

**SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER
SENIORS AND PERSONS WITH DISABILITIES (SPD) TECHNICAL WORKGROUP
Meeting #2 – Thursday, February 25, 2010
10:00am – 3:00pm
Sacramento Convention Center, Room 103**

The meeting convened at 10:05 AM.

Attendance

Technical Workgroup members attending: Richard Bock, Molina Healthcare of California; Alex Briscoe, Alameda County Health Care Services Agency; David Ford, California Medical Association; Mary Giammona, San Mateo Health Plan; Bradley Gilbert, Inland Empire Health Plan; Michael Humphrey, Sonoma County In-Home Supportive Services Public Authority; Jerry Jeffe, California Council of Community Mental Health Agencies; Lisa Kodmur, LA Care Health Plan; Elizabeth Landsberg, Western Center on Law and Poverty; Jackie McGrath, California Council of the Alzheimer's Association; Christina Mills, California Foundation for Independent Living Centers; Santiago Munoz, University of California; Erica Murray, California Association of Public Hospitals; Chris Perrone, California Healthcare Foundation (by phone); Cheryl Phillips, On Lok Lifeways; Brenda Premo, Western University of Health Sciences; Jacqueline Ritacco, AltaMed Health Services; Deb Roth, SEIU; Leila Saadat, Alameda Alliance for Health; Margaret Tatar, CalOptima; Casey Young, AARP.

Others attending: David Maxwell-Jolly, Director, Department of Health Care Services (DHCS); Gregory Franklin, Director of Medi-Cal Operations and Project Director, 1115 Demonstration Waiver Project, DHCS; Tanya Homman, DHCS; Rita Marowitz, DHCS; Luis Rico, DHCS; Bobbie Wunsch, Pacific Health Consulting Group.

Public in Attendance: 24 individuals attended in person, and 31 people called in on the listen-only telephone line.

Welcome and Introductions; Overview of the Purpose and Desired Outcomes of the SPD Technical Workgroup; Workgroup Structure and Process

Bobbie Wunsch, Pacific Health Consulting Group, introduced the structure of the meeting, and welcomed participants on the phone. The agenda focuses on Utilization and on Performance Standards and Monitoring. The afternoon agenda includes small groups on what it would take to assure access to services and quality in Medi-Cal managed care, assuming that CHCF recommendations are adopted.

Subsequent meetings will focus on consumer protections, enrollment issues, and other issues necessary to consider should the state implement the transition of SPD into mandatory managed care.

Tanya Homman discussed the 23 documents that have been posted on the SPD TWG website since the last meeting on February 4. Those materials are available at <http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupSPDs.aspx>

Elizabeth Landsberg, WCLP asked if and when FFS data on this population will be made available to the Workgroup. Tanya Homman said that the fourth meeting will focus on data from the FFS system. Elizabeth also said that the authorizing legislation refers to managed care or other organized delivery system, and urged the group to think of their charge as developing protections for any organized delivery system, and not assume only the existing Medi-Cal managed care systems.

Overview of Current State Practices in Managed Care – Monitoring/Performance Standards

Rita Marowitz, Program Data & Performance Measurement Section Chief, Medi-Cal Managed Care, DHCS provided an overview of the existing monitoring and performance standards for Medi-Cal managed care. Highlights of the presentation included the following:

HEDIS “Use of Services” Measures

- Picking the HEDIS measures involves balancing concerns about cost, demographics, and burden on plans. When DHCS first began requiring reporting, HEDIS measures required differed by model, but the Department has moved to requiring consistent measures.
- Plans that score below the 25th percentile for Medicaid plans must submit an improvement plan.
- In addition to measures compiled and submitted monthly, plans must provide additional utilization data annually. These measures can't be audited externally (due to cost), but plans are all using NCQA specifications so DHCS is confident that these data also are unbiased and complete.
- The original HEDIS measures focused on women and children, but DHCS has since added measures more relevant to the members with chronic diseases (e.g., asthma and diabetes) and SPD populations (e.g., imaging for low back pain).
- DHCS has to be cognizant of that SPDs represent a small percentage of mandatory enrollees and can't switch required measures too often. In addition, six of the required HEDIS measures are used for the auto assignment default program, which must be considered when changing measures.

Consumer Satisfaction -- CAHPS

- Every other year, plans are required to have members participate in a consumer satisfaction survey. It is very expensive, requires a NCQA-certified vendor, and also requires significant phone follow-up.
- NCQA-certified versions of the survey are only available only in English and Spanish. DHCS does intend to administer the survey in other languages as certified versions become available.

Quality Improvement

- Plans are required to have 2 Quality Improvement Projects (QIPS) underway at all times, which are validated on an annual basis by external review organization to assure compliance with federal requirements for QIPs.

Observations Re: Utilization Differences Among/Between Models

- Inpatient utilization is higher overall for COHS, although not in all age bands
- Maternity inpatient utilization is similar across all models.
- Cost of prescriptions is markedly higher for COHS beginning at ages 18-34 and continuing to ages 75-84.
- Number of prescriptions for COHS begin to increase relative to other models at ages 35-49 and continuing.
- Some of the differences seen in COHS are likely due to the greater numbers of SPD in those plans.

Performance Measurement Findings 2009

- In general, Medi-Cal managed care plans show an upward trend over time.
- Plans perform particularly well on: immunizations, well-child visits at ages 2 - 10, appropriate treatment for upper respiratory infections in children
- Plans perform somewhat poorly on: timeliness of prenatal care, postpartum care, well-child visits in months 1 – 15, adolescent care, avoidance of inappropriate antibiotics in adults
- COHS plans outperform GMC and Two-Plan plans on most measures, probably because of the greater continuity of enrolled members.

Cheryl Phillips, On Lok Lifeways expressed concerns about taking measurements for younger populations and applying them to SPDs. Specifically, none of the HEDIS measures for chronic care go beyond age 75. She said this is appropriate, since we can harm people when we apply these measures to the frail elderly. While they may apply to younger PWDs, a 92-year-old bed-bound woman with Alzheimer's probably shouldn't have a mammogram, colonoscopy, or aggressive diabetes treatment. HEDIS misses the boat for this frail and vulnerable population.

Mary Giammona, Health Plan of San Mateo echoed and amplified these concerns:

- Data is missing for Medi-Medis: in the Health Plan of San Mateo, as members became dually eligible, they lost data concerning their hospitalizations, ED use, and all the other things that Medicare pays for. Now that HPSM has a special needs plan (SNP), and 60% of Medi-Medis have enrolled in it, they use 13 HEDIS structural process measures that are also Medicare measures.
- Measures designed for the elderly often are inappropriate for their younger dual-eligibles, many of whom have SMI or DD – they had to justify being so high in deliveries, for example, but it's because they have younger women enrolled.
- Standard utilization measures also don't work well for their elderly members with SMI or DD: they may be taking drugs that are contraindicated for the elderly, but that they need to maintain in the community.

Brad Gilbert, IEHP said that:

- 1) The vast majority of the population under discussion by the Workgroup is under 65 and PWD, so HEDIS chronic disease measures seem reasonable to consider.
- 2) The level of resources required to accomplish HEDIS reporting, chart abstraction, and encounter data reporting is significant. IEHP is sending 65 staff out for 2 – 4

weeks to do chart abstraction for HEDIS reporting, for example. It is difficult to think of entities other than managed care plans that could meet these requirements.

- 3) A number of health plans are NCQA-accredited, and that accreditation has its own monitoring and reporting requirements, with approximately 40-50 HEDIS measures.
- 4) IEHP does a separate consumer satisfaction survey with its members who have disabilities.

Michael Humphrey, IHSS Public Authority, Sonoma County, suggested that an important area for measurement was around discharge from acute care settings and subsequent disposition, whether to LTC or home. Rita Marowitz said this data is not available from the DHCS database, and would have to come from plans. Bobbie Wunsch asked whether plans were able to look at that link back to home and community-based services.

Jackie McGrath, Alzheimer's Association asked how the data on top 20 diagnoses presented by DHCS was used. Rita Marowitz responded that in FFS, they can identify the relative costs of different diagnoses by looking at encounter data. Since DHCS doesn't get the cost of each encounter in managed care, they pulled the diagnoses and divided them by aid code. Exactly how the information will be used is not yet known, and staff are working on more refined analysis.

Deb Roth, SEIU asked whether the same patient could be represented in more than one diagnosis code, and Rita Marowitz said that this was true. *Richard Bock, Molina Healthcare* said that without frequency information, the title of "top diagnoses" is misleading and should be changed.

Jerry Jeffe, CCCHMA noted that while many seniors have depression, that diagnosis did not make the list. He suggested that DHCS track prescriptions by age as a way at getting at depression. Rita Marowitz responded that since mental health is largely carved out of Medi-Cal managed care, this data is limited (i.e., prescriptions for anti-psychotics). When depression comes up during a preventive visit, that diagnosis may not be indicated in the encounter data. Other states have said that to get really good information you have to go to the chart level, and one approach is to pay extra to get that information directly from the providers.

Mary Giammona said that capitated physicians don't have much incentive to submit encounter data, so HPSM has begun paying a small amount for that data and reporting has increased by 20%. They are hoping that ARRA funds for electronic health records will help.

David Ford said that the comparisons across plans aren't apples to apples, and that a more relevant comparison might be COHS and FFS. Rita Marowitz responded that unfortunately, FFS does not have HEDIS measures.

In response to a question about what happens to plans with low scores in HEDIS measures, Rita Marowitz said that when a plan falls below the 25% Medicaid plan level (MPL) benchmark on any individual measure, they have to submit an improvement plan. Few plans stay below MPL for more than a few years. DHCS does not use take a punitive approach, but rather works with plans to encourage ongoing improvement. DHCS does reward good performance by giving those plans more default enrollment.

CHCF Recommendations: Utilization Data and Monitoring/Performance Standards
Performance Measurement in Medicaid Managed Care for SPD

Brenda Premo, Western University of Health Sciences led a presentation focused on the 2005 report *Performance Standards for Medi-Cal Managed Care Organizations Serving Persons with Disabilities and Chronic Conditions*, prepared for CHCF by the Center for Disability Issues and the Health Professions, the Center for Health Care Strategies, and the Lewin Group, and the 2008 *Medi-Cal Health Plan Readiness Assessment Tool*, prepared by the Lewin Group as a practical tool for implementing the recommendations of the 2005 report. The full report is available at <http://www.dhcs.ca.gov/provgovpart/Documents/CHCF%20Medi-Cal%20Performance%20Standards%20Recommendations.pdf>, and the *Readiness Tool* is at <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/FEB24/CHCF%20Medi-Cal%20Health%20Plan%20Readiness%20Tool%2002.2008.pdf>. For the purposes of this meeting, DHCS prepared a document that collates the majority of the “essential” recommendations, which is available at <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/FEB24/CHCF%20Essential%20Recommendations%20for%20SPDs.pdf>.

By way of introduction, Brenda Premo noted that the report was focused on Medi-Cal – not Medi-Medi or Medicare. While there are some similarities in needs between those already enrolled in Medi-Cal managed care and persons with disabilities – such as preventive care – other needs are very different. Most PWD don’t have single diagnosis, and need an array of services. If we don’t have measures that look separately at PWD with multiple diagnoses, we can’t know if we’re appropriately serving a population we want to make mandatory.

Regardless of the type of organized system, the CHCF standards should be met. Although the document focuses on managed care, it applies equally to other organized care systems.

Moira Forbes, The Lewin Group (by phone) offered additional detail on the *Readiness Tool*, which is designed primarily for plans to use for self-assessment, but which can also be used by states to determine readiness, or by outside stakeholders. It assumes a certain level of document review as well as interviews with health plan staff, and includes specific recommendations of what to assess.

Lisa Kodmur described LA Care’s work to develop a member satisfaction survey specifically for adults and children with disabilities. (Approximately 40,000 individuals in SPD aid codes are enrolled in LA Care.) The survey addressed access to care, care coordination, and functional limitations, among other topics, and has been useful to the plan in identifying areas for improvement. Among the findings:

- PWD had similar levels of satisfaction as those in non-disability aid codes.
- 65% adults reported 4 or more chronic conditions
- 30% of adults reported 10 or more chronic conditions
- 30% of parents reported 4 or more chronic conditions in their children with disabilities

- 25% of parents reported 10 or more chronic conditions in their children with disabilities
- Depression and anxiety show up among top conditions.

Lisa said that LA Care pulled certain HEDIS measures for people in the SPD aid codes. As expected, women with disabilities have lower rates of breast and cervical cancer screening, so LA Care has established a workgroup to address those disparities.

Brenda Premo said that the first job is to look at existing HEDIS measures to see what we already have, but that we may also need to collect additional, non-HEDIS, data. The CHCF recommendations include one (PM-SR-1) charging the MMCD Quality Improvement Committee with developing and pilot testing three new, non-HEDIS, measures.

Brad Gilbert clarified that the 2005 report includes the following recommendations:

- 1) HEDIS
 - a. stratify a plan-wide measure specific to SPD (46: PM-CR-1)
 - b. additional HEDIS measures (47: PM-CR-2)
- 2) Consumer satisfaction survey (49: PM-SR-2)
- 3) Three additional non-HEDIS measures, one of which one might be the discharge data suggested earlier by Michael Humphrey, and another the ambulatory care-sensitive measures, as suggested by Cheryl Phillips (PM-SR-1)

Mary Giammona said that HPSM does stratify their HEDIS reporting by aid code, and has also found a lower rate of screening for women with disabilities. Some of this may be related to the need for sedation for cervical cancer screening by some members with developmental disabilities, some to the fact that some families decline screening for members with DD. *Brenda Premo* said plans needed to remain sensitive to letting plans and family members make their own health decisions.

Mary Giammona also cited SNP measures on care transition that were developed for Medicare but could apply to younger groups.

Brad Gilbert said that IEHP did member satisfaction surveys with PWD in 2006, 2007, 2008, and 2010. Based on the first survey, the plan set up a disability advisory committee which has been very helpful on issues including specialty referrals.

June Isaacson Kailes, Associate Director, Center for Disability and Health Policy (by phone) discussed the use of the member satisfaction surveys with PWD:

- The survey has to be accessible to the patient/member and their representative, who may also be disabled.
- People may not be able to see a written or mail survey, and may not be able to do a phone survey. Proxies are important.
- Questions relevant to access and other key issues should be integrated into general member surveys, since not all PWD are in aid codes identifying them as such.

Brenda Premo said that providers had been surveyed regarding how to increase care for PWD, with the following results: Money was the most frequently cited incentive, with additional time to treat patients with disabilities coming second. Providers also asked for greater availability of educational materials and consultation, as well as specialized equipment (tables, scales, etc.).

Elizabeth Landsberg wondered what plans have done to identify individuals with disabilities in non-disability aid codes. She also said that a number of people in the Medi-Cal only SPD aid codes were in fact seniors who had not paid into Medicare for some reason. The Workgroup discussed this issue in some detail, including particular challenges for children on CCS who are part of a family aid code, and those in the 3N aid code. The Workgroup was provided with the following statistics on current FFS SPD beneficiaries:

| | |
|-------------------------|--------------------|
| FFS-SPD Total | 1.4 million |
| • Medicare-eligible | 59% |
| • Non-Medicare eligible | 41% (498,000) |
| ○ 0-18% | 12% |
| ○ 19-64 | 74% |
| ○ 65+ | 14% (72,500) |

Tanya Homman, DHCS noted that plans are required to assess *all* members' health and needs, regardless of aid code, and that with the choice form for plan enrollment there will be a self-assessment. *June Isaacson Kailes* said that self-assessment is also not a perfect measure, and that CDC data could potentially be used to stratify issues like smoking and obesity by disability status. Attitudinal and access barriers persist: a provider says to a patient, "If I were you, I would smoke too." Or people are asked to guess their own weights if they can't be accommodated on traditional scales.

Michael Humphrey said that left unresolved from the first TWG meeting was how care coordination is defined and how managed care programs will connect to community-based programs that deliver LTC. IHSS sees many situations in which the caregiver is trying to deal with complex health needs, and often the caregivers are the first to notice the exacerbation of chronic conditions. Involving them in the care partnership will be essential to keeping people out of the ED.

Alex Briscoe, Alameda County Health Services Agency noted the success that the county has had since realignment in decreasing inpatient days on the SMI side, through a service team model and in wraparound care for foster children. The underlying assumption of this Workgroup seems to be that care coordination should go on in the plan, but he questioned whether the expertise is in fact there, and if there isn't a stronger history in other systems. Is it easier to bring primary care into the structures that are already doing the coordination?

Deb Roth said that SEIU is working on a proposal that would involve IHSS in coordinated care as part of a team approach. The caregiver is often the first person aware of patient needs – this should remain a consumer-driven model, recognizing that this becomes more difficult when it gets into the medical model.

Small Group Discussions

Bobbie Wunsch introduced the question for small group discussions:

If the state adopted the essential CHCF recommendations by the state as part of the transition of SPD into managed care, what else would be needed in the areas of care management and care coordination, and in the areas of performance measurement and monitoring?

The three groups met for approximately one hour, working from the document that collates the highest priority recommendations from the CHCF 2005 report (available at <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/FEB24/CHCF%20Essential%20Recommendations%20for%20SPDs.pdf>). Note: Four recommendations rated essential in the report were mistakenly left out of this document. Three of the four have been adopted already by the plans and DHCS.

Group 3:

Brad Gilbert, IEHP, reported for the group:

Recs 32 and 51 re: connections that the organized delivery system should have locally with other entities:

- It is critical that there be adequate assessment of individual need, and relationships set up ahead of time via MOUs, outstationing, etc.
- For some people, the key person following care might not be in the medical system – in those cases, how will the money work?

Rec 2 re: assessment:

- There was consensus that the HCO should not be the entity responsible for administering the initial screen.
- Someone should look at each person's claims data before they are enrolled in an organized system.
- 120 days too long

Recs 27-30 re: care management:

- Rec 30 should also include re-assessment on an annual basis, and at triggering events (hospitalization, ED visit, etc)
- Consumer education is important – members can't ask for care management if they don't know about it

Recs 42-49 re: measurement:

- In addition, the state should implement recommendation PM-SR-1 from the report, which calls for 3 new non-HEDIS measurements for the SPD population. Two of these might be discharge measures and ambulatory care-sensitive diagnoses.
- Member satisfaction surveys should allow for proxies to respond.
- The language limitations in CAHPS are unacceptable
- Cultural competency training of providers and plans needs to be bumped up to essential level.

Brenda Premo noted that not all PWD involved in plans are patients: some may be caregivers and employees. Cultural competency training of providers is essential throughout. The report contained a recommendation that plans have a designated person addressing PWD issues – and in fact, in plans where such an internal advocate is on staff, they have seen a difference. *Mary Giammona* said that HPSM had done much the same with cultural and linguistic issues, and that it has worked well there too.

Tanya Homman noted that DHCS has just finished an RFP to provide cultural competency training on SPD populations at the plan and provider level, and it is posted on the procurement website.

Group 2:

Luis Rico, DHCS, reported for the group. Much of the conversation centered on enhancements to existing recommendations.

Rec 2 re: assessment:

- Screening responsibility at the enrollment broker level is not appropriate.
- A screen is not sufficient; there should be a more in-depth assessment.
- The assessment should identify existing providers, so that care networks can be maintained.

Mary Giammona said that many plan networks overlap with FFS, though there are exceptions (Kaiser). She suggested using existing data to keep as much of the existing care network as possible intact.

Richard Bock said that plans have some experience with this – the challenge is in identifying those people and working with the state and FFS providers who have the data to ensure the continuity.

Rec 26 re: care management definition:

- The state contract language regarding care management is not sufficient for the SPD population. It should also reference IHSS and adult day services.
- Linkages between health plans and community services should be part of care management.
- Care management needs to consider co-morbidities.

Rec 32 re carve-outs:

- We need to end the carve-outs.

Casey Young, AARP said that while the standards call for coordination, MOUs, etc., these don't feel real in normal times, but especially not in the current fiscal environment. The medical side needs to be managing BH and other carve-out services as well as acute medical services – they should be carved in.

Jackie McGrath said that California still has models for more expansive care coordination, such as MSSP. It would be good to empower the plan to have all those resources from community services all the way through the nursing home.

Erica Murray noted that resources are key. There is a disconnect between what we're trying to accomplish in these processes and the state continuing to cut and cut – we may be creating a shift in responsibility without additional resources. Additional resources through the waiver are essential.

Michael Humphrey said that redirecting some SNF money to community services would give plans an incentive to facilitate community services, leading to better care for the member as well as dollar savings.

Recs 34-49 re: performance measurement should focus on

- Inpatient days
- ED use
- Transitions from hospital to home or lowest-level care

Other:

- All plans should have an SPD stakeholder committee
- Consideration of family caregivers is missing from the recommendations
- The specific needs of SPD for wellness and health maintenance are missing from the recommendations

Group 1

Tanya Homman reported for the group. Their key points included:

- Additional quality measures for SPD population
- Willing specialists should be able to serve as primary care providers and possibly be capitated at the primary care rate
- PCP should be redefined to include specialists
- Measures re: ambulatory care sensitive diagnoses and transition-aged youth should be included
- The medical home should not be bound by the walls of the facility
- Any auto-assignment needs to consider specialty needs before assignment to provider
- At state level, there should be more frequent monitoring/oversight re: plan network, acceptance of new members, length of time to get an appt, etc.

- The algorithm for default assignment (based on HEDIS) should also take into account providers serving uninsured such as FQHCs, RHCs, CBOs

Tanya Homman noted that recommendation CC-CR-3, which has already been implemented, calls for “meaningful consumer participation” but needs to be made more robust to include stakeholder organizations, and specifically community-centered design of the plan itself, and some oversight by the state. *Michael Humphrey* suggested that it be spelled out in the recommendation that the advisory committee composition reflect the population of the plan.

Jackie Ritacco suggested having standing referrals for patients with multiple conditions so they have direct access to specialist. *Tanya Homman* replied that this is already a contract requirement.

Brad Gilbert said that plans need data on the front end to make good placement decisions. Plans already do this all the time with *no* information, but shouldn’t do it this way for this population. *Elizabeth Landsberg* said that there should not be *any* default assignment for this population – the FFS data should be used up front, in plan assignment and in provider assignment.

Brenda Premo said that if plans are going to be rewarded through additional enrollment, then the measures used have to be those that meet the needs of the population.

Michael Humphrey said that choice is a key factor, and that members should not be required to remain with their existing providers, especially as in FFS they may have had very little choice of provider.

Mary Giammona suggested that, while HEDIS monitoring is important to do, perhaps it should not be used for auto-assignment in the beginning. Instead, something more concrete and specific to SPD should be used in the beginning, with a move to NCQA/HEDIS standards for SPD as they’re developed.

Chris Perrone, CHCF said that many issues not touched today would come up in the next meeting in discussion of network adequacy. *Brenda Premo* said that one problem that can’t be solved by standards is provider supply – we’re not training medical students about disability, and we don’t have enough geriatricians. It is difficult to get doctors to come to trainings because they’re so overwhelmed. How do we look at bringing the pipeline up – so people come with understanding of clinical and cultural needs?

Bobbie Wunsch asked *Tanya Homman*: From DHCS’s perspective, have you heard anything today that’s impossible to conceive of implementing? *Tanya Homman* responded that while everything is possible, and CHCF’s recommendations are doable in their intent - DHCS has already implemented 11 of 55 – DHCS will need to evaluate the resources impact on the system.

Greg Franklin, DHCS agreed, saying that nothing recommended so far is undoable, and that DHCS wants to build a better program. In the area of data, we will need workarounds

until a better infrastructure, including electronic health records, is in place. But even in the current system, we can talk about getting data from the plans to the data warehouse.

Jackie Ritacco asked whether the Workgroup could influence DHCS's priorities around enrollment of SPD, given that the state cannot achieve all the recommendations at once. Greg Franklin responded that DHCS is focused on supporting the safety net.

Jackie Ritacco asked when the Workgroup could see the waiver, and Greg Franklin responded that the next draft will build off the concept paper with the addition of the kind of detail being discussed in these meetings.

Elizabeth Landsberg asked when the financial piece comes in, who makes the first step and when? Greg Franklin responded that DHCS is currently calculating budget neutrality, and figuring out how much they will have to work with. A consultant is assisting the DHCS staff in this work.

Next Meeting and Feedback on Today's Meeting

The next meeting will be Thursday March 11, 10am – 3pm, at the USC State Capitol Center, 1800 I Street, Sacramento.

WCLP and Health Access will present on consumer protections, Brenda Premo will present on access standards and enrollment processes and Michael Humphrey may present on Sonoma County's work in transitioning SPD into mandatory managed care.

Rita Marowitz said that DHCS will have its preliminary report on the overlap between FFS and plan providers by end of March. Brad Gilbert asked several questions about the DHCS methodology, noting that setting a financial threshold did not accurately identify providers who actually see significant numbers of SPD patients, and that IEHP ended up setting a threshold of 52 encounters/year to identify those providers who actually serve these populations.

The meeting was adjourned at 2:55 PM.