

**SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER
STAKEHOLDER ADVISORY COMMITTEE (SAC)
Meeting #4 – Thursday, June 10, 2010
9:30am – 11:30am
VIA WEBINAR**

The meeting convened at 9:30 AM.

Attendance

Members attending: David Alexander, Lucile Packard Foundation for Children's Health; Jack Burrows, Association of California Health Care Districts; Richard Chambers, CalOptima; Mike Clark, Kern Regional Center; Diana Dooley, California Children's Hospital Association (CCHA); Catherine Douglas, Private Essential Access Community Hospitals (PEACH); Juno Duenas, Family Voices; Teresa Favuzzi, California Foundation for Independent Living Centers; Jeff Flick, Anthem Blue Cross; Bradley Gilbert, Inland Empire Health Plan (IEHP); Sandra Naylor Goodwin, California Institute of Mental Health (CiMH); Daniel Gould, California LGBT Health and Human Services Network; Peter Harbage, SEIU; Marilyn Holle, Disability Rights California; Michael Humphrey, Sonoma County IHSS Public Authority; Liz Kniss, California State Association of Counties (CSAC); Ingrid Lamirault, Alameda Alliance for Health; Elizabeth Landsberg, Western Center on Law & Poverty (WCLP); Marty Lynch, LifeLong Medical Care; Jackie McGrath, California Council of the Alzheimer's Association; Anne McLeod, California Hospital Association (CHA); Santiago Munoz, University of California, Office of the President (UCOP); Chris Perrone, California HealthCare Foundation; Cheryl Phillips, OnLok/PACE; Robert Phillips, The California Endowment; Bob Prath, AARP California Executive Council; Brenda Premo, Harris Family Center for Disability and the Health Professions (CDHP); Sharon Rapport, Corporation for Supportive Housing (CSH); Judith Reigel, County Health Executives Association of California (CHEAC); John Schunhoff, Los Angeles County Department of Health Services (LAC DHS); Timothy Schwab, Senior Care Action Network (SCAN) Health Plan; Al Senella, California Association of Alcohol and Drug Program Executives; Barbara Seigel, Neighborhood Legal Services of Los Angeles County (NLS); Stuart Seigel, Children's Hospital Los Angeles (CHLA); Herman Spetzler, Open Door Community Health Centers; Richard Thomason, Blue Shield of California Foundation.

Others attending: David Maxwell-Jolly, DHCS; Greg Franklin, DHCS; Bobbie Wunsch, Pacific Health Consulting Group.

Public in attendance: Including those people listed above, 100 individuals participated in the Webinar.

Welcome and Introductions and Purpose of Today's Meeting: Review Logistics for Today's Meeting and Webinar

Bobbie Wunsch, Pacific Health Consulting Group, welcomed the Committee members and the public and explained webinar logistics. The meeting agenda includes an update of the status of the waiver proposal in the legislature and with the federal Centers for Medicaid and Medicare Services (CMS). The agenda was revised slightly to accommodate the schedules of legislative staff.

David Maxwell-Jolly, DHCS, said that the Department has been working in conjunction with the legislature on the waiver proposal for 18 months. DHCS submitted the Implementation Plan to the legislature in early May, and the waiver proposals are currently being considered through both the budget and policy processes. David Maxwell-Jolly introduced David Panush and Sumi Sousa to give an update on the status of the waiver proposals.

Legislative Update Related to 1115 Waiver Renewal

Sumi Sousa, Assembly Speaker's Office, California Legislature, said that most of the policy language in the waiver proposal will be going through the legislature's policy processes. Legislative staff are currently meeting with stakeholders. She encouraged Committee members and members of the public, to the extent that they have suggested amendments, to submit them to legislative staff immediately. The Speaker of the Assembly and the Senate President Pro-Tempore both have bills in the other house, and hearings on those bills are currently scheduled for June 29 and 30.

David Panush, Senate President Pro-Tempore's Office, said that both the President Pro-Tem and the Speaker signaled last year that they would be authors of waiver-implementing legislation, and both leaders already had vehicles in process when the Implementation Plan was submitted. While the Administration proposed implementing legislation through the budget trailer bill, legislative leadership felt that it would be preferable to use the policy process. Accordingly, SB 208 (Steinberg) and AB 342 (Perez) are in the policy committees of their respective opposite houses.

Sumi Sousa said staff of all the relevant policy committees have been involved in the waiver conversations throughout, and that they have tried to attend or listen to the Stakeholder and Workgroup meetings. However, she again encouraged stakeholders to make their opinions known to staff, and stressed the short timeline for these conversations, since the bills must move concurrently with the budget process and have to be done by the end of the legislative session.

There were no questions for David Panush or Sumi Sousa from SAC members.

CMS Update on Waiver Implementation Plan: Presentation and Discussion with Stakeholders

David Maxwell-Jolly, Director, DHCS, provided an update on several waiver-related developments.

