialists may admit to either facility, please address how the Plan will resolve admitting issues for other specialties. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

96. Please provide a roster of the Blue Shield directly contracted San Mateo physicians and to what hospital they admit.

Santa Clara County

O'Connor Hospital

97. Regional Medical Center of San Jose is at 84% occupancy capacity for medical/surgical beds and Good Samaritan Hospital is at 83% occupancy capacity for the same type of beds. Please provide the Plan's analysis as to the actual capacity of the hospital to deliver this service and why redirecting enrollees to this hospital would still constitute reasonable access and availability for this service. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

Sonoma County

Sutter Medical Center of Santa Rosa/Sutter Warrack Hospital

98. Please disclose which of the alternate hospital(s) will be the primary admitting facility for those in Sonoma County Primary Care and those in the Blue Shield direct network.

99. Santa Rosa Memorial Hospital, an alternate for both Sutter Warrack Hospital and Sutter Medical Center Santa Rosa operates at 110% of bed occupancy capacity for intensive care and 83% capacity for Medical/Surgical beds. Please provide the Plan's analysis as to the actual capacity of the hospital to deliver the listed service and why redirecting enrollees to this hospital would still constitute reasonable access and availability for the listed service.

100. Please confirm that each of the receiving hospitals have at least the same level of services as Sutter Warrack Hospital.

101. Please confirm that each of the alternate hospitals have at least the same level of services as Sutter Medical Center Santa Rosa.
Sutter Medical Group -- Redwoods

102. The Sonoma County Primary Care group has no Allergy/Immunology or Plastic Surgery specialist. Please explain how enrollees transitioned to this group will be able to access such services. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

103. The Blue Shield direct network for Sonoma has no endocrinologist. Please explain how enrollee will have access to this type of specialist. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

104. For both the Sonoma County Primary Care and the directly contracted Blue Shield network, for PCPs and specialists, please disclose what percent have admitting privileges at each of the alternate proposed hospitals.

105. The transition plan for Sutter Medical Group –Redwoods does not indicate that Petaluma Valley Hospital is a facility affiliated with either Sonoma County Primary Care or the Blue Shield direct contract network. This facility is listed in the Sutter Medical Center of Santa Rosa and Sutter Warrack Hospital transition plans. Please provide further explanation.

Stansislaus County

Memorial Hospital Medical Center of Modesto

106. The Plan states that Doctor's Hospital Modesto has an 88% overall bed occupancy rate. Please provide the Plan's analysis as to the actual capacity of the hospital to deliver services and why redirecting enrollees to this hospital would still constitute reasonable access and availability for services. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

Sutter Gould Medical Foundation

107. Please provide more data as to AllCare IPA's financial condition, including percentage of claims payments paid on time for the past year. Rule 1300.70(b)(2)(H)(1).

108. The Department has learned that AllCare IPA is losing Lodi Primary Care Medical Associates, a loss of 25 PCPs. Please describe how this will affect access to services and the group's financial condition. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2, 1300.70(b)(2)(H)(1).

109. AllCare IPA has no endocrinologist. Please explain how get affected enrollees will get access to the services of this type of specialist. In addition AllCare IPA only has one gastroenterologist. Please explain if one gastroenterologist is sufficient to care for the number of transitioned enrollees, in addition to existing AllCare enrollees. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

Tulare County

Sierra View District Hospital

110. The alternate proposed hospital, Kaweah Delta District Hospital is at 123.9% over occupancy capacity for medical and surgical beds and 151%

over capacity for intensive care newborn nursery beds. Please provide the Plan's analysis as to the actual capacity of the hospital to deliver the listed services and why redirecting enrollees to this hospital would still constitute reasonable access and availability for the listed services. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

111. The Plan maintains that it is the pattern of practice for affected enrollees to travel to Visalia for services. If this is the case, please explain why none of the Key Medical Group physicians that have been treating affected enrollees have admitting privileges at Kaweah Delta District Hospital. In addition, please provide the number of hospitalists that will be available to admit enrollees to Kaweah Delta District Hospital and provide an analysis as to the sufficiency of that number to admit enrollees to the hospital. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

112. As none of the specialists for the affected enrollees have admitting privileges at Kaweah Delta, Plan states that, "Members will be redirected to the Key Medical Group specialists in Visalia, where they have a complete panel of specialists with the exception of obstetrical services." Please explain the process for, as an example, a Porterville specialist of Key Medical Group to refer an enrollee to another specialist in Visalia to access services. Will the enrollee have to undergo re-evaluation and receive re-authorization for a service by the Visalia specialist in order to be admitted to Kaweah Delta District Hospital? How will a Visalia specialist care for the patient of another doctor?

Ventura County

St. Johns Pleasant Valley Hospital/St. Johns Regional Medical Center

113. The Plan states that the alternate facility, Community Memorial Hospital of San Buenaventura is at 96% overall bed capacity. Please provide the Plan's analysis as to the actual capacity of the hospital to deliver services and why redirecting enrollees to this hospital would still constitute reasonable access and availability for services. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

114. The Plan proposes affected enrollees who need acute rehabilitation to access UCLA Medical Center, as this service is not available at Community Memorial Hospital of San Buenaventura. UCLA Medical Center is an unreasonably far distance to send enrollees. Please propose an alternate facility that is geographically accessible to area enrollees.

115. The Plan states that enrollees will remain in Seaview IPA and be directed to proposed hospital. Aside from hospital capacity noted above, please

provide further analysis and explanation of the accessibility/capacity of the proposed medical network to provide services at the hospital given facility location, provider/service mix, provider location, provider hospital privileges and open/closed status.

116. The Plan states that only 65% of Seaview IPA's PCPs have admitting privileges to Community Memorial Hospital of San Buenaventura. Please provide the number of hospitalists that will be available and analyze whether the number of hospitalists will be sufficient given their current caseload and the number of transitioned enrollees. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

Yolo County

Sutter Davis Hospital

117. Please provide an affirmation that Woodland Community Hospital has the same range of services as Sutter Davis.

Sutter West Medical Group

118. Please provide the number of enrollees, regardless of plan, Woodland Clinic currently serves.

119. Since members who live in South Yolo County, i.e. Winters, will travel beyond the 15 mile / 30 minute accessibility standard when they travel to Woodland Memorial Hospital, what hospital and medical group assignments are being proposed for these enrollees?

120. Woodland Clinic does not have the following specialists that Sutter West Medical Group has: Plastic Surgery, Orthopedic surgery. Please explain how enrollees will access these services. Section 1367(d), (e), Rules 1300.67.1, 1300.67.2.

Exhibit I-9 Enrollee Notice Templates

121. The proposed notice letters to enrollees makes reference to an attached list of hospitals that are to be excluded. The Plan did not file the proposed attachment. Please file.

122. Please address the following regarding the notice titled "SAME PCP LETTER DRAFT":

    a. "Please be advised your hospital affiliation may change." This statement is confusing in that the very reason the enrollee is

changing medical groups is because of the exclusion of the hospital that which they were "affiliated." Please revise. Please also revise the "NEW IPA/NEW PCP" notice which has the same statement.

b. "If you have any emergency medical problem or are unable to reach your new Personal Physician, please call 911 or go immediately to the Emergency Room of the nearest hospital. Please contact your new Personal Physician as soon as possible after receiving services so that he/she may coordinate your follow-up care." Enrollee is not changing Personal Physician. Please revise.

c. The notice, and other notices, reference a "Continuity of Care Frequently Asked Questions" document. Please explain if this document has been previously filed with and approved by the Department. If not, please submit for review.

d. The Plan has put the wrong website for the Department. Please revise to state: www.hmohelp.ca.gov, not www.hmohelp.com. Please revise all notice letters, the 2005 Blue Shield CALPERS Provider Network Frequently Asked Questions, and any other documents that will be provided to CALPERS enrollees to give the correct website.

123. Please address the following regarding the proposed notice titled "NEW IPA/NEW PCP":

a. The notice states that it is necessary to choose a new PCP no later than October 15, 2004, but then does not state what happens if the enrollees fails to make a choice. Please revise.

b. "Except in an emergency situation or in certain circumstances as discussed below, you will be unable to access care at the hospitals on the attached list." Below this statement is a discussion of emergencies situation, but not of the "certain circumstances." Please revise.

124. Please address the following regarding the "2005 Blue Shield CALPERS Provider Network Frequently Asked Questions" ("FAQs Document"): Question #10 states that, "You may also refer to Blue Shield's Continuity of Care Policy and Continuity of Care Frequently Asked Questions." Unless this document is attached or supplied along with the FAQs Document, please advise enrollees how to obtain the Blue Shield Continuity of Care Policy and Continuity of Care Frequently Asked Questions documents.

125. The proposed notices do not appear to fit the proposed notice letters given the unique circumstances of those enrollees who access Desert Regional Medical Center and Madera Community Hospital. Please provide further explanation as to how these enrollees will be notified.

Please review the above comments and revise all Plan documents and exhibits that contain similar language or provisions to ensure that any similar deficiencies are eliminated in all documents before filing the Plan's responsive amendment. Also, please be sure all changes to the amended information are highlighted by strikeout, underline or other method in accordance with Rule 1300.52. The Department's review of this Notice will continue when the Plan's responsive amendment is filed.

Please file, **within 10 days** of the date of this letter, the Plan's response as an amendment to the above-referenced Notice and include a cover letter addressed to the Department's Filing Clerk, which identifies the amendment as a "Response to Comment Letter." When submitting the Plan's responsive amendment at the Department's web portal, please ensure accurate entry of the Associated Filing Number. The Plan may, but is not required to, also forward a courtesy copy of the responsive amendment as an attachment to e-mail addressed directly to me.

Please contact me if there are any questions regarding the above.

Sincerely,

Mike Punja
Staff Counsel

Cc:

Bill Barcellona, Chief of Licensing Division
Lou Chartrand, Chief Deputy Director

APPENDIX C – DEVELOPMENT OF PHYSICIAN SUPPLY ESTIMATES

DEVELOPMENT OF PHYSICIAN SUPPLY ESTIMATES ACCORDING TO SPECIALTY SACRAMENTO-YOLO-EL DORADO-PLACER COUNTY AREA

Rosters of physician specialists were obtained for all affected medical groups/IPAs, including receiving and exiting groups.

1. Exiting groups:

    - Sutter Medical Group
    - Sutter Independent Physicians
    - Sutter West Medical Group

2. Receiving Groups

    - Hill Physicians Medical Group
    - MedClinic Medical Group
    - Woodland Clinic Medical Group
    - UC Davis Medical Group
    - Sierra Nevada Medical Association
    - Golden State

Of the three exiting Sutter groups, only Sutter West is 100-percent comprised of members that are not affiliated with any of the receiving groups. The other two Sutter groups comprise significant numbers of members that are also affiliated with at least one of the receiving groups. It was thus essential to develop an inclusive list of physicians, by name, indicating which group(s) they are affiliated with. This involved producing an unduplicated list of all physicians in the above nine groups. Since PCP capacity in the receiving groups in each county is sufficient to serve the CalPERS population, this exercise was not necessary with respect to PCPs.

The final unduplicated count resulted in 1,009 receiving specialists and 481 excluded specialists. The latter include all Sutter physicians that are not affiliated with any of the receiving networks. These 1,009 specialists will be available to the CalPERS population in the Sacramento area. The rosters, however, do not indicate

FTEs available to CalPERS, only practicing physicians available to the entire population.

To assess adequacy of specialist supply we could only evaluate the total number of physicians (receiving and excluded) in each specialty in relation to the total four-county population. The resulting counts are estimates of the aggregate specialist physician supply in the four-county area, with two exceptions: (1) independent physicians not affiliated with any group; and (2) Kaiser-Permanente physicians. This assessment is an aggregate one – i.e., total physicians according to specialty relative to total population.

Kaiser Health Plan membership data according to county, to subtract from total population, were not available. We did, however, have a count of Kaiser physician FTEs according to specialty, produced by Sutter Medical Foundation in a July 2004 report. We added the Kaiser physician counts to our unduplicated counts for all other groups to arrive at estimates of total physician supply according to specialty. For each major specialty, physicians per 100,000 population were calculated and compared to national averages.[6] This source also provided averages for Kaiser Health Plan. We report both, since CalPERS is a managed-care population, and the Sacramento region has managed-care penetration far above the national average.

The results are presented in the table below. Our estimates suggest, as expected, some specialties are in abundant supply and some are in shortage, relative to the national average. Relative to the Kaiser standard, however, there is only one specialty showing a shortage -- general surgery. And this shortage is only 1 percent below the standard. Relative to the national average, there are only two specialties with substantial shortages on a percentage basis -- general surgery and plastic surgery. It is possible the national average for the former includes some subspecialties not otherwise specified.

The lower Kaiser physician-population ratios in all but two specialties reflects both the relative efficiencies

[6] The national averages were obtained from Jonathan P. Weiner, "Prepaid Group Practice Staffing and U.S. Physician Supply: Lessons for Workforce Policy," Health Affairs – Web Exclusive, February 2004, Exhibit 2.

inherent in managed care and differences in population characteristics between managed-care and other populations (including fee-for-service commercial, Medicare, Medicaid, and so on).

While aggregate supply shortages or surpluses do not necessarily imply plan-specific deficiencies, such data are useful in assessing plan capacity. Our estimates, for example, should alert any plan to the possibility of some network problems in general surgery and plastic surgery.

DEVELOPMENT OF PHYSICIAN SUPPLY ESTIMATES
ACCORDING TO SPECIALTY
SACRAMENTO-YOLO-EL DORADO-PLACER COUNTY AREA

Specialty	Note	# of Receiving Physicians	# of Excluded Sutter Phys.	Add: Kaiser Physicians (5)	Total Phys. Supply	Benchmark FTE Ratio (3)	Kaiser FTE Ratio (3)
Medicine:							
Allergy		15	2	7	**24.0**	1.2	1.0
Cardiology	Note 1/2	48	34	9	**91.0**	6.6	2.9
Dermatology		26	8	17	**51.0**	3.1	2.4
Gastroenterology		38	3	11	**52.0**	3.4	2.1
Hematology/Oncology		23	7	11	**41.0**	1.1	2.0
Neurology	Note 1/2	32	6	10	**48.0**	3.6	1.7
Pulmonary Medicine	Note 1/2	38	0	0	**38.0**	2.5	0.9
Surgery:							
Thoracic Surgery	Note 1/2	11	4	6	**21.0**	1.7	0.8
General Surgery	Note 1/2	51	13	15	**79.0**	10.6	5.8
Neurosurgery		16	2	6	**24.0**	1.5	0.8
OB-GYN	Note 1/2	96	19	63	**178.0**	13.1	10.1
Ophthalmology		44	18	27	**89.0**	6.2	3.6
Orthopaedic Surgery	Note 1/2	44	21	21	**86.0**	6.9	4.1
Otolarynology		25	5	17	**47.0**	3	2.5
Plastic Surgery	Note 1/2	9	2	4	**15.0**	2.1	1.0
Urology	Note 1/2	22	7	15	**44.0**	3.4	2.5

Specialty	Note	Supply Required @ US Average	Supply Required @ Kaiser Avg	US Variance	Kaiser Variance	US Variance %	Kaiser Variance %
Medicine:							
Allergy		**16.7**	**13.9**	**7.3**	10.1	43.9%	60.6%
Cardiology	Note 1/2	**91.7**	**40.3**	**-0.7**	50.7	-0.8%	55.3%
Dermatology		**43.1**	**33.4**	**7.9**	17.6	18.4%	40.9%
Gastroenterology		**47.3**	**29.2**	**4.7**	22.8	10.0%	48.3%
Hematology/Oncology		**15.3**	**27.8**	**25.7**	13.2	168.1%	86.3%
Neurology	Note 1/2	**50.0**	**23.6**	**-2.0**	24.4	-4.1%	48.7%
Pulmonary Medicine	Note 1/2	**34.8**	**12.5**	**3.3**	25.5	9.4%	73.4%
Surgery:							
Thoracic Surgery	Note 1/2	**23.6**	**11.1**	**-2.6**	9.9	-11.1%	41.8%
General Surgery	Note 1/2	**147.3**	**80.6**	**-68.3**	-1.6	-46.4%	-1.1%
Neurosurgery		**20.9**	**11.1**	**3.2**	12.9	15.1%	61.8%
OB-GYN	Note 1/2	**182.1**	**140.4**	**-4.1**	37.6	-2.2%	20.7%
Ophthalmology		**86.2**	**50.0**	**2.8**	39.0	3.3%	45.2%
Orthopaedic Surgery	Note 1/2	**95.9**	**57.0**	**-9.9**	29.0	-10.3%	30.2%
Otolarynology		**41.7**	**34.8**	**5.3**	12.3	12.7%	29.4%
Plastic Surgery	Note 1/2	**29.2**	**13.9**	**-14.2**	1.1	-48.6%	3.8%
Urology	Note 1/2	**47.3**	**34.8**	**-3.3**	9.3	-6.9%	19.6%

1 - Denotes an undersupply (shortage) relative to the US Average

2 - In most specialties, Kaiser ratio of physicians to population is substantially below the US average

3 -The national averages benchmark ratios and the Kaiser ratios, in terms of FTEs per 100,000 population, were obtained from Jonathan P. Weiner, "Prepaid Group Practice Staffing and U.S. Physician Supply: Lessons for Workforce Policy" Health Affairs – Web Exclusive, February 2004, Exhibit 2.

4 - Population estimate from www.Cattaneostroud.com, August 2004

5 - Kaiser physician counts for four county area derived from Sutter Medical Foundation report, July 2, 2004

APPENDIX D- UNDERTAKINGS AND ORDER

STATE OF CALIFORNIA
BUSINESS, TRANSPORTATION AND HOUSING AGENCY
DEPARTMENT OF MANAGED HEALTH CARE

File No.	933-0043
Order No.	S-04-1296
Filing Nos.	20040557[7]

Licensee: **California Physicians' Service, d/b/a Blue Shield of California, Inc.**

ORDER

APPROVING IN PART AND DENYING IN PART THE NOTICE OF MATERIAL MODIFICATION

Pursuant to Health and Safety Code section 1352(b), the terms of the Notice of Material Modification ("Notice") filed on June 30, 2004 by California Physicians' Service, d/b/a Blue Shield of California, Inc., along with all Amendments submitted, regarding the Proposed CalPERS narrow provider network and associated block transfer filings are approved in part and denied in part as of the date set forth below. This Order is subject to the conditions set forth in the undertakings listed in Attachment A, and concerns the specific hospitals and provider groups set forth in Attachment B. This Order shall remain in effect until revoked or superceded by further Order of the Director. IT IS SO ORDERED.

Dated: August 5, 2004
Sacramento, California

G. LEWIS CHARTRAND, JR.
Chief Deputy Director
Department of Managed Health Care

[7] Associated Filing Nos. 20040601, 20040639, 20040644, 20040645, 20040716, 20040731, 20040754, 20040899, 20040903, 20040920, 20040921, 20040922, 20040923, 20040924, 20040925, 20040926, 20040927, 20040929, 20040930, 20040931, 20040933, 20040934, 20040935, 20040940.

WHEREAS, California Physicians' Service, d/b/a Blue Shield of California, Inc. (the "Plan"), a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975, as amended (the "Act"), filed with the Department a Notice of Material Modification on June 30, 2004 ("Material Modification"), along with all Amendments to the Material Modification filed thereafter, proposing a change that would narrow its provider network. The Department approved in part and denied in part the Material Modification on August 5, 2004 (the "Order").

NOW THEREFORE, the Plan submits to the Director of the Department of Managed Health Care (the "Department") the following undertakings:

Undertaking No.1

The Plan shall require that "Sacramento Groups" in the "Greater Sacramento Area" provide access for CalPERS members to specialty services in accordance with the standards set forth below. For the purposes of this undertaking, the "Sacramento Groups" are Golden State IPA, Hill Physicians Sacramento, MedClinic, Sierra Nevada Medical Associates, UC Davis Medical Group and Woodland Medical Clinic and the "Greater Sacramento Area" shall be the Counties of El Dorado, Nevada, Placer, Sacramento and Yolo.

The Plan shall ensure that Sacramento Groups participating in the Plan's 2005 CalPERS network in the Greater Sacramento Area shall provide CalPERS members with access to medically necessary specialist referrals according to the following standards:

24 hours	-	Urgent appointment offered with a specialist.
2 weeks	-	Routine non-urgent appointment offered for an established patient visit.
4 weeks	-	Routine non-urgent appointment offered for a new patient consult with secondary specialist.
8 weeks	-	Routine non-urgent appointment offered for a new patient consult with sub-specialist or tertiary specialist.

If a Sacramento Group is unable to offer an appointment with a qualified specialist within its own network in accordance with the above standards, the group shall undertake reasonable efforts to make arrangements to have that care provided through an appropriate specialist from another Sacramento Group.

The Plan shall monitor compliance with these standards as follows:

(a) The Plan shall monitor the complaints received from CalPERS enrollees regarding access to specialty services to identify any trends showing non-compliance with the above standards. Appropriate corrective action shall be taken to remedy systemic and individual occurrences of non-compliance.

(b) The Plan shall monitor access to specialty services at each Sacramento Group to determine the wait time for the first available appointment for a new patient consult. The Plan shall conduct this monitoring on a monthly basis for the first twelve (12) months following implementation of the 2005 CalPERS provider network and then quarterly thereafter. The Plan shall take appropriate corrective action in the event of systemic or individual occurrences of non-compliance with these standards.

Moreover, upon receipt of an enrollee complaint, if the Plan is unable to arrange for an appropriate timely specialist appointment through the enrollee's medical group/IPA, the Plan shall directly undertake to secure a timely appointment with a qualified provider.

Undertaking No. 2

The Plan shall authorize admissions to and provide full benefits for CalPERS enrollees for medically necessary admissions at the following hospitals that are otherwise excluded from the 2005 CalPERS provider network if the Plan is unable to provide access for enrollees in Plan facilities within standards required by current practice patterns in compliance with the Act:

- Sutter Delta Hospital
- Memorial Hospital of Los Banos
- Washington Hospital (OB services only)

In addition, the Plan shall authorize and provide full benefits for CalPERS enrollees for outpatient radiology services at Memorial Hospital of Los Banos.

Undertaking No. 3

The Plan shall offer those affected enrollees who would otherwise qualify for continuity of care, the ability to continue care, upon request, with an otherwise excluded provider, subject to all requirements in accordance with Section 1373.96 of the Act. The Plan shall implement the continuity of care plan and utilize the continuity of care policies, documents and notifications that are currently on file with the Department.

All Plan communications with enrollees impacted by the exclusion of a provider from the network, as described in this filing, shall include notice regarding the enrollees' rights to request continuity of care.

Undertaking No. 4.

The undertakings set forth herein shall be enforceable to the fullest extent of the authority and power of the Director of the Department under the provisions of the Knox-Keene Act, including all civil, criminal, and administrative remedies (such as Cease and Desist Orders, freezing enrollment, and assessment of fines and penalties). The enforcement remedies enumerated in this Undertaking 4 are not exclusive and may be sought and employed in any combination deemed advisable by the Director of the Department to enforce these undertakings.

Undertaking No. 5.

The undertakings set forth herein shall be subject to the following terms and conditions:

(a) **Binding Effect.** The undertakings set forth herein shall be binding on Blue Shield and its respective successors and permitted assigns. If Blue Shield fails to fulfill its obligations to the Department as provided under the undertakings set forth herein, Blue Shield stipulates and agrees that the Department shall have the authority to enforce the provisions of these undertakings in a California court of competent jurisdiction.

(b) **Governing Law.** The undertakings set forth herein and their validity, enforcement, and interpretation, shall for all purposes be governed by and construed in accordance with the laws of the State of California.

(c) **Invalidity.** In the event any undertakings or any portion of any undertaking set forth herein shall be declared invalid or unenforceable for any reason by a court of competent jurisdiction, such undertaking or any portion of any undertaking, to the extent declared invalid or unenforceable, shall not affect the validity or enforceability of any other undertakings, and such other undertakings shall remain in full force and effect and shall be enforceable to the maximum extent permitted by applicable law.

(d) **Duration.** The undertakings set forth herein shall become effective upon the effective date of the Order issued on the Material Modification, and except as to those provisions of the undertakings that contain separate termination provisions, shall remain in full force and effect until terminated by Blue Shield with the written consent of the Department.

(e) **Third Party Rights**. Nothing in the undertakings set forth herein is intended to provide any person other than Blue Shield and the Department, and their respective successors and permitted assigns, with any legal or equitable right or remedy with respect to any provision of any undertaking set forth herein.

(f) **Amendment**. The undertakings set forth herein may be amended only by written agreement signed by Blue Shield and approved or consented to in writing by the Department.

(g) **Assignment.** No undertaking set forth herein may be assigned by Blue Shield, in whole or in part, without the prior written consent of the Department.

(h) **Specific Performance.** In the event of any breach of these undertakings, Blue Shield acknowledges that the State of California would be irreparably harmed and could not be made whole by monetary damages. It is accordingly agreed that Blue Shield shall waive the defense in any action for specific performance that a remedy at law would be adequate, and the Department should be entitled to seek an injunction or injunctions to prevent breaches of the provisions of these undertakings and to seek to specifically enforce the terms and provisions stated herein. The Department's right to seek an injunction does not supersede the remedies available to the Director described in Undertaking 4.

DATE: August 5, 2004

Print Name: ________________________

Print Title: __________________________

California Physicians' Services, d/b/a

Blue Shield of California, Inc.

HOSPITAL	EXHIBIT NO.	APPROVED	DENIED	WITHDRAWN
1. California Pacific Medical Center Campus Hospital	I-8-01	X		
2. Cedars Sinai Medical Center	I-8-02	X		
3. City of Hope National Medical Center	I-8-03			X
4. Delano Regional Medical Center	I-8-04			X
5. Desert Regional Medical Center	I-8-05	X		
6. Eden Hospital Medical Center	I-8-06	X		
7. Hoag Memorial Hospital Presbyterian	I-8-07	X		
8. Madera Community Hospital	I-8-08			X
9. Memorial Hospital of Los Banos	I-8-09	X		
10. Memorial Hospital Medical Center - Modesto	I-8-10	X		
11. O'Connor Hospital	I-8-11	X		
12. Presbyterian Intercommunity Hospital	I-8-12		X	
13. Selma Community Hospital	I-8-13	X		
14. Seton Medical Center	I-8-14	X		
15. Sharp Chula Vista Medical Center	I-8-15			X
16. Sharp Coronado Hospital and Healthcare Center	I-8-16			X
17. Sharp Grossmont Hospital	I-8-17			X
18. Sharp Mary Birch Hospital for Women	I-8-18			X
19. Sharp Memorial Hospital	I-8-19			X
20. Sierra View District Hospital	I-8-20		X	
21. St. Dominic's Hospital	I-8-21	X		
22. St. Francis Memorial Hospital	I-8-22			X
23. St. John's Regional Medical Center Mercy - Ventura/Pleasant Valley	I-8-23		X	
24. St. Luke's Hospital	I-8-24	X		
25. St. Mary Medical Center	I-8-25	X		
26. St. Vincent Medical Center	I-8-26			X
27. Sutter Davis Hospital	I-8-27	X		
28. Sutter Delta Medical Center	I-8-28	X		
29. Sutter General Hospital	I-8-29	X		
30. Sutter Medical Center of Santa Rosa	I-8-30	X		
31. Sutter Memorial Hospital	I-8-31	X		
32. Sutter Roseville Medical Center	I-8-32	X		
33. Sutter Tracy Community Hospital	I-8-33	X		

HOSPITAL	EXHIBIT NO.	APPROVED	DENIED	WITHDRAWN
34. Sutter Warrack Hospital	I-8-34	X		
35. USC University Hospital	I-8-35	X		
36. Washington Hospital	I-8-36	X		
37. West Hills Hospital Medical Center	I-8-37	X		

MEDICAL GROUP/IPA	EXHIBIT NO.	APPROVED	DENIED	WITHDRAWN
38. Cedars Sinai Medical Group	I-8-38	X		
39. Cedars Sinai Health Associates	I-8-39	X		
40. Delano Regional Medical Group	I-8-40			X
41. Delta IPA	I-8-41	X		
42. Greater Newport Physicians	I-8-42	X		
43. Physicians of Greater Long Beach	I-8-43	X		
44. Presbyterian Health Physicians	I-8-44		X	
45. San Diego Physicians Medical Group – East County	I-8-45			X
46. Sharp Community Medical Group	I-8-46			X
47. Sharp Mission Park Coronado	I-8-47			X
48. Sharp Rees Stealy	I-8-48			X
49. Sutter Gould Medical Foundation	I-8-49	X		
50. Sutter Independent Physicians	I-8-50	X		
51. Sutter Medical Group	I-8-51	X		
52. Sutter Medical Group - Redwoods	I-8-52	X		
53. Sutter West Medical Group	I-8-53	X		

APPENDIX E- HOSPITAL TABLES

Appendix E

Table 1

Placer County - Sutter Roseville Hospital

Figure	SUTTER ROSEVILLE MEDICAL CENTER	MERCY SAN JUAN HOSPITAL	UNIVERSITY OF CALIFORNIA, DAVIS MEDICAL CENTER	MERCY HOSPITAL OF FOLSOM	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	8	25	78	8	
Medical/Surgical IC PD Adult	2,484	4,755	13,625	1,163	
ICU Occupied	85.1%	52.1%	47.9%	39.8%	
Coronary Care Available	8	11	8		
Coronary Care PD Adult	2,304	3,808	2,497		
CCU Occupied	78.9%	94.8%	85.5%	NA	
Pediatric IC Available			16		
Pediatric IC PD Pediatric			3,176		
PICU Occupied	NA	NA	54.4%	NA	
Neonatal IC Available		20	38		
Neonatal IC PD Pediatric		5,956	10,831		
NICU Occupied	NA	81.6%	78.1%	NA	
Burn Care Available			8		
Burn Care PD Adult			2,778		
Burn Care PD Pediatric					
Burn Care Occupied	NA	NA	95.1%	NA	
Other IC Available			10		
Other IC PD Adult			3,175		
Other IC PD Pediatric					
Other ICU Occupied	NA	NA	87.0%	NA	
Definitive Observation Available	30	57			
Definitive Observation PD Adult	11,607	8,796			
Definitive Observation PD Pediatric					
DOU Occupied	106.0%	42.3%	NA	NA	
Medical/Surgical Acute Available	95	94	286	81	
Medical/Surgical Acute PD Adult	26,023	33,753	83,641	8,668	
Medical/Surgical Occupied	75.0%	98.4%	80.1%	29.3%	
Pediatric Acute Available	9	8	36		
Pediatric Acute PD Pediatric	1,234	2,218	11,017		
Pediatrics Occupied	37.6%	76.0%	83.8%	NA	
Obstetrics Acute Available	22	32	29		
Obstetrics Acute PD Adult	5,191	6,205	7,362		
Obstetrics Occupied	64.6%	53.1%	69.6%	NA	

Appendix E

Table 1

Placer County - Sutter Roseville Hospital

Figure	SUTTER ROSEVILLE MEDICAL CENTER	MERCY SAN JUAN HOSPITAL	UNIVERSITY OF CALIFORNIA, DAVIS MEDICAL CENTER	MERCY HOSPITAL OF FOLSOM	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available				6	
Alternate Birthing Center PD Adult				2,835	
ABC Occupied	NA	NA	NA	129.5%	
Physical Rehabilitation Care Available			19		
Physical Rehabilitation Care PD Adult			4,835		
Physical Rehabilitation Care PD Pediatrics					
Rehab Occupied	NA	NA	69.7%	NA	
Other Acute Care Available					
Other Acute Care PD Adult					
Other Acute Care PD Pediatric					
Other Acute Occupied	NA	NA	NA	NA	
Total Licensed	172	247	528	95	
Total Available	172	247	528	95	
Total Staffed	172	247	528	95	
Total PD Adult	47,609	57,317	117,913	12,666	
Total PD Pediatrics	1,234	8,174	25,024		
Total Discharge Total	12,418	15,029	25,226	4,263	
GAC Available Beds	172	247	528	95	
GAC PD	48,843	65,491	142,937	12,666	
ADC	134	179	392	35	
Available Occupied	77.8%	72.6%	74.2%	36.5%	
ADC at 80% Occupied	137.6	197.6	422.4	76.0	
Excess Beds	3.8	18.2	30.8	41.3	90.3
PERS PD	1,733				
PERS ADC	4.75				
Beds Needed at 80%	5.93				
Distance From Hospital 1 (in miles)		9.9	20.5	9.9	
Travel Time From Hospital 1 (in minutes)		15	26	25	
Distance From Hospital 2 (in miles)					
Travel Time From Hospital 2 (in minutes)					

Appendix E

Table 2

Sacramento County - Sutter Memorial / Sutter General Hospital

Figure	SUTTER GENERAL & SUTTER MEMORIAL HOSPITALS	MERCY GENERAL HOSPITAL	MERCY SAN JUAN HOSPITAL	METHODIST HOSPITAL-SACRAM ENTO	UNIVERSITY OF CALIFORNIA, DAVIS MEDICAL CENTER	MERCY HOSPITAL OF FOLSOM	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	40	14	25	20	78	8	
Medical/Surgical IC PD Adult	10,541	3,643	4,755	3,282	13,625	1,163	
ICU Occupied	72.2%	71.3%	52.1%	45.0%	47.9%	39.8%	
Coronary Care Available	16		11		8		
Coronary Care PD Adult	4,244		3,808		2,497		
CCU Occupied	72.7%	NA	94.8%	NA	85.5%	NA	
Pediatric IC Available	17				16		
Pediatric IC PD Pediatric	5,039				3,176		
PICU Occupied	81.2%	NA	NA	NA	54.4%	NA	
Neonatal IC Available	55		20	12	38		
Neonatal IC PD Pediatric	18,521		5,956	1,760	10,831		
NICU Occupied	92.3%	NA	81.6%	40.2%	78.1%	NA	
Burn Care Available					8		
Burn Care PD Adult					2,778		
Burn Care PD Pediatric							
Burn Care Occupied	NA	NA	NA	NA	95.1%	NA	
Other IC Available		14			10		
Other IC PD Adult		4,397			3,175		
Other IC PD Pediatric							
Other ICU Occupied	NA	86.0%	NA	NA	87.0%	NA	
Definitive Observation Available	95	100	57	15			
Definitive Observation PD Adult	25,597	27,274	8,796	10,436			
Definitive Observation PD Pediatric							
DOU Occupied	73.8%	74.7%	42.3%	190.6%	NA	NA	
Medical/Surgical Acute Available	163	82	94	85	286	81	
Medical/Surgical Acute PD Adult	47,329	19,196	33,753	7,892	83,641	8,668	
Medical/Surgical Occupied	79.6%	64.1%	98.4%	25.4%	80.1%	29.3%	
Pediatric Acute Available	36		8	8	36		
Pediatric Acute PD Pediatric	8,709		2,218	2,072	11,017		
Pediatrics Occupied	66.3%	NA	76.0%	71.0%	83.8%	NA	
Obstetrics Acute Available	61		32		29		
Obstetrics Acute PD Adult	13,380		6,205		7,362		
Obstetrics Occupied	60.1%	NA	53.1%	NA	69.6%	NA	

Appendix E

Table 2

Sacramento County - Sutter Memorial / Sutter General Hospital

Figure	SUTTER GENERAL & SUTTER MEMORIAL HOSPITALS	MERCY GENERAL HOSPITAL	MERCY SAN JUAN HOSPITAL	METHODIST HOSPITAL-SACRAM ENTO	UNIVERSITY OF CALIFORNIA, DAVIS MEDICAL CENTER	MERCY HOSPITAL OF FOLSOM	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available		56		22		6	
Alternate Birthing Center PD Adult		6,138		4,607		2,835	
ABC Occupied	NA	30.0%	NA	57.4%	NA	129.5%	
Physical Rehabilitation Care Available		25			19		
Physical Rehabilitation Care PD Adult		4,577			4,835		
Physical Rehabilitation Care PD Pediatrics							
Rehab Occupied	NA	50.2%	NA	NA	69.7%	NA	
Other Acute Care Available							
Other Acute Care PD Adult							
Other Acute Care PD Pediatric							
Other Acute Occupied	NA	NA	NA	NA	NA	NA	
Total Licensed	754	395	247	333	528	95	
Total Available	670	386	247	333	528	95	
Total Staffed	667	386	247	333	528	95	
Total PD Adult	154,922	76,551	57,317	73,626	117,913	12,666	
Total PD Pediatrics	32,269		8,174	3,832	25,024		
Total Discharge Total	29,625	16,909	15,029	8,102	25,226	4,263	
GAC Available Beds	483	291	247	162	528	95	
GAC PD	133,360	65,225	65,491	30,049	142,937	12,666	
ADC	365	179	179	82	392	35	
Available Occupied	75.6%	61.4%	72.6%	50.8%	74.2%	36.5%	
ADC at 80% Occupied	386.4	232.8	197.6	129.6	422.4	76.0	
Excess Beds	21.0	54.1	18.2	47.3	30.8	41.3	191.6
PERS PD	6,185						
PERS ADC	16.95						
Beds Needed at 80%	21.18						
Distance From Hospital 1 (in miles)		0.9	13.1	10.3	1.8	20.4	
Travel Time From Hospital 1 (in minutes)		3	22	17	8	27	
Distance From Hospital 2 (in miles)		1.1	12	8.5	1.6	22.2	
Travel Time From Hospital 2 (in minutes)		4	18	12	5	26	

Appendix E

Table 3

Yolo County - Sutter Davis Hospital

Figure	SUTTER DAVIS HOSPITAL	WOODLAND MEMORIAL HOSPITAL	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	6	8	
Medical/Surgical IC PD Adult	912	1,674	
ICU Occupied	41.6%	57.3%	
Coronary Care Available			
Coronary Care PD Adult			
CCU Occupied	NA	NA	
Pediatric IC Available			
Pediatric IC PD Pediatric			
PICU Occupied	NA	NA	
Neonatal IC Available			
Neonatal IC PD Pediatric			
NICU Occupied	NA	NA	
Burn Care Available			
Burn Care PD Adult			
Burn Care PD Pediatric			
Burn Care Occupied	NA	NA	
Other IC Available			
Other IC PD Adult			
Other IC PD Pediatric			
Other ICU Occupied	NA	NA	
Definitive Observation Available			
Definitive Observation PD Adult			
Definitive Observation PD Pediatric			
DOU Occupied	NA	NA	
Medical/Surgical Acute Available	30	81	
Medical/Surgical Acute PD Adult	5,667	7,810	
Medical/Surgical Occupied	51.8%	26.4%	
Pediatric Acute Available		7	
Pediatric Acute PD Pediatric		401	
Pediatrics Occupied	NA	15.7%	
Obstetrics Acute Available	12		
Obstetrics Acute PD Adult	2,246		
Obstetrics Occupied	51.3%	NA	

Appendix E

Table 3

Yolo County - Sutter Davis Hospital

Figure	SUTTER DAVIS HOSPITAL	WOODLAND MEMORIAL HOSPITAL	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available		7	
Alternate Birthing Center PD Adult		1,345	
ABC Occupied	NA	52.6%	
Physical Rehabilitation Care Available			
Physical Rehabilitation Care PD Adult			
Physical Rehabilitation Care PD Pediatrics			
Rehab Occupied	NA	NA	
Other Acute Care Available			
Other Acute Care PD Adult			
Other Acute Care PD Pediatric			
Other Acute Occupied	NA	NA	
Total Licensed	48	111	
Total Available	48	111	
Total Staffed	48	111	
Total PD Adult	8,825	13,500	
Total PD Pediatrics		401	
Total Discharge Total	3,069	3,938	
GAC Available Beds	48	103	
GAC PD	8,825	11,230	
ADC	24	31	
Available Occupied	50.4%	29.9%	
ADC at 80% Occupied	38.4	82.4	
Excess Beds	14.2	51.6	51.6
PERS PD	450		
PERS ADC	1.23		
Beds Needed at 80%	1.54		
Distance From Hospital 1 (in miles)		10.6	
Travel Time From Hospital 1 (in minutes)		16	
Distance From Hospital 2 (in miles)			
Travel Time From Hospital 2 (in minutes)			

Appendix E

Table 4

Alameda County - Eden Medical Center

Figure	EDEN MEDICAL CENTER	ALAMEDA HOSPITAL	ALTA BATES MEDICAL CENTER	ALTA BATES SUMMIT MEDICAL CENTER	ST. ROSE HOSPITAL	VALLEYCARE HEALTH SYSTEM	CHILDREN'S HOSPITAL & RESEARCH CENTER AT OAKLAND	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	11		36	30	15	12		
Medical/Surgical IC PD Adult	3,041		7,473	6,700	2,629	3,569		
ICU Occupied	75.7%	NA	56.9%	61.2%	48.0%	81.5%	NA	
Coronary Care Available	11	8						
Coronary Care PD Adult	2,236	1,070						
CCU Occupied	55.7%	44.0%	NA	NA	NA	NA	NA	
Pediatric IC Available							23	
Pediatric IC PD Pediatric							6,300	
PICU Occupied	NA	NA	NA	NA	NA	NA	75.0%	
Neonatal IC Available	3		55	22		4	47	
Neonatal IC PD Pediatric	385		18,401	2,749		672	11,724	
NICU Occupied	35.2%	NA	91.7%	34.2%	NA	46.0%	68.3%	
Burn Care Available								
Burn Care PD Adult								
Burn Care PD Pediatric								
Burn Care Occupied	NA	NA	NA	NA	NA	NA	NA	
Other IC Available				6				
Other IC PD Adult				1,703				
Other IC PD Pediatric								
Other ICU Occupied	NA	NA	NA	77.8%	NA	NA	NA	
Definitive Observation Available		29		10			8	
Definitive Observation PD Adult		3,646		10,134				
Definitive Observation PD Pediatric							2,594	
DOU Occupied	NA	41.4%	NA	277.6%	NA	NA	88.8%	
Medical/Surgical Acute Available	86	63	161	315	97	62		
Medical/Surgical Acute PD Adult	20,160	5,525	48,457	56,250	20,077	19,725		
Medical/Surgical Occupied	64.2%	28.8%	82.5%	48.9%	56.7%	87.2%	NA	
Pediatric Acute Available						4	93	
Pediatric Acute PD Pediatric						36	28,230	
Pediatrics Occupied	NA	NA	NA	NA	NA	2.5%	83.2%	
Obstetrics Acute Available	13		55	29	17	15		
Obstetrics Acute PD Adult	4,673		16,934	8,100	3,650	3,957		
Obstetrics Occupied	98.5%	NA	84.4%	76.5%	58.8%	72.3%	NA	

Appendix E

Table 4

Alameda County - Eden Medical Center

Figure	EDEN MEDICAL CENTER	ALAMEDA HOSPITAL	ALTA BATES MEDICAL CENTER	ALTA BATES SUMMIT MEDICAL CENTER	ST. ROSE HOSPITAL	VALLEYCARE HEALTH SYSTEM	CHILDREN'S HOSPITAL & RESEARCH CENTER AT OAKLAND	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available								
Alternate Birthing Center PD Adult								
ABC Occupied	NA	NA	NA	NA	NA	NA	NA	
Physical Rehabilitation Care Available	31		42				11	
Physical Rehabilitation Care PD Adult	5,956		9,090					
Physical Rehabilitation Care PD Pediatrics							3,277	
Rehab Occupied	52.6%	NA	59.3%	NA	NA	NA	81.6%	
Other Acute Care Available								
Other Acute Care PD Adult								
Other Acute Care PD Pediatric								
Other Acute Occupied	NA	NA	NA	NA	NA	NA	NA	
Total Licensed	264	135	543	524	175	182	205	
Total Available	245	135	509	500	175	141	182	
Total Staffed	245	135	509	279	175	124	182	
Total PD Adult	50,433	15,380	117,840	96,106	32,333	39,208		
Total PD Pediatrics	385		25,688	2,749		708	52,125	
Total Discharge Total	9,733	2,518	22,703	19,495	6,879	7,477	9,575	
GAC Available Beds	155	100	349	412	129	97	182	
GAC PD	36,451	10,241	100,355	85,636	26,356	27,959	52,125	
ADC	100	34	275	235	72	77	143	
Available Occupied	64.4%	33.7%	78.8%	56.9%	56.0%	79.0%	78.5%	
ADC at 80% Occupied	124.0	80.0	279.2	329.6	103.2	77.6	145.6	
Excess Beds	24.1	46.3	4.3	95.0	31.0	1.0	2.8	134.0
PERS PD	385							
PERS ADC	1.05							
Beds Needed at 80%	1.32							
Distance From Hospital 1 (in miles)		13.4	15.3	15.3	8.1	13.7	16.2	
Travel Time From Hospital 1 (in minutes)		20	18	18	10	15	18	
Distance From Hospital 2 (in miles)								
Travel Time From Hospital 2 (in minutes)								

Appendix E

Table 5

Alameda County - Washington Hospital

Figure	WASHINGTON HOSPTIAL	ALTA BATES MEDICAL CENTER	ALTA BATES SUMMIT MEDICAL CENTER	ST. ROSE HOSPITAL	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	12	36	30	15	
Medical/Surgical IC PD Adult	3,597	7,473	6,700	2,629	
ICU Occupied	82.1%	56.9%	61.2%	48.0%	
Coronary Care Available	16				
Coronary Care PD Adult	3,711				
CCU Occupied	63.5%	NA	NA	NA	
Pediatric IC Available					
Pediatric IC PD Pediatric					
PICU Occupied	NA	NA	NA	NA	
Neonatal IC Available		55	22		
Neonatal IC PD Pediatric		18,401	2,749		
NICU Occupied	NA	91.7%	34.2%	NA	
Burn Care Available					
Burn Care PD Adult					
Burn Care PD Pediatric					
Burn Care Occupied	NA	NA	NA	NA	
Other IC Available			6		
Other IC PD Adult			1,703		
Other IC PD Pediatric					
Other ICU Occupied	NA	NA	77.8%	NA	
Definitive Observation Available	32		10		
Definitive Observation PD Adult	7,861		10,134		
Definitive Observation PD Pediatric					
DOU Occupied	67.3%	NA	277.6%	NA	
Medical/Surgical Acute Available	177	161	315	97	
Medical/Surgical Acute PD Adult	38,666	48,457	56,250	20,077	
Medical/Surgical Occupied	59.8%	82.5%	48.9%	56.7%	
Pediatric Acute Available	15				
Pediatric Acute PD Pediatric	824				
Pediatrics Occupied	15.1%	NA	NA	NA	
Obstetrics Acute Available	22	55	29	17	
Obstetrics Acute PD Adult	7,835	16,934	8,100	3,650	
Obstetrics Occupied	97.6%	84.4%	76.5%	58.8%	

Appendix E

Table 5

Alameda County - Washington Hospital

Figure	WASHINGTON HOSPTIAL	ALTA BATES MEDICAL CENTER	ALTA BATES SUMMIT MEDICAL CENTER	ST. ROSE HOSPITAL	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available					
Alternate Birthing Center PD Adult					
ABC Occupied	NA	NA	NA	NA	
Physical Rehabilitation Care Available		42			
Physical Rehabilitation Care PD Adult		9,090			
Physical Rehabilitation Care PD Pediatrics					
Rehab Occupied	NA	59.3%	NA	NA	
Other Acute Care Available					
Other Acute Care PD Adult					
Other Acute Care PD Pediatric					
Other Acute Occupied	NA	NA	NA	NA	
Total Licensed	274	543	524	175	
Total Available	274	509	500	175	
Total Staffed	274	509	279	175	
Total PD Adult	61,670	117,840	96,106	32,333	
Total PD Pediatrics	824	25,688	2,749		
Total Discharge Total	15,057	22,703	19,495	6,879	
GAC Available Beds	274	349	412	129	
GAC PD	62,494	100,355	85,636	26,356	
ADC	171	275	235	72	
Available Occupied	62.5%	78.8%	56.9%	56.0%	
ADC at 80% Occupied	219.2	279.2	329.6	103.2	
Excess Beds	48.0	4.3	95.0	31.0	130.2
PERS PD	448				
PERS ADC	1.23				
Beds Needed at 80%	1.53				
Distance From Hospital 1 (in miles)		28.3	28.3	11.2	
Travel Time From Hospital 1 (in minutes)		33	33	14	
Distance From Hospital 2 (in miles)					
Travel Time From Hospital 2 (in minutes)					

Appendix E

Table 6

Contra Costa County - Sutter Delta Medical Center

Figure	SUTTER DELTA MEDICAL CENTER	JOHN MUIR MEDICAL CENTER	MT. DIABLO MEDICAL CENTER	SAN RAMON REGIONAL MEDICAL CENTER	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	12	24	25	6	
Medical/Surgical IC PD Adult	2,327	7,341	6,372	2,770	
ICU Occupied	53.1%	83.8%	69.8%	126.5%	
Coronary Care Available		11			
Coronary Care PD Adult		3,344			
CCU Occupied	NA	83.3%	NA	NA	
Pediatric IC Available					
Pediatric IC PD Pediatric					
PICU Occupied	NA	NA	NA	NA	
Neonatal IC Available		17		2	
Neonatal IC PD Pediatric		6,006		381	
NICU Occupied	NA	96.8%	NA	52.2%	
Burn Care Available					
Burn Care PD Adult					
Burn Care PD Pediatric					
Burn Care Occupied	NA	NA	NA	NA	
Other IC Available					
Other IC PD Adult					
Other IC PD Pediatric					
Other ICU Occupied	NA	NA	NA	NA	
Definitive Observation Available	12	29		12	
Definitive Observation PD Adult	5,175	9,284		5,701	
Definitive Observation PD Pediatric					
DOU Occupied	118.2%	87.7%	NA	130.2%	
Medical/Surgical Acute Available	73	182	229	93	
Medical/Surgical Acute PD Adult	12,846	42,217	39,214	12,261	
Medical/Surgical Occupied	48.2%	63.6%	46.9%	36.1%	
Pediatric Acute Available		15			
Pediatric Acute PD Pediatric		2,575			
Pediatrics Occupied	NA	47.0%	NA	NA	
Obstetrics Acute Available		28		10	
Obstetrics Acute PD Adult		10,057		2,703	
Obstetrics Occupied	NA	98.4%	NA	74.1%	

Appendix E

Table 6

Contra Costa County - Sutter Delta Medical Center

Figure	SUTTER DELTA MEDICAL CENTER	JOHN MUIR MEDICAL CENTER	MT. DIABLO MEDICAL CENTER	SAN RAMON REGIONAL MEDICAL CENTER	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available	14				
Alternate Birthing Center PD Adult	4,619				
ABC Occupied	90.4%	NA	NA	NA	
Physical Rehabilitation Care Available		23			
Physical Rehabilitation Care PD Adult		5,687			
Physical Rehabilitation Care PD Pediatrics					
Rehab Occupied	NA	67.7%	NA	NA	
Other Acute Care Available					
Other Acute Care PD Adult					
Other Acute Care PD Pediatric					
Other Acute Occupied	NA	NA	NA	NA	
Total Licensed	111	329	254	123	
Total Available	111	329	254	123	
Total Staffed	111	276	254	123	
Total PD Adult	24,967	77,930	45,586	23,435	
Total PD Pediatrics		8,581		381	
Total Discharge Total	6,818	16,784	9,564	5,771	
GAC Available Beds	111	329	254	123	
GAC PD	24,967	86,511	45,586	23,816	
ADC	68	237	125	65	
Available Occupied	61.6%	72.0%	49.2%	53.0%	
ADC at 80% Occupied	88.8	263.2	203.2	98.4	
Excess Beds	20.4	26.2	78.3	33.2	137.6
PERS PD	242				
PERS ADC	0.66				
Beds Needed at 80%	0.83				
Distance From Hospital 1 (in miles)		18.5	16.1	33.6	
Travel Time From Hospital 1 (in minutes)		28	22	40	
Distance From Hospital 2 (in miles)					
Travel Time From Hospital 2 (in minutes)					

Appendix E

Table 7

San Francisco - California Pacific Medical Center and St. Luke's Hospital

Figure	CALIFORNIA PACIFIC MEDICAL CENTER	ST. LUKE'S HOSPITAL	SAINT FRANCIS MEMORIAL HOSPITAL	ST. MARY'S MEDICAL CENTER, SAN FRANCISCO	THE MEDICAL CENTER AT UCSF	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	37	15	18	37	31	
Medical/Surgical IC PD Adult	9,132	2,323	4,080	4,780	7,247	
ICU Occupied	67.6%	42.4%	62.1%	35.4%	64.0%	
Coronary Care Available	22				16	
Coronary Care PD Adult	7,421				5,133	
CCU Occupied	92.4%	NA	NA	NA	87.9%	
Pediatric IC Available	8				18	
Pediatric IC PD Pediatric	1,077				6,055	
PICU Occupied	36.9%	NA	NA	NA	92.2%	
Neonatal IC Available	26	7			51	
Neonatal IC PD Pediatric	7,050	976			15,196	
NICU Occupied	74.3%	38.2%	NA	NA	81.6%	
Burn Care Available			10			
Burn Care PD Adult			1,980			
Burn Care PD Pediatric						
Burn Care Occupied	NA	NA	54.2%	NA	NA	
Other IC Available					15	
Other IC PD Adult					4,871	
Other IC PD Pediatric						
Other ICU Occupied	NA	NA	NA	NA	89.0%	
Definitive Observation Available	20					
Definitive Observation PD Adult	6,664					
Definitive Observation PD Pediatric						
DOU Occupied	91.3%	NA	NA	NA	NA	
Medical/Surgical Acute Available	334	100	92	277	453	
Medical/Surgical Acute PD Adult	68,019	22,598	21,718	25,742	85,160	
Medical/Surgical Occupied	55.8%	61.9%	64.7%	25.5%	51.5%	
Pediatric Acute Available	25				75	
Pediatric Acute PD Pediatric	3,590				18,960	
Pediatrics Occupied	39.3%	NA	NA	NA	69.3%	
Obstetrics Acute Available	83	20			29	
Obstetrics Acute PD Adult	18,406	3,138			7,561	
Obstetrics Occupied	60.8%	43.0%	NA	NA	71.4%	

Appendix E

Table 7

San Francisco - California Pacific Medical Center and St. Luke's Hospital

Figure	CALIFORNIA PACIFIC MEDICAL CENTER	ST. LUKE'S HOSPITAL	SAINT FRANCIS MEMORIAL HOSPITAL	ST. MARY'S MEDICAL CENTER, SAN FRANCISCO	THE MEDICAL CENTER AT UCSF	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available						
Alternate Birthing Center PD Adult						
ABC Occupied	NA	NA	NA	NA	NA	
Physical Rehabilitation Care Available	32		20	24		
Physical Rehabilitation Care PD Adult	6,934		4,841	6,319		
Physical Rehabilitation Care PD Pediatrics						
Rehab Occupied	59.4%	NA	66.3%	72.1%	NA	
Other Acute Care Available						
Other Acute Care PD Adult						
Other Acute Care PD Pediatric						
Other Acute Occupied	NA	NA	NA	NA	NA	
Total Licensed	1,263	260	356	430	688	
Total Available	785	250	209	430	688	
Total Staffed	785	177	209	430	688	
Total PD Adult	170,953	59,841	53,713	46,650	109,972	
Total PD Pediatrics	11,717	976		5,191	40,211	
Total Discharge Total	29,099	7,022	7,262	7,335	24,464	
GAC Available Beds	587	142	140	338	688	
GAC PD	128,293	29,035	32,619	36,841	150,183	
ADC	351	80	89	101	411	
Available Occupied	59.9%	56.0%	63.8%	29.9%	59.8%	
ADC at 80% Occupied	469.6	113.6	112.0	270.4	550.4	
Excess Beds	118.1	34.1	22.6	169.5	138.9	331.0
PERS PD	1513	72	58			
PERS ADC	4.15	0.20	0.16			
Beds Needed at 80%	5.18	0.25	0.20			
Distance From Hospital 1 (in miles)				0.9	0.4	
Travel Time From Hospital 1 (in minutes)				3	1	
Distance From Hospital 2 (in miles)				3.7	4	
Travel Time From Hospital 2 (in minutes)				10	10	

Appendix E

Table 8

San Mateo County - Seton Medical Center / Seton Medical Center Coastside

Figure	SETON MEDICAL CENTER	SETON MEDICAL CENTER - COASTSIDE	MILLS PENINSULA MEDICAL CENTER	SEQUOIA HEALTH SERVICES	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	14		12	186	
Medical/Surgical IC PD Adult	2,004		3,376	3,780	
ICU Occupied	79.1%	NA	77.1%	5.6%	
Coronary Care Available	14		12		
Coronary Care PD Adult	1,947		1,474		
CCU Occupied	76.8%	NA	33.7%	NA	
Pediatric IC Available					
Pediatric IC PD Pediatric					
PICU Occupied	NA	NA	NA	NA	
Neonatal IC Available					
Neonatal IC PD Pediatric					
NICU Occupied	NA	NA	NA	NA	
Burn Care Available					
Burn Care PD Adult					
Burn Care PD Pediatric					
Burn Care Occupied	NA	NA	NA	NA	
Other IC Available				48	
Other IC PD Adult				11,714	
Other IC PD Pediatric					
Other ICU Occupied	NA	NA	NA	66.9%	
Definitive Observation Available			31		
Definitive Observation PD Adult			9,273		
Definitive Observation PD Pediatric					
DOU Occupied	NA	NA	82.0%	NA	
Medical/Surgical Acute Available	152	5	110	151	
Medical/Surgical Acute PD Adult	19,557	7	29,904	10,632	
Medical/Surgical Occupied	71.1%	0.8%	74.5%	19.3%	
Pediatric Acute Available			4		
Pediatric Acute PD Pediatric			479		
Pediatrics Occupied	NA	NA	32.8%	NA	
Obstetrics Acute Available	20			15	
Obstetrics Acute PD Adult	1,011			3,592	
Obstetrics Occupied	27.9%	NA	NA	65.6%	

Appendix E

Table 8

San Mateo County - Seton Medical Center / Seton Medical Center Coastside

Figure	SETON MEDICAL CENTER	SETON MEDICAL CENTER - COASTSIDE	MILLS PENINSULA MEDICAL CENTER	SEQUOIA HEALTH SERVICES	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available			33		
Alternate Birthing Center PD Adult			6,832		
ABC Occupied	NA	NA	56.7%	NA	
Physical Rehabilitation Care Available			28	12	
Physical Rehabilitation Care PD Adult			3,923	945	
Physical Rehabilitation Care PD Pediatrics					
Rehab Occupied	NA	NA	38.4%	21.6%	
Other Acute Care Available					
Other Acute Care PD Adult					
Other Acute Care PD Pediatric					
Other Acute Occupied	NA	NA	NA	NA	
Total Licensed	357	121	403	660	
Total Available	283	121	374	478	
Total Staffed	283	121	363	464	
Total PD Adult	38,928	20,166	97,722	42,324	
Total PD Pediatrics			2,285		
Total Discharge Total	4,639	49	15,843	8,588	
GAC Available Beds	200	5	230	412	
GAC PD	24,519	7	55,261	30,663	
ADC	135	0	151	84	
Available Occupied	67.7%	0.8%	65.8%	20.4%	
ADC at 80% Occupied	160.0	4.0	184.0	329.6	
Excess Beds	24.5	4.0	32.6	245.6	278.2
PERS PD	348				
PERS ADC	0.95				
Beds Needed at 80%	1.19				
Distance From Hospital 1 (in miles)			9.8	21.7	
Travel Time From Hospital 1 (in minutes)			12	24	
Distance From Hospital 2 (in miles)					
Travel Time From Hospital 2 (in minutes)					

Appendix E

Table 9

Santa Clara County - O'Connor Hospital

Figure	O'CONNOR HOSPITAL	REGIONAL MEDICAL CENTER OF SAN JOSE	COMMUNITY HOSPITAL OF LOS GATOS	GOOD SAMARITAN HOSPITAL	SAN JOSE MEDICAL CENTER	SAINT LOUISE REGIONAL HOSPITAL	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	22	12	15	17	17	8	
Medical/Surgical IC PD Adult	2,174	3,937	3,514	2,989	4,940	696	
ICU Occupied	54.6%	89.9%	64.2%	48.2%	79.6%	48.1%	
Coronary Care Available				17			
Coronary Care PD Adult				2,679			
CCU Occupied	NA	NA	NA	43.2%	NA	NA	
Pediatric IC Available					8		
Pediatric IC PD Pediatric					705		
PICU Occupied	NA	NA	NA	NA	24.1%	NA	
Neonatal IC Available		6	2	35	7		
Neonatal IC PD Pediatric		1,652	483	10,935			
NICU Occupied	NA	75.4%	66.2%	85.6%	0.0%	NA	
Burn Care Available							
Burn Care PD Adult							
Burn Care PD Pediatric							
Burn Care Occupied	NA	NA	NA	NA	NA	NA	
Other IC Available							
Other IC PD Adult							
Other IC PD Pediatric							
Other ICU Occupied	NA	NA	NA	NA	NA	NA	
Definitive Observation Available							
Definitive Observation PD Adult							
Definitive Observation PD Pediatric							
DOU Occupied	NA	NA	NA	NA	NA	NA	
Medical/Surgical Acute Available	180	91	80	118	157	44	
Medical/Surgical Acute PD Adult	15,430	15,211	19,263	31,368	17,246	4,363	
Medical/Surgical Occupied	47.4%	45.8%	66.0%	72.8%	30.1%	54.8%	
Pediatric Acute Available	24	22	2		29		
Pediatric Acute PD Pediatric	596	2,254	319	2,410	1,637		
Pediatrics Occupied	13.7%	28.1%	43.7%	NA	15.5%	NA	
Obstetrics Acute Available	34	20	14	65		16	
Obstetrics Acute PD Adult	3,707	7,899	2,749	10,870		931	
Obstetrics Occupied	60.2%	108.2%	53.8%	45.8%	NA	32.1%	

Appendix E

Table 9

Santa Clara County - O'Connor Hospital

Figure	O'CONNOR HOSPITAL	REGIONAL MEDICAL CENTER OF SAN JOSE	COMMUNITY HOSPITAL OF LOS GATOS	GOOD SAMARITAN HOSPITAL	SAN JOSE MEDICAL CENTER	SAINT LOUISE REGIONAL HOSPITAL	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available					28		
Alternate Birthing Center PD Adult							
ABC Occupied	NA	NA	NA	NA	0.0%	NA	
Physical Rehabilitation Care Available			30		30		
Physical Rehabilitation Care PD Adult			4,410		3,711		
Physical Rehabilitation Care PD Pediatrics							
Rehab Occupied	NA	NA	40.3%	NA	33.9%	NA	
Other Acute Care Available		37			26		
Other Acute Care PD Adult		12,694			7,571		
Other Acute Care PD Pediatric							
Other Acute Occupied	NA	94.0%	NA	NA	79.8%	NA	
Total Licensed	358	204	143	451	328	93	
Total Available	306	188	143	292	328	89	
Total Staffed	225	188	143	204	117	89	
Total PD Adult	26,189	39,741	29,936	59,116	40,473	7,662	
Total PD Pediatrics	596	3,906	802	13,345	2,342		
Total Discharge Total	6,261	10,346	6,051	15,976	7,250	1,751	
GAC Available Beds	260	188	143	252	302	68	
GAC PD	21,907	43,647	30,738	61,251	35,810	5,990	
ADC	121	120	84	168	98	33	
Available Occupied	46.6%	63.6%	58.9%	66.6%	32.5%	48.7%	
ADC at 80% Occupied	208.0	150.4	114.4	201.6	241.6	54.4	
Excess Beds	87.0	30.8	30.2	33.8	143.5	21.3	259.6
PERS PD	356						
PERS ADC	0.98						
Beds Needed at 80%	1.22						
Distance From Hospital 1 (in miles)		7.7	6.5	7.6	6.3	35.2	
Travel Time From Hospital 1 (in minutes)		11	11	11	11	38	
Distance From Hospital 2 (in miles)							
Travel Time From Hospital 2 (in minutes)							

Appendix E

Table 10

Sonoma County - Sutter Medical Center of Santa Rosa / Sutter Warrack Hospital

Figure	SUTTER MEDICAL CENTER OF SANTA ROSA	SUTTER WARRACK HOSPITAL	HEALDSBURG DISTRICT HOSPITAL	PETALUMA VALLEY HOSPITAL	SANTA ROSA MEMORIAL HOSPITAL	PALM DRIVE HOSPITAL	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	10	5	4	9	16	5	
Medical/Surgical IC PD Adult	2,713	528		1,507	5,640	576	
ICU Occupied	74.3%	28.9%	0.0%	45.9%	96.6%	47.6%	
Coronary Care Available							
Coronary Care PD Adult							
CCU Occupied	NA	NA	NA	NA	NA	NA	
Pediatric IC Available	6						
Pediatric IC PD Pediatric	791						
PICU Occupied	36.1%	NA	NA	NA	NA	NA	
Neonatal IC Available	10				15		
Neonatal IC PD Pediatric	2,980				1,679		
NICU Occupied	81.6%	NA	NA	NA	30.7%	NA	
Burn Care Available							
Burn Care PD Adult							
Burn Care PD Pediatric							
Burn Care Occupied	NA	NA	NA	NA	NA	NA	
Other IC Available							
Other IC PD Adult							
Other IC PD Pediatric							
Other ICU Occupied	NA	NA	NA	NA	NA	NA	
Definitive Observation Available							
Definitive Observation PD Adult							
Definitive Observation PD Pediatric							
DOU Occupied	NA	NA	NA	NA	NA	NA	
Medical/Surgical Acute Available	64	37	30	41	220	34	
Medical/Surgical Acute PD Adult	15,846	7,390	1,207	8,173	47,316	3,492	
Medical/Surgical Occupied	67.8%	54.7%	14.6%	54.6%	58.9%	42.4%	
Pediatric Acute Available	9				6		
Pediatric Acute PD Pediatric	708				1,030		
Pediatrics Occupied	21.6%	NA	NA	NA	47.0%	NA	
Obstetrics Acute Available	18			10	15		
Obstetrics Acute PD Adult	4,965			1,258	4,176		
Obstetrics Occupied	75.6%	NA	NA	34.5%	76.3%	NA	

Appendix E

Table 10

Sonoma County - Sutter Medical Center of Santa Rosa / Sutter Warrack Hospital

Figure	SUTTER MEDICAL CENTER OF SANTA ROSA	SUTTER WARRACK HOSPITAL	HEALDSBURG DISTRICT HOSPITAL	PETALUMA VALLEY HOSPITAL	SANTA ROSA MEMORIAL HOSPITAL	PALM DRIVE HOSPITAL	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available							
Alternate Birthing Center PD Adult							
ABC Occupied	NA	NA	NA	NA	NA	NA	
Physical Rehabilitation Care Available					19		
Physical Rehabilitation Care PD Adult					3,471		
Physical Rehabilitation Care PD Pediatrics							
Rehab Occupied	NA	NA	NA	NA	50.1%	NA	
Other Acute Care Available							
Other Acute Care PD Adult							
Other Acute Care PD Pediatric							
Other Acute Occupied	NA	NA	NA	NA	NA	NA	
Total Licensed	175	63	43	80	365	49	
Total Available	157	42	43	80	365	49	
Total Staffed	157	42	39	80	325	49	
Total PD Adult	36,662	7,918	2,278	15,215	80,014	4,735	
Total PD Pediatrics	4,479				2,709		
Total Discharge Total	8,442	1,369	440	3,905	14,984	1,019	
GAC Available Beds	117	42	34	60	291	39	
GAC PD	28,003	7,918	1,207	10,938	63,312	4,068	
ADC	77	22	4	30	173	17	
Available Occupied	65.6%	51.7%	12.9%	49.9%	59.6%	43.1%	
ADC at 80% Occupied	93.6	33.6	27.2	48.0	232.8	31.2	
Excess Beds	16.9	11.9	22.8	18.0	59.3	14.4	114.6
PERS PD	481	94					
PERS ADC	1.32	0.26					
Beds Needed at 80%	1.65	0.32					
Distance From Hospital 1 (in miles)			16	19.6	2.5	10.3	
Travel Time From Hospital 1 (in minutes)			20	23	10	19	
Distance From Hospital 2 (in miles)			20.8	19.4	2.6	10.1	
Travel Time From Hospital 2 (in minutes)			26	24	8	19	

Appendix E

Table 11

Fresno County - Selma Community Hospital

Figure	SELMA COMMUNITY HOSPITAL	COMMUNITY MEDICAL CENTER CLOVIS	COMMUNITY MEDICAL CENTER FRESNO	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available		7	38	
Medical/Surgical IC PD Adult		1,708	11,797	
ICU Occupied	NA	66.8%	85.1%	
Coronary Care Available			8	
Coronary Care PD Adult			2,478	
CCU Occupied	NA	NA	84.9%	
Pediatric IC Available				
Pediatric IC PD Pediatric				
PICU Occupied	NA	NA	NA	
Neonatal IC Available				
Neonatal IC PD Pediatric				
NICU Occupied	NA	NA	NA	
Burn Care Available			6	
Burn Care PD Adult			2,079	
Burn Care PD Pediatric				
Burn Care Occupied	NA	NA	94.9%	
Other IC Available				
Other IC PD Adult				
Other IC PD Pediatric				
Other ICU Occupied	NA	NA	NA	
Definitive Observation Available			62	
Definitive Observation PD Adult			16,502	
Definitive Observation PD Pediatric				
DOU Occupied	NA	NA	72.9%	
Medical/Surgical Acute Available	33	56	375	
Medical/Surgical Acute PD Adult	3,514	17,199	75,408	
Medical/Surgical Occupied	29.2%	84.1%	55.1%	
Pediatric Acute Available			47	
Pediatric Acute PD Pediatric			4,015	
Pediatrics Occupied	NA	NA	23.4%	
Obstetrics Acute Available	10		91	
Obstetrics Acute PD Adult	1,548		19,094	
Obstetrics Occupied	42.4%	NA	57.5%	

Appendix E

Table 11

Fresno County - Selma Community Hospital

Figure	SELMA COMMUNITY HOSPITAL	COMMUNITY MEDICAL CENTER CLOVIS	COMMUNITY MEDICAL CENTER FRESNO	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available		37		
Alternate Birthing Center PD Adult		5,827		
ABC Occupied	NA	43.1%	NA	
Physical Rehabilitation Care Available			33	
Physical Rehabilitation Care PD Adult			5,910	
Physical Rehabilitation Care PD Pediatrics				
Rehab Occupied	NA	NA	49.1%	
Other Acute Care Available				
Other Acute Care PD Adult				
Other Acute Care PD Pediatric				
Other Acute Occupied	NA	NA	NA	
Total Licensed	57	100	755	
Total Available	57	100	755	
Total Staffed	25	100	755	
Total PD Adult	8,446	24,734	159,021	
Total PD Pediatrics			4,015	
Total Discharge Total	2,492	8,083	31,313	
GAC Available Beds	43	100	660	
GAC PD	5,062	24,734	137,283	
ADC	14	68	376	
Available Occupied	32.3%	67.8%	57.0%	
ADC at 80% Occupied	34.4	80.0	528.0	
Excess Beds	20.5	12.2	151.9	164.1
PERS PD	51			
PERS ADC	0.14			
Beds Needed at 80%	0.17			
Distance From Hospital 1 (in miles)		28.7	17.7	
Travel Time From Hospital 1 (in minutes)		34	23	
Distance From Hospital 2 (in miles)				
Travel Time From Hospital 2 (in minutes)				

Appendix E

Table 12

Merced County - Memorial Hospital of Los Banos

Figure	MEMORIAL HOSPITAL LOS BANOS	MERCY HOSPITAL - COMMUNITY CAMPUS	MERCY HOSPITAL & HEALTH SERVICES	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	4	12	10	
Medical/Surgical IC PD Adult	840	2,293	2,241	
ICU Occupied	57.5%	52.4%	61.4%	
Coronary Care Available				
Coronary Care PD Adult				
CCU Occupied	NA	NA	NA	
Pediatric IC Available				
Pediatric IC PD Pediatric				
PICU Occupied	NA	NA	NA	
Neonatal IC Available				
Neonatal IC PD Pediatric				
NICU Occupied	NA	NA	NA	
Burn Care Available				
Burn Care PD Adult				
Burn Care PD Pediatric				
Burn Care Occupied	NA	NA	NA	
Other IC Available				
Other IC PD Adult				
Other IC PD Pediatric				
Other ICU Occupied	NA	NA	NA	
Definitive Observation Available				
Definitive Observation PD Adult				
Definitive Observation PD Pediatric				
DOU Occupied	NA	NA	NA	
Medical/Surgical Acute Available	34	105	93	
Medical/Surgical Acute PD Adult	5,977	14,144	22,709	
Medical/Surgical Occupied	48.2%	36.9%	66.9%	
Pediatric Acute Available		7		
Pediatric Acute PD Pediatric		825		
Pediatrics Occupied	NA	32.3%	NA	
Obstetrics Acute Available	10	26	12	
Obstetrics Acute PD Adult	1,215	2,977	2,864	
Obstetrics Occupied	33.3%	31.4%	65.4%	

Appendix E

Table 12

Merced County - Memorial Hospital of Los Banos

Figure	MEMORIAL HOSPITAL LOS BANOS	MERCY HOSPITAL - COMMUNITY CAMPUS	MERCY HOSPITAL & HEALTH SERVICES	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available				
Alternate Birthing Center PD Adult				
ABC Occupied	NA	NA	NA	
Physical Rehabilitation Care Available				
Physical Rehabilitation Care PD Adult				
Physical Rehabilitation Care PD Pediatrics				
Rehab Occupied	NA	NA	NA	
Other Acute Care Available				
Other Acute Care PD Adult				
Other Acute Care PD Pediatric				
Other Acute Occupied	NA	NA	NA	
Total Licensed	48	174	115	
Total Available	48	174	115	
Total Staffed	48	174	115	
Total PD Adult	8,032	19,922	27,814	
Total PD Pediatrics		825		
Total Discharge Total	1,830	4,864	5,797	
GAC Available Beds	48	150	115	
GAC PD	8,032	20,239	27,814	
ADC	22	55	76	
Available Occupied	45.8%	37.0%	66.3%	
ADC at 80% Occupied	38.4	120.0	92.0	
Excess Beds	16.4	64.6	15.8	80.3
PERS PD	81			
PERS ADC	0.22			
Beds Needed at 80%	0.28			
Distance From Hospital 1 (in miles)		37.4	37.4	
Travel Time From Hospital 1 (in minutes)		55	55	
Distance From Hospital 2 (in miles)				
Travel Time From Hospital 2 (in minutes)				

Appendix E

Table 13

San Joaquin County - Sutter Tracy Community Hospital and St. Dominic's Hospital

Figure	SUTTER TRACY COMMUNITY HOSPITAL	ST. DOMINIC'S HOSPITAL	DAMERON HOSPITAL ASSOCIATION	SAN JOAQUIN GENERAL HOSPITAL	ST. JOSEPH'S MEDICAL CENTER OF STOCKTON	DOCTORS HOSPITAL OF MANTECA	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	8	6	12	16	20	8	
Medical/Surgical IC PD Adult	1,577	1,084	3,975	4,392	6,400	1,650	
ICU Occupied	54.0%	49.5%	90.8%	75.2%	87.7%	56.5%	
Coronary Care Available			12		9		
Coronary Care PD Adult			3,738		2,757		
CCU Occupied	NA	NA	85.3%	NA	83.9%	NA	
Pediatric IC Available							
Pediatric IC PD Pediatric							
PICU Occupied	NA	NA	NA	NA	NA	NA	
Neonatal IC Available			16	25	14		
Neonatal IC PD Pediatric			4,290	6,091	3,729		
NICU Occupied	NA	NA	73.5%	66.8%	73.0%	NA	
Burn Care Available							
Burn Care PD Adult							
Burn Care PD Pediatric							
Burn Care Occupied	NA	NA	NA	NA	NA	NA	
Other IC Available							
Other IC PD Adult							
Other IC PD Pediatric							
Other ICU Occupied	NA	NA	NA	NA	NA	NA	
Definitive Observation Available				25	43		
Definitive Observation PD Adult				7,643	15,100		
Definitive Observation PD Pediatric							
DOU Occupied	NA	NA	NA	83.8%	96.2%	NA	
Medical/Surgical Acute Available	65	16	112	82	115	60	
Medical/Surgical Acute PD Adult	10,332	3,215	33,649	17,556	41,295	11,833	
Medical/Surgical Occupied	43.5%	55.1%	82.3%	58.7%	98.4%	54.0%	
Pediatric Acute Available			15	15	13		
Pediatric Acute PD Pediatric			1,937	2,461	2,119		
Pediatrics Occupied	NA	NA	35.4%	44.9%	44.7%	NA	
Obstetrics Acute Available	6	5	21		37	5	
Obstetrics Acute PD Adult	1,514	1,030	5,053		4,637	1,714	
Obstetrics Occupied	69.1%	56.4%	65.9%	NA	34.3%	93.9%	

Appendix E

Table 13

San Joaquin County - Sutter Tracy Community Hospital and St. Dominic's Hospital

Figure	SUTTER TRACY COMMUNITY HOSPITAL	ST. DOMINIC'S HOSPITAL	DAMERON HOSPITAL ASSOCIATION	SAN JOAQUIN GENERAL HOSPITAL	ST. JOSEPH'S MEDICAL CENTER OF STOCKTON	DOCTORS HOSPITAL OF MANTECA	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available				16			
Alternate Birthing Center PD Adult				5,672			
ABC Occupied	NA	NA	NA	97.1%	NA	NA	
Physical Rehabilitation Care Available				24			
Physical Rehabilitation Care PD Adult				2,540			
Physical Rehabilitation Care PD Pediatrics							
Rehab Occupied	NA	NA	NA	29.0%	NA	NA	
Other Acute Care Available							
Other Acute Care PD Adult							
Other Acute Care PD Pediatric							
Other Acute Occupied	NA	NA	NA	NA	NA	NA	
Total Licensed	79	77	188	236	294	73	
Total Available	79	77	188	203	294	73	
Total Staffed	78	77	188	134	294	73	
Total PD Adult	13,423	22,690	46,415	37,803	79,340	15,197	
Total PD Pediatrics			6,227	8,552	5,848		
Total Discharge Total	3,836	2,042	12,329	9,363	16,630	3,550	
GAC Available Beds	79	27	188	203	251	73	
GAC PD	13,423	5,329	52,642	46,355	76,037	15,197	
ADC	37	15	144	127	208	42	
Available Occupied	46.6%	54.1%	76.7%	62.6%	83.0%	57.0%	
ADC at 80% Occupied	63.2	21.6	150.4	162.4	200.8	58.4	
Excess Beds	26.4	7.0	6.2	35.4	(7.5)	16.8	50.8
PERS PD	203	83					
PERS ADC	0.56	0.23					
Beds Needed at 80%	0.70	0.28					
Distance From Hospital 1 (in miles)			22.3	16.3	22.8	16.4	
Travel Time From Hospital 1 (in minutes)			25	18	27	22	
Distance From Hospital 2 (in miles)			16.1	10.1	16.6	2.9	
Travel Time From Hospital 2 (in minutes)			20	13	22	7	

Appendix E

Table 14

Stanilaus County - Memorial Medical Center

Figure	MEMORIAL MEDICAL CENTER	DOCTORS MEDICAL CENTER OF MODESTO	EMANUEL MEDICAL CENTER	OAK VALLEY HOSPITAL	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	35	51	12	5	
Medical/Surgical IC PD Adult	9,371	13,618	1,573	499	
ICU Occupied	73.4%	73.2%	35.9%	27.3%	
Coronary Care Available		12			
Coronary Care PD Adult		3,608			
CCU Occupied	NA	82.4%	NA	NA	
Pediatric IC Available					
Pediatric IC PD Pediatric					
PICU Occupied	NA	NA	NA	NA	
Neonatal IC Available	6	45	6		
Neonatal IC PD Pediatric	1,946	11,743	1,099		
NICU Occupied	88.9%	71.5%	50.2%	NA	
Burn Care Available					
Burn Care PD Adult					
Burn Care PD Pediatric					
Burn Care Occupied	NA	NA	NA	NA	
Other IC Available		8			
Other IC PD Adult		2,273			
Other IC PD Pediatric					
Other ICU Occupied	NA	77.8%	NA	NA	
Definitive Observation Available		36	15		
Definitive Observation PD Adult		11,131	4,395		
Definitive Observation PD Pediatric					
DOU Occupied	NA	84.7%	80.3%	NA	
Medical/Surgical Acute Available	209	161	71	24	
Medical/Surgical Acute PD Adult	73,034	51,915	15,625	6,158	
Medical/Surgical Occupied	95.7%	88.3%	60.3%	70.3%	
Pediatric Acute Available	28	22	10		
Pediatric Acute PD Pediatric	6,098	3,176	1,442		
Pediatrics Occupied	59.7%	39.6%	39.5%	NA	
Obstetrics Acute Available	22	56	32		
Obstetrics Acute PD Adult	5,896	12,544	3,075		
Obstetrics Occupied	73.4%	61.4%	26.3%	NA	

Appendix E

Table 14

Stanilaus County - Memorial Medical Center

Figure	MEMORIAL MEDICAL CENTER	DOCTORS MEDICAL CENTER OF MODESTO	EMANUEL MEDICAL CENTER	OAK VALLEY HOSPITAL	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available				4	
Alternate Birthing Center PD Adult				720	
ABC Occupied	NA	NA	NA	49.3%	
Physical Rehabilitation Care Available					
Physical Rehabilitation Care PD Adult					
Physical Rehabilitation Care PD Pediatrics					
Rehab Occupied	NA	NA	NA	NA	
Other Acute Care Available					
Other Acute Care PD Adult					
Other Acute Care PD Pediatric					
Other Acute Occupied	NA	NA	NA	NA	
Total Licensed	300	398	340	148	
Total Available	300	391	328	148	
Total Staffed	264	300	297	148	
Total PD Adult	88,301	95,089	83,291	45,985	
Total PD Pediatrics	8,044	14,919	2,541		
Total Discharge Total	19,300	20,065	7,188	2,822	
GAC Available Beds	300	391	146	33	
GAC PD	96,345	110,008	27,209	7,377	
ADC	264	301	75	20	
Available Occupied	88.0%	77.1%	51.1%	61.2%	
ADC at 80% Occupied	240.0	312.8	116.8	26.4	
Excess Beds	(24.0)	11.4	42.3	6.2	59.9
PERS PD	2,320				
PERS ADC	6.36				
Beds Needed at 80%	7.95				
Distance From Hospital 1 (in miles)		1.6	16.9	12	
Travel Time From Hospital 1 (in minutes)		4	32	25	
Distance From Hospital 2 (in miles)					
Travel Time From Hospital 2 (in minutes)					

Appendix E

Table 15

Tulare County - Sierra View District Hospital

Figure	SIERRA VIEW DISTRICT HOSPITAL	KAWEAH DELTA HEALTH CARE DISTRICT	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	10	21	
Medical/Surgical IC PD Adult	1,982	6,105	
ICU Occupied	54.3%	79.6%	
Coronary Care Available			
Coronary Care PD Adult			
CCU Occupied	NA	NA	
Pediatric IC Available			
Pediatric IC PD Pediatric			
PICU Occupied	NA	NA	
Neonatal IC Available		10	
Neonatal IC PD Pediatric		3,038	
NICU Occupied	NA	83.2%	
Burn Care Available			
Burn Care PD Adult			
Burn Care PD Pediatric			
Burn Care Occupied	NA	NA	
Other IC Available		34	
Other IC PD Adult		11,520	
Other IC PD Pediatric			
Other ICU Occupied	NA	92.8%	
Definitive Observation Available			
Definitive Observation PD Adult			
Definitive Observation PD Pediatric			
DOU Occupied	NA	NA	
Medical/Surgical Acute Available	98	154	
Medical/Surgical Acute PD Adult	19,601	45,867	
Medical/Surgical Occupied	54.8%	81.6%	
Pediatric Acute Available		12	
Pediatric Acute PD Pediatric		2,344	
Pediatrics Occupied	NA	53.5%	
Obstetrics Acute Available	10	44	
Obstetrics Acute PD Adult	3,935	8,118	
Obstetrics Occupied	107.8%	50.5%	

Appendix E

Table 15

Tulare County - Sierra View District Hospital

Figure	SIERRA VIEW DISTRICT HOSPITAL	KAWEAH DELTA HEALTH CARE DISTRICT	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available			
Alternate Birthing Center PD Adult			
ABC Occupied	NA	NA	
Physical Rehabilitation Care Available		30	
Physical Rehabilitation Care PD Adult		6,437	
Physical Rehabilitation Care PD Pediatrics			
Rehab Occupied	NA	58.8%	
Other Acute Care Available			
Other Acute Care PD Adult			
Other Acute Care PD Pediatric			
Other Acute Occupied	NA	NA	
Total Licensed	147	489	
Total Available	147	453	
Total Staffed	147	382	
Total PD Adult	34,650	118,875	
Total PD Pediatrics		5,382	
Total Discharge Total	7,351	19,796	
GAC Available Beds	118	305	
GAC PD	25,518	83,429	
ADC	70	229	
Available Occupied	59.2%	74.9%	
ADC at 80% Occupied	94.4	244.0	
Excess Beds	24.5	15.4	15.4
PERS PD	379		
PERS ADC	1.04		
Beds Needed at 80%	1.30		
Distance From Hospital 1 (in miles)		32.6	
Travel Time From Hospital 1 (in minutes)		49	
Distance From Hospital 2 (in miles)			
Travel Time From Hospital 2 (in minutes)			

Appendix E

Table 16

Los Angeles County - Cedars Sinai Medical Center

Figure	CEDARS~SINAI MEDICAL CENTER	UCLA MEDICAL CENTER	SANTA MONICA - UCLA MEDICAL CENTER	SAINT JOHN'S HEALTH CENTER	MIDWAY HOSPITAL MEDICAL CENTER	BROTMAN MEDICAL CENTER	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	40	44	22	25	12		
Medical/Surgical IC PD Adult	13,204	12,561	5,801	7,626	3,748		
ICU Occupied	90.4%	78.2%	72.2%	83.6%	85.6%	NA	
Coronary Care Available	34	26				10	
Coronary Care PD Adult	10,675	9,099				3,325	
CCU Occupied	86.0%	95.9%	NA	NA	NA	91.1%	
Pediatric IC Available	8	20					
Pediatric IC PD Pediatric	1,654	5,966					
PICU Occupied	56.6%	81.7%	NA	NA	NA	NA	
Neonatal IC Available	45	23	15	4			
Neonatal IC PD Pediatric	12,774	6,746	4,095	1,526			
NICU Occupied	77.8%	80.4%	74.8%	104.5%	NA	NA	
Burn Care Available							
Burn Care PD Adult							
Burn Care PD Pediatric							
Burn Care Occupied	NA	NA	NA	NA	NA	NA	
Other IC Available						10	
Other IC PD Adult						2,987	
Other IC PD Pediatric							
Other ICU Occupied	NA	NA	NA	NA	NA	81.8%	
Definitive Observation Available	88	53		6	42		
Definitive Observation PD Adult	29,044	12,929		1,967	8,029		
Definitive Observation PD Pediatric							
DOU Occupied	90.4%	66.8%	NA	89.8%	52.4%	NA	
Medical/Surgical Acute Available	468	385	223	164	140	245	
Medical/Surgical Acute PD Adult	151,671	98,524	29,792	50,995	17,117	35,313	
Medical/Surgical Occupied	88.8%	70.1%	36.6%	85.2%	33.5%	39.5%	
Pediatric Acute Available	31	78	12				
Pediatric Acute PD Pediatric	6,954	19,384	1,250				
Pediatrics Occupied	61.5%	68.1%	28.5%	NA	NA	NA	
Obstetrics Acute Available	64	30	19	34			
Obstetrics Acute PD Adult	20,604	5,675	7,967	7,326			
Obstetrics Occupied	88.2%	51.8%	114.9%	59.0%	NA	NA	

Appendix E

Table 16

Los Angeles County - Cedars Sinai Medical Center

Figure	CEDARS~SINAI MEDICAL CENTER	UCLA MEDICAL CENTER	SANTA MONICA - UCLA MEDICAL CENTER	SAINT JOHN'S HEALTH CENTER	MIDWAY HOSPITAL MEDICAL CENTER	BROTMAN MEDICAL CENTER	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available							
Alternate Birthing Center PD Adult							
ABC Occupied	NA	NA	NA	NA	NA	NA	
Physical Rehabilitation Care Available	29					32	
Physical Rehabilitation Care PD Adult	10,317					9,709	
Physical Rehabilitation Care PD Pediatrics							
Rehab Occupied	97.5%	NA	NA	NA	NA	83.1%	
Other Acute Care Available		11			10		
Other Acute Care PD Adult		1,633			2,260		
Other Acute Care PD Pediatric							
Other Acute Occupied	NA	40.7%	NA	NA	61.9%	NA	
Total Licensed	898	670	337	233	225	420	
Total Available	875	670	337	233	225	385	
Total Staffed	735	250	73	436	410	85	
Total PD Adult	258,004	140,421	57,235	67,914	35,916	77,070	
Total PD Pediatrics	21,382	32,096	5,345	1,526			
Total Discharge Total	45,043	27,725	10,644	13,761	5,060	9,718	
GAC Available Beds	807	670	291	233	204	297	
GAC PD	256,897	172,517	48,905	69,440	31,154	51,334	
ADC	704	473	134	190	85	141	
Available Occupied	87.2%	70.5%	46.0%	81.7%	41.8%	47.4%	
ADC at 80% Occupied	645.6	536.0	232.8	186.4	163.2	237.6	
Excess Beds	(58.2)	63.4	98.8	(3.8)	77.8	97.0	333.1
PERS PD	462						
PERS ADC	1.27						
Beds Needed at 80%	1.58						
Distance From Hospital 1 (in miles)		4.3	9.9	9.4	2.3	4.7	
Travel Time From Hospital 1 (in minutes)		12	18	17	6	12	
Distance From Hospital 2 (in miles)							
Travel Time From Hospital 2 (in minutes)							

Appendix E

Table 17

Los Angeles County - St. Mary Medical Center

Figure	ST. MARY MEDICAL CENTER	LONG BEACH MEMORIAL MEDICAL CENTER	LAKEWOOD REGIONAL MEDICAL CENTER	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	39	61	31	
Medical/Surgical IC PD Adult	5,698	20,644	6,765	
ICU Occupied	40.0%	92.7%	59.8%	
Coronary Care Available				
Coronary Care PD Adult				
CCU Occupied	NA	NA	NA	
Pediatric IC Available	8			
Pediatric IC PD Pediatric	1,109			
PICU Occupied	38.0%	NA	NA	
Neonatal IC Available	25			
Neonatal IC PD Pediatric	4,940			
NICU Occupied	54.1%	NA	NA	
Burn Care Available				
Burn Care PD Adult				
Burn Care PD Pediatric				
Burn Care Occupied	NA	NA	NA	
Other IC Available				
Other IC PD Adult				
Other IC PD Pediatric				
Other ICU Occupied	NA	NA	NA	
Definitive Observation Available	40	28	32	
Definitive Observation PD Adult	13,010	6,470	9,327	
Definitive Observation PD Pediatric				
DOU Occupied	89.1%	63.3%	79.9%	
Medical/Surgical Acute Available	101	285	51	
Medical/Surgical Acute PD Adult	19,842	84,465	16,061	
Medical/Surgical Occupied	53.8%	81.2%	86.3%	
Pediatric Acute Available	28			
Pediatric Acute PD Pediatric	2,972			
Pediatrics Occupied	29.1%	NA	NA	
Obstetrics Acute Available	37		10	
Obstetrics Acute PD Adult	7,960		2,582	
Obstetrics Occupied	58.9%	NA	70.7%	

Appendix E

Table 17

Los Angeles County - St. Mary Medical Center

Figure	ST. MARY MEDICAL CENTER	LONG BEACH MEMORIAL MEDICAL CENTER	LAKEWOOD REGIONAL MEDICAL CENTER	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available		83		
Alternate Birthing Center PD Adult		2,479		
ABC Occupied	NA	8.2%	NA	
Physical Rehabilitation Care Available	46	42	19	
Physical Rehabilitation Care PD Adult	13,637	7,762	3,601	
Physical Rehabilitation Care PD Pediatrics				
Rehab Occupied	81.2%	50.6%	51.9%	
Other Acute Care Available				
Other Acute Care PD Adult				
Other Acute Care PD Pediatric				
Other Acute Occupied	NA	NA	NA	
Total Licensed	431	541	161	
Total Available	427	541	161	
Total Staffed	75	136	339	
Total PD Adult	75,263	129,494	42,289	
Total PD Pediatrics	9,021			
Total Discharge Total	13,843	28,976	9,665	
GAC Available Beds	324	499	143	
GAC PD	69,168	121,820	38,336	
ADC	190	334	105	
Available Occupied	58.5%	66.9%	73.4%	
ADC at 80% Occupied	259.2	399.2	114.4	
Excess Beds	69.7	65.4	9.4	74.8
PERS PD	142			
PERS ADC	0.39			
Beds Needed at 80%	0.49			
Distance From Hospital 1 (in miles)		2.5	11.7	
Travel Time From Hospital 1 (in minutes)		6	18	
Distance From Hospital 2 (in miles)				
Travel Time From Hospital 2 (in minutes)				

Appendix E

Table 18

Los Angeles County - Presbyterian Intercommunity Hospital

Figure	PRESBYTERIAN INTERCOMMUNITY HOSPITAL	WHITTIER HOSPITAL MEDICAL CENTER	LONG BEACH MEMORIAL MEDICAL CENTER	ST. JOSEPH HOSPITAL	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	24	16	61	27	
Medical/Surgical IC PD Adult	5,312	4,357	20,644	6,642	
ICU Occupied	60.6%	74.6%	92.7%	67.4%	
Coronary Care Available				11	
Coronary Care PD Adult				2,468	
CCU Occupied	NA	NA	NA	61.5%	
Pediatric IC Available					
Pediatric IC PD Pediatric					
PICU Occupied	NA	NA	NA	NA	
Neonatal IC Available	26			14	
Neonatal IC PD Pediatric	6,812			1,516	
NICU Occupied	71.8%	NA	NA	29.7%	
Burn Care Available					
Burn Care PD Adult					
Burn Care PD Pediatric					
Burn Care Occupied	NA	NA	NA	NA	
Other IC Available					
Other IC PD Adult					
Other IC PD Pediatric					
Other ICU Occupied	NA	NA	NA	NA	
Definitive Observation Available	36	49	28	57	
Definitive Observation PD Adult	8,816	10,833	6,470	12,978	
Definitive Observation PD Pediatric					
DOU Occupied	67.1%	60.6%	63.3%	62.4%	
Medical/Surgical Acute Available	116	58	285	163	
Medical/Surgical Acute PD Adult	29,864	11,563	84,465	44,626	
Medical/Surgical Occupied	70.5%	54.6%	81.2%	75.0%	
Pediatric Acute Available	26	8			
Pediatric Acute PD Pediatric	1,561	510			
Pediatrics Occupied	16.4%	17.5%	NA	NA	
Obstetrics Acute Available		28		57	
Obstetrics Acute PD Adult		5,098		12,768	
Obstetrics Occupied	NA	49.9%	NA	61.4%	

Appendix E

Table 18

Los Angeles County - Presbyterian Intercommunity Hospital

Figure	PRESBYTERIAN INTERCOMMUNITY HOSPITAL	WHITTIER HOSPITAL MEDICAL CENTER	LONG BEACH MEMORIAL MEDICAL CENTER	ST. JOSEPH HOSPITAL	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available	32		83		
Alternate Birthing Center PD Adult	8,264		2,479		
ABC Occupied	70.8%	NA	8.2%	NA	
Physical Rehabilitation Care Available	17		42		
Physical Rehabilitation Care PD Adult	1,992		7,762		
Physical Rehabilitation Care PD Pediatrics					
Rehab Occupied	32.1%	NA	50.6%	NA	
Other Acute Care Available					
Other Acute Care PD Adult					
Other Acute Care PD Pediatric					
Other Acute Occupied	NA	NA	NA	NA	
Total Licensed	327	181	541	425	
Total Available	327	181	541	366	
Total Staffed	225	153	136	366	
Total PD Adult	66,646	39,645	129,494	88,111	
Total PD Pediatrics	8,373	510		1,516	
Total Discharge Total	16,815	9,115	28,976	22,158	
GAC Available Beds	277	159	499	329	
GAC PD	62,621	32,361	121,820	80,998	
ADC	172	89	334	222	
Available Occupied	61.9%	55.8%	66.9%	67.5%	
ADC at 80% Occupied	221.6	127.2	399.2	263.2	
Excess Beds	50.0	38.5	65.4	41.3	145.3
PERS PD	629				
PERS ADC	1.72				
Beds Needed at 80%	2.15				
Distance From Hospital 1 (in miles)		3	19.2	20.7	
Travel Time From Hospital 1 (in minutes)		7	24	27	
Distance From Hospital 2 (in miles)					
Travel Time From Hospital 2 (in minutes)					

Appendix E

Table 19

Los Angeles County - West Hills Hospital and Medical Center

Figure	WEST HILLS HOSPITAL AND MEDICAL CENTER	ENCINO-TARZANA REGIONAL MEDICAL CENTER	ENCINO-TARZANA REGIONAL MEDICAL CENTER	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	8	18		
Medical/Surgical IC PD Adult	2,057	6,752		
ICU Occupied	70.4%	102.8%	NA	
Coronary Care Available	8		15	
Coronary Care PD Adult	1,844		2,878	
CCU Occupied	63.2%	NA	52.6%	
Pediatric IC Available		7		
Pediatric IC PD Pediatric		931		
PICU Occupied	NA	36.4%	NA	
Neonatal IC Available	11	17		
Neonatal IC PD Pediatric	1,458	4,723		
NICU Occupied	36.3%	76.1%	NA	
Burn Care Available				
Burn Care PD Adult				
Burn Care PD Pediatric				
Burn Care Occupied	NA	NA	NA	
Other IC Available				
Other IC PD Adult				
Other IC PD Pediatric				
Other ICU Occupied	NA	NA	NA	
Definitive Observation Available		26		
Definitive Observation PD Adult		8,345		
Definitive Observation PD Pediatric				
DOU Occupied	NA	87.9%	NA	
Medical/Surgical Acute Available	154	108	69	
Medical/Surgical Acute PD Adult	26,115	31,919	14,578	
Medical/Surgical Occupied	46.5%	81.0%	57.9%	
Pediatric Acute Available	7	8		
Pediatric Acute PD Pediatric	1,149	2,671		
Pediatrics Occupied	45.0%	91.5%	NA	
Obstetrics Acute Available	24	27		
Obstetrics Acute PD Adult	3,915	9,034		
Obstetrics Occupied	44.7%	91.7%	NA	

Appendix E

Table 19

Los Angeles County - West Hills Hospital and Medical Center

Figure	WEST HILLS HOSPITAL AND MEDICAL CENTER	ENCINO-TARZANA REGIONAL MEDICAL CENTER	ENCINO-TARZANA REGIONAL MEDICAL CENTER	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available				
Alternate Birthing Center PD Adult				
ABC Occupied	NA	NA	NA	
Physical Rehabilitation Care Available			25	
Physical Rehabilitation Care PD Adult			6,026	
Physical Rehabilitation Care PD Pediatrics				
Rehab Occupied	NA	NA	66.0%	
Other Acute Care Available				
Other Acute Care PD Adult				
Other Acute Care PD Pediatric				
Other Acute Occupied	NA	NA	NA	
Total Licensed	236	236	151	
Total Available	236	211	151	
Total Staffed	337	161	193	
Total PD Adult	38,951	56,050	35,464	
Total PD Pediatrics	2,607	8,325		
Total Discharge Total	8,214	13,245	3,855	
GAC Available Beds	212	211	109	
GAC PD	36,538	64,375	23,482	
ADC	100	176	64	
Available Occupied	47.2%	83.6%	59.0%	
ADC at 80% Occupied	169.6	168.8	87.2	
Excess Beds	69.5	(7.6)	22.9	15.3
PERS PD	61			
PERS ADC	0.17			
Beds Needed at 80%	0.21			
Distance From Hospital 1 (in miles)		8.4	8.4	
Travel Time From Hospital 1 (in minutes)		14	14	
Distance From Hospital 2 (in miles)				
Travel Time From Hospital 2 (in minutes)				

Appendix E

Table 20

Los Angeles County - USC University Hospital

Figure	USC UNIVERSITY HOSPITAL	UCLA MEDICAL CENTER	ST. VINCENT MEDICAL CENTER	GOOD SAMARITAN HOSPITAL	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	26	44	24	41	
Medical/Surgical IC PD Adult	8,615	12,561	2,463	11,231	
ICU Occupied	90.8%	78.2%	56.7%	75.0%	
Coronary Care Available	8	26	43	10	
Coronary Care PD Adult	2,626	9,099	2,095	2,687	
CCU Occupied	89.9%	95.9%	26.9%	73.6%	
Pediatric IC Available		20			
Pediatric IC PD Pediatric		5,966			
PICU Occupied	NA	81.7%	NA	NA	
Neonatal IC Available		23		23	
Neonatal IC PD Pediatric		6,746		7,461	
NICU Occupied	NA	80.4%	NA	88.9%	
Burn Care Available					
Burn Care PD Adult					
Burn Care PD Pediatric					
Burn Care Occupied	NA	NA	NA	NA	
Other IC Available					
Other IC PD Adult					
Other IC PD Pediatric					
Other ICU Occupied	NA	NA	NA	NA	
Definitive Observation Available	65	53		76	
Definitive Observation PD Adult	16,813	12,929		20,617	
Definitive Observation PD Pediatric					
DOU Occupied	70.9%	66.8%	NA	74.3%	
Medical/Surgical Acute Available	92	385	224	130	
Medical/Surgical Acute PD Adult	34,768	98,524	23,039	30,204	
Medical/Surgical Occupied	103.5%	70.1%	56.8%	63.7%	
Pediatric Acute Available		78			
Pediatric Acute PD Pediatric		19,384			
Pediatrics Occupied	NA	68.1%	NA	NA	
Obstetrics Acute Available		30		31	
Obstetrics Acute PD Adult		5,675		10,703	
Obstetrics Occupied	NA	51.8%	NA	94.6%	

Appendix E

Table 20

Los Angeles County - USC University Hospital

Figure	USC UNIVERSITY HOSPITAL	UCLA MEDICAL CENTER	ST. VINCENT MEDICAL CENTER	GOOD SAMARITAN HOSPITAL	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available					
Alternate Birthing Center PD Adult					
ABC Occupied	NA	NA	NA	NA	
Physical Rehabilitation Care Available	32			23	
Physical Rehabilitation Care PD Adult	7,322			4,058	
Physical Rehabilitation Care PD Pediatrics					
Rehab Occupied	62.7%	NA	NA	48.3%	
Other Acute Care Available		11			
Other Acute Care PD Adult		1,633			
Other Acute Care PD Pediatric					
Other Acute Occupied	NA	40.7%	NA	NA	
Total Licensed	293	670	350	390	
Total Available	256	670	318	362	
Total Staffed	290	250	251	217	
Total PD Adult	73,401	140,421	31,755	86,933	
Total PD Pediatrics		32,096		7,461	
Total Discharge Total	8,505	27,725	5,069	17,003	
GAC Available Beds	223	670	291	334	
GAC PD	70,144	172,517	27,597	86,961	
ADC	192	473	152	238	
Available Occupied	86.2%	70.5%	52.4%	71.3%	
ADC at 80% Occupied	178.4	536.0	232.8	267.2	
Excess Beds	(13.8)	63.4	80.3	29.0	172.6
PERS PD	557				
PERS ADC	1.53				
Beds Needed at 80%	1.91				
Distance From Hospital 1 (in miles)		18.7	4.7	5.4	
Travel Time From Hospital 1 (in minutes)		24	10	11	
Distance From Hospital 2 (in miles)					
Travel Time From Hospital 2 (in minutes)					

Appendix E

Table 21

Orange County - Hoag Memorial Hospital Presbyterian

Figure	HOAG MEMORIAL HOSPITAL PRESBYTERIAN	FOUNTAIN VALLEY REGIONAL MEDICAL CENTER	MISSION HOSPITAL REGIONAL MEDICAL CENTER	ST. JOSEPH HOSPITAL	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	24	25	12	27	
Medical/Surgical IC PD Adult	5,605	7,309	3,493	6,642	
ICU Occupied	64.2%	80.1%	79.7%	67.4%	
Coronary Care Available	12		19	11	
Coronary Care PD Adult	3,855		6,982	2,468	
CCU Occupied	88.3%	NA	100.7%	61.5%	
Pediatric IC Available		11			
Pediatric IC PD Pediatric		2,502			
PICU Occupied	NA	62.3%	NA	NA	
Neonatal IC Available	12	23		14	
Neonatal IC PD Pediatric	3,787	7,099		1,516	
NICU Occupied	86.7%	84.6%	NA	29.7%	
Burn Care Available					
Burn Care PD Adult					
Burn Care PD Pediatric					
Burn Care Occupied	NA	NA	NA	NA	
Other IC Available	14				
Other IC PD Adult	4,530				
Other IC PD Pediatric					
Other ICU Occupied	88.9%	NA	NA	NA	
Definitive Observation Available		90		57	
Definitive Observation PD Adult		16,843		12,978	
Definitive Observation PD Pediatric					
DOU Occupied	NA	51.3%	NA	62.4%	
Medical/Surgical Acute Available	205	159	155	163	
Medical/Surgical Acute PD Adult	67,820	36,120	40,958	44,626	
Medical/Surgical Occupied	90.9%	62.2%	72.4%	75.0%	
Pediatric Acute Available	7	13			
Pediatric Acute PD Pediatric	969	4,105			
Pediatrics Occupied	38.0%	86.5%	NA	NA	
Obstetrics Acute Available	59	39	26	57	
Obstetrics Acute PD Adult	12,919	10,924	8,328	12,768	
Obstetrics Occupied	60.2%	76.7%	87.8%	61.4%	

Appendix E

Table 21

Orange County - Hoag Memorial Hospital Presbyterian

Figure	HOAG MEMORIAL HOSPITAL PRESBYTERIAN	FOUNTAIN VALLEY REGIONAL MEDICAL CENTER	MISSION HOSPITAL REGIONAL MEDICAL CENTER	ST. JOSEPH HOSPITAL	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available					
Alternate Birthing Center PD Adult					
ABC Occupied	NA	NA	NA	NA	
Physical Rehabilitation Care Available			28		
Physical Rehabilitation Care PD Adult			6,000		
Physical Rehabilitation Care PD Pediatrics					
Rehab Occupied	NA	NA	58.7%	NA	
Other Acute Care Available					
Other Acute Care PD Adult					
Other Acute Care PD Pediatric					
Other Acute Occupied	NA	NA	NA	NA	
Total Licensed	409	400	277	425	
Total Available	353	400	254	366	
Total Staffed	353	400	242	366	
Total PD Adult	99,200	79,114	68,834	88,111	
Total PD Pediatrics	4,756	13,706		1,516	
Total Discharge Total	24,731	17,959	14,769	22,158	
GAC Available Beds	333	360	240	329	
GAC PD	99,485	84,902	65,761	80,998	
ADC	273	233	180	222	
Available Occupied	82.1%	64.6%	75.1%	67.5%	
ADC at 80% Occupied	266.4	288.0	192.0	263.2	
Excess Beds	(6.9)	55.4	11.8	41.3	108.5
PERS PD	423				
PERS ADC	1.16				
Beds Needed at 80%	1.45				
Distance From Hospital 1 (in miles)		9.3	20.6	14.9	
Travel Time From Hospital 1 (in minutes)		14	25	18	
Distance From Hospital 2 (in miles)					
Travel Time From Hospital 2 (in minutes)					

Appendix E

Table 22

Ventura County - St. John's Regional Medical Center / St. John's Pleasant Valley Hospital

Figure	ST. JOHN'S REGIONAL MEDICAL CENTER	ST. JOHN'S PLEASANT VALLEY HOSPITAL	COMMUNITY MEMORIAL HOSPITAL OF SAN BUENAVENTURA	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Medical/Surgical IC Available	10	8	11	
Medical/Surgical IC PD Adult	3,138	2,134	3,094	
ICU Occupied	86.0%	73.1%	77.1%	
Coronary Care Available	10		10	
Coronary Care PD Adult	3,281		3,672	
CCU Occupied	89.9%	NA	100.6%	
Pediatric IC Available				
Pediatric IC PD Pediatric				
PICU Occupied	NA	NA	NA	
Neonatal IC Available	16		12	
Neonatal IC PD Pediatric	3,713		4,989	
NICU Occupied	63.6%	NA	113.9%	
Burn Care Available				
Burn Care PD Adult				
Burn Care PD Pediatric				
Burn Care Occupied	NA	NA	NA	
Other IC Available				
Other IC PD Adult				
Other IC PD Pediatric				
Other ICU Occupied	NA	NA	NA	
Definitive Observation Available				
Definitive Observation PD Adult				
Definitive Observation PD Pediatric				
DOU Occupied	NA	NA	NA	
Medical/Surgical Acute Available	157	66	160	
Medical/Surgical Acute PD Adult	32,966	8,672	40,572	
Medical/Surgical Occupied	57.5%	36.0%	69.5%	
Pediatric Acute Available				
Pediatric Acute PD Pediatric				
Pediatrics Occupied	NA	NA	NA	
Obstetrics Acute Available	28	7	27	
Obstetrics Acute PD Adult	5,558	1,533	8,522	
Obstetrics Occupied	54.4%	60.0%	86.5%	

Appendix E

Table 22

Ventura County - St. John's Regional Medical Center / St. John's Pleasant Valley Hospital

Figure	ST. JOHN'S REGIONAL MEDICAL CENTER	ST. JOHN'S PLEASANT VALLEY HOSPITAL	COMMUNITY MEMORIAL HOSPITAL OF SAN BUENAVENTURA	RECEIVING HOSPITALS' TOTAL EXCESS BEDS
Alternate Birthing Center Available				
Alternate Birthing Center PD Adult				
ABC Occupied	NA	NA	NA	
Physical Rehabilitation Care Available	23			
Physical Rehabilitation Care PD Adult	6,831			
Physical Rehabilitation Care PD Pediatrics				
Rehab Occupied	81.4%	NA	NA	
Other Acute Care Available				
Other Acute Care PD Adult				
Other Acute Care PD Pediatric				
Other Acute Occupied	NA	NA	NA	
Total Licensed	266	180	220	
Total Available	266	180	220	
Total Staffed	266	180	220	
Total PD Adult	57,075	36,426	55,860	
Total PD Pediatrics	3,713		4,989	
Total Discharge Total	13,567	4,093	14,478	
GAC Available Beds	244	81	220	
GAC PD	55,487	12,339	60,849	
ADC	152	34	167	
Available Occupied	62.3%	41.7%	75.8%	
ADC at 80% Occupied	195.2	64.8	176.0	
Excess Beds	43.2	31.0	9.3	9.3
PERS PD	205	55		
PERS ADC	0.56	0.15		
Beds Needed at 80%	0.70	0.19		
Distance From Hospital 1 (in miles)			15.9	
Travel Time From Hospital 1 (in minutes)			22	
Distance From Hospital 2 (in miles)				
Travel Time From Hospital 2 (in minutes)				

Name (PCP #2)	"	"	0	0	0	0	IPA/Medical Group 1	IPA/Medical Group 2
Name (PCP #3)	"	"	0	0	0	0	IPA/Medical Group 1	IPA/Medical Group 2
" "	"	"	0	0	0	0	IPA/Medical Group 1	IPA/Medical Group 2
" "	"	"	0	0	0	0	IPA/Medical Group 1	IPA/Medical Group 2
" "	"	"	0	0	0	0	IPA/Medical Group 1	IPA/Medical Group 2
Total PCP Capacity - Internal Medicine		0	0	0	0	0		

Pediatrics (Detail)

OB-GYN (Detail)

Other (Detail)

Report 1A Definitions:

Column (1)	Description of primary care physician (PCP) specialties available through receiving physician network
Column (2)	Total number of full time equivalent (FTE) PCPs accepting new patients through the receiving provider network
Column (3)	Total number of PCPs in the receiving provider network accepting new members
Column (4)	Total number of HMO patients that PCP is willing to accept through the receiving network
Column (5)	Total number of HMO members currently assigned to PCPs through the receiving network
Column (6)	Sum of Column (4) less Column (5) = the number of new HMO patients that can be assigned

Report 1B Definitions:

Column (1)	Physical name of PCP accepting new HMO members
Column (2)	Unique identifier of PCP accepting new HMO patients
Column (3)	Maximum HMO capacity of PCP through the receiving network (confirmed directly with PCP)
Column (4)	Total number of HMO members currently assigned to PCP through receiving network only
Column (5)	Additional HMO members that can be assigned to PCP through the receiving network (confirmed directly with PCP)
Column (6)	Board certification(s), if applicable
Column (7)	Name of other network affiliation, if any
Column (8)	Name of other network affiliation, if any
Column (9)	Name of primary hospital affiliation
Column (10)	Name of secondary hospital affiliation, if any

APPENDIX G

RECOMMENDED SPECIALISTS REPORTING FORMAT

Name of Receiving IPA/Medical Group	**ABC Medical Group, Inc.**
Geographical Service Area	**Sacramento County**
Effective Date of Specialty Information	**January 1, 2005**

Report 2A - Specialty Summary Information

Specialty Description	Total Specialty Physician Count (FTE)	# Specialists Accepting New Patients	Aggregate Capacity New HMO Patients
(1)	(2)	(3)	(4)
Specialty Physician Capacity:			
Allergy	0	0	0
Cardiology	0	0	0
Dermatology	0	0	0
Endocrinology	0	0	0
Gastroenterology	0	0	0
"	0	0	0
"	0	0	0
Urology	0	0	0
Total Specialty Capacity	0	0	0

Report 2B - Physician Specific Detailed Information

Specialty Description	Specialists Accepting New Referrals	Max. Patient Visits per Day (Full)	Actual Patient Visits per Day (All Payors)	Add'l HMO Patient Capacity per Day	Board Certification Primary	Board Certification Additional	Other Network Affiliation 1	Other Network Affiliation 2	Primary Hosp. Affiliation 1
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Allergy (Summary):									
Name (Allergist #1)	Unique Physician Identifier	0	0	0	Describe	Describe	IPA/Med Group 1	IPA/Med Group 2	Hospital
Name (Allergist #2)	" " "	0	0	0	Describe	Describe	IPA/Med Group 1	IPA/Med Group 2	Hospital
Name (Allergist #3)	" " "	0	0	0	Describe	Describe	IPA/Med Group 1	IPA/Med Group 2	Hospital
" "	" " "	0	0	0	Describe	Describe	IPA/Med Group 1	IPA/Med Group 2	Hospital
" "	" " "	0	0	0	Describe	Describe	IPA/Med Group 1	IPA/Med Group 2	Hospital #
" "	" " "	0	0	0	Describe	Describe	IPA/Med Group 1	IPA/Med Group 2	Hospital #

Total Specialty Capacity	0	0	0	0						

Cardiology (Summary):

Name (Cardiologist #1)	Unique Physician Identifier	0	0	0	Describe	Describe	IPA/Med Group 1	IPA/Med Group 2	Hospital #1	Hospital #2
Name (Cardiologist #2)	" " "	0	0	0	Describe	Describe	IPA/Med Group 1	IPA/Med Group 2	Hospital #1	Hospital #2
Name (Cardiologist #3)	" " "	0	0	0	Describe	Describe	IPA/Med Group 1	IPA/Med Group 2	Hospital #1	Hospital #2
" "	" " "	0	0	0	Describe	Describe	IPA/Med Group 1	IPA/Med Group 2	Hospital #1	Hospital #2
" "	" " "	0	0	0	Describe	Describe	IPA/Med Group 1	IPA/Med Group 2	Hospital #1	Hospital #2
" "	" " "	0	0	0	Describe	Describe	IPA/Med Group 1	IPA/Med Group 2	Hospital #1	Hospital #2
Total Specialty Capacity	0	0	0	0						

Report 2A Definitions:

Column (1)	Description of referral specialties available through the receiving physician network
Column (2)	Total number of full time equivalent (FTE) specialties available through the receiving provider network
Column (3)	Total number of specialists in the receiving provider network accepting new referrals
Column (4)	Aggregate referral capacity of all physicians in each specialty to accept new members

Report 2B Definitions:

Column (1)	Name of each specialist accepting new HMO patient referrals
Column (2)	Unique identifier of each specialists accepting new HMO patient referrals
Column (3)	Maximum patient referral capacity of each specialist (as confirmed with specialist directly)
Column (4)	actual number of patient visits per day across all payors/affiliations (as confirmed with specialist directly)
Column (5)	Additional (HMO) patient referral capacity available
Column (6)	Specialist's primary board certification, if applicable
Column (7)	Additional board certifications, if applicable
Column (8)	Name of second network affiliation, if any
Column (9)	Name of third network affiliation, if any
Column (10)	Name of primary hospital affiliation
Column (11)	Name of secondary hospital affiliation, if any

APPENDIX H- CONSULTANTS & STAFF

The Consulting Team

Karen Taranto - Principal, pmpm® Consulting, Inc.

Ms. Taranto has more than 30 years of experience in the health care field. She has specific expertise in the development and administration of managed health care systems, specializing in operations. As co-founder of ***pmpm®*** Consulting Group Inc., established in 1994, Ms. Taranto serves a national clientele, working with physicians and physician organizations, hospitals and integrated delivery systems, health plans, public and community-based health care entities, and other health care professionals.

Ms. Taranto's experience includes senior level positions in hospitals, Health Maintenance Organizations, Independent Practice Associations, and Physician Management Companies. Through these diversified health care leadership roles, Ms. Taranto has acquired an experience base that includes the full range of activities associated with the development and management of MSO, PHO, and IPA entities. She has specific expertise in the building and implementation of utilization and quality management programs, provider and member services departments, business office functions including claims adjudication and revenue recovery operations, and evaluation, selection and oversight of the installation of management information systems. Ms. Taranto also has direct hands-on experience with the development of complete Knox-Keene licensure applications, as well as the direction and oversight of the entire filing process.

***Russell D. Foster* -** Principal, pmpm® Consulting, Inc.

Mr. Foster has over 20 years of experience in development and management of health care systems, including expertise in capitation agreements, rate development methodology, and business plan development. Specializing in financial modeling and analysis, he co-founded ***pmpm®*** Consulting Group Inc., where he works with clients nationwide in financial modeling and analysis relating to IPA and MSO development and enhancement, capitated reimbursement programs, design and analysis of utilization and cost structures, and all other aspects of managed care systems. He also served as Executive Director for two IPAs and one MSO. Mr. Foster had primary responsibility for several groundbreaking projects. He developed and implemented a capitated Medicaid program in Kansas City, Missouri. This project resulted in the development of Missouri's capitation rate methodology, a utilization and cost reporting system, and an annual financial compliance audit program. He managed JBI's MediCal claims processing centers in Santa Barbara and Monterey, California, developing the first fully automated personal physician

accounting system for MediCal providers.. Mr. Foster served for five years as Chief of the Financial and Management Evaluation Section of the California Department of Health Services Audits and Investigations Division. Here he planned, organized and directed the audits of all capitated MediCal provider organizations. He was responsible for conducting annual examinations of utilization and cost reports. He also developed and negotiated annual capitation rates for the State of California.

***Max C. Jack* -** Principal, pmpm® Consulting, Inc.

Mr. Jack has more than twenty-five years of experience in developing successful collaborative ventures among health care providers, insurers and employers. He is a skilled strategic planner, problem-solver, facilitator and project manager.

Mr. Jack's experience in the health care industry includes creating successful organizations and long -term business relationships among healthcare providers, payors and vendors. His consulting activities have spanned medical group and network formation, physician compensation program design, physician and hospital alliance and venture development, clinical service line program development, health system integration, managed care contracting strategy development and negotiation, development of public-private partnerships and development of direct contracting models of employee health programs.

Mr. Jack received a Masters of Public Health from the University of California in Berkeley. He is an active member of the Managed Care Committee of the Northern California Healthcare Financial Management Association.

Henry W. Zaretsky, Ph.D. – President, Henry W. Zaretsky & Associates, Inc.

Dr. Zaretsky has over 30 years of experience in the health care field. He established his own health care consulting firm in 1981. His firm provides consulting services in the areas of strategic planning, HMO development, reimbursement, economic analysis, market studies, payment negotiations, litigation support and policy analysis. Prior to this, he served as Director of the Office of Statewide Health Planning and Development for the State of California, appointed by Governor Edmund G. Brown, Jr. He was the first director of that department, which administered California's health planning program; developed the State Health Plan, as a basis for State health policy; administered a State guaranteed mortgage program for health facilities; approved architectural plans for health facilities; developed a biennial State health manpower plan; conducted pilot projects in the use of health personnel; administered programs to encourage availability of medical personnel in

needed areas and specialties; and coordinated the health planning functions of all health-related departments. He also served for six years as the Director of Research and Development for the California Hospital Association.

Dr. Zaretsky holds academic degrees in economics (both undergraduate and graduate) from San Francisco State University and a doctorate in economics from the University of California, Davis. He currently serves as adjunct faculty at the University of Southern California Graduate Program in Health Services Administration where he teaches a course in Healthcare Economics

Department of Managed Health Care Staff

William J. Barcellona (Bill)

Bill Barcellona is the Deputy Director for Plan-Provider Relations for the Department of Managed Health Care in Sacramento, California. He joined the Department in June 2001 as the Department formed the Special Compliance Branch to respond to the increasing trend of provider contract terminations and closures in the California HMO industry, serving as its first chief. He has managed more than 550 block transfers of enrollees in his time with the Department; seeing more than 4 million enrollees moved safely to new providers and hospitals. In 2002, Bill managed the allocation of thousands of enrollees out of two insolvent HMOs, Lifeguard and Health Plan of the Redwoods. In 2003, Bill served as the lead drafter of AB 1286/SB 244, the Continuity of Care law. Bill was promoted to Chief of the Licensing Division in 2004, and has worked to restructure the business processes surrounding the timeliness and efficiency of health plan licensure filings within the Department. Bill is working on a Masters in Healthcare Administration at the University of Southern California and is deeply interested in health care policy issues. He has practiced law for 19 years in California, most recently as a partner with the Sacramento firm of Greve, Clifford, Wengel & Paras, LLP. Bill received degrees from California State University at Fullerton in 1982 (Political Science) and Western State University in 1985 (J.D.).

Mike Punja

Mike Punja is a staff counsel with the DMHC. He has been with DMHC since May 2001. The team he heads in Licensing handles a wide range of issues including plan continuity of care policies, block transfers of enrollees due to provider disruptions, service area expansions and withdrawals and license surrenders. Since working at the Department, he has reviewed over 800 block transfer filings and reviewed and approved almost 30 continuity of care policy filings in 2004. Mike received his BA in International Studies at University of Washington in Seattle, Washington and is a graduate of the Northwestern School of Law of Lewis and Clark College in Portland, Oregon

Ellen Badley

Ellen Badley is a Health Care Service Plan Analyst in the Division of Licensing for the Department of Managed Health Care. Prior to joining the Department in 2004, she served for nine years as the executive director of the San Joaquin Medical Society, a professional association for physicians. During her tenure with the DMHC she has worked on the development of new processes to streamline the Licensing Division. She is currently a Masters Candidate in Health Care Administration at the University of Southern California. Her undergraduate degree from California State University, Fresno is in Business Administration with a Health Care Management Emphasis.