DHCS has worked closely with CMS on the staff level regarding the waiver proposal, including through regular conference calls, and shared the Implementation Plan with them in May. In the first week of June, DHCS submitted a more formal Waiver Proposal which includes some of the key financial elements that were not part of the Implementation Plan. That document was posted subsequent to the webinar and is available at <http://www.dhcs.ca.gov/provgovpart/Documents/A%20Bridge%20to%20Reform%206-10-2010.pdf>. Associated materials are available on the Stakeholder Advisory Committee web page at <http://www.dhcs.ca.gov/Pages/SACMeetings.aspx>.

The Waiver Proposal focuses on the 1115 waiver as a key element of California's effort to prepare for the changes that the health care delivery system will undergo in 2014 under federal health care reform (as authorized by the Patient Protection and Affordable Care Act – PPACA). Many of the key components provide an important foundation for that effort. From that perspective, the lead effort is the expansion of the Health Care Coverage Initiatives (HCCI). California is proposing to make a substantial and early coverage expansion for childless adults <133% of the federal poverty level (FPL), taking advantage of the Medicaid option but in the context of a county-based HCCI structure. In addition, the Proposal includes expansion of HCCIs to cover adults up to 200% FPL. As in the Implementation Plan, the Waiver Proposal includes discussion of expanding enrollment in accountable care systems for seniors and persons with disabilities (SPDs) and for dually-eligible individuals. The Waiver Proposal includes new detail regarding expansion of funding for the safety net system through continuation and expansion of the Safety Net Care Pool (SNCP), and delineates a series of uses for those funds, including investment in the overall delivery system to ensure sufficient infrastructure to accommodate increased levels of service anticipated under HCR. Finally, the Waiver Proposal asks for pilot authority to make reforms in how public hospitals are paid, and to help prepare them for 2014.

- **HCCI:** The Waiver Proposal lays out in detail the current status of HCCI, and a plan for expansion. The expansion plan includes the following elements: participation in HCCI would be available to all counties in the state; enrollment processes would be expanded and regularized; benefit levels would be made consistent over time across all participating counties. Under the Proposal, HCCI will be funded by available federal funds through the waiver matched by local funds, with enrollment calibrated to the availability of these local indigent funds. DHCS believes that, with additional federal funds, counties will be in a position to enroll indigents and provide a

comprehensive set of benefits in a more organized system. This will allow California to enroll in the HCCIs the population eligible for full-scope Medi-Cal in 2014, and to get an early start on meeting their health care needs so that the overall capacity to deal with Medi-Cal expansion is increased.

The Waiver Proposal also proposes new ways of financing the HCCI not based solely on the Certified Public Expenditure (CPE) approach that has been used to date. Options include actuarially-based payments that would include both CPE and inter-governmental transfers (IGT). These changes will offer important incentives for public hospital and county indigent care systems to be full partners after 2014.

SNCP: The Waiver Proposal discusses the Safety Net Care Pool (SNCP) in much greater detail than earlier documents. The Proposal would provide continued funding for the set of programs that the State has been funding through SNCP, including the Breast and Cervical Cancer Treatment program, the California Children Services program, the Genetically Handicapped Persons program, the Expanded Access to Care Program, the Aids Drug Assistance Program, the County Medical Services Program, uninsured mental health services and the Medically Indigent Long Term Care Program, and asks for an expansion of this list to include state's high-risk medical care pool, services provided to developmentally disabled individuals, health care provided to parolees, and the costs of short-term inpatient stays for prisoners. DHCS would also like to use additional federal funds for workforce development programs, with the goal of increasing the number of health care professionals providing primary care and serving in medically underserved areas.

Another important innovation discussed in the Proposal is the dedication of SNCP funds to a Delivery System Improvement Pool (DSIP). DHCS proposes to match federal funds with IGT to allow infrastructure development that will help public hospitals be full participants in the care delivery system.

The Waiver Proposal asks for authority to establish a Global Payment System Demonstration Project, as authorized by the PPACA. Such a project offers the promise of realigning incentives and driving providers to offer more cost effective, high quality care.

- **SPD and Dual-Eligibles:** DHCS proposes better-organized care for SPD and dual-eligibles. Pilot projects for dual-eligibles are included according to the proposal submitted to the legislature.
- **CSHCN and BHI:** The Waiver Proposal does not go into detail regarding children with special health-care needs or behavioral health integration. Pilots have been

discussed in both arenas, and DHCS is planning to develop more concrete proposals during the first year of the waiver and then to continue the discussion with CMS.

- **Budget Neutrality:** Another significant part of the Waiver Proposal is the discussion of budget neutrality and related calculations. The State's analysis shows a net savings ("without waiver" compared to "with waiver") during the waiver period of approximately \$9.5 billion, the federal share of which is \$4.8 billion. This savings supports asking for substantial new federal investment of approximately \$1 billion per year, which added to the existing SNCP totals approximately \$2 billion annually over five years. The argument to CMS justifying this level of investment relies in large part on the state's historical control over hospital spending, as well as on projections regarding future growth of hospital costs.

Finally, the Waiver Proposal includes a list of provisions in federal law that DHCS is requesting be waived, a description of work that has been done through the stakeholder process, and various other items.

CMS has had a preliminary view of the Waiver Proposal in anticipation of a meeting June 10th between Governor Schwarzenegger and HHS Secretary Sebelius. David Maxwell-Jolly said that there is strong interest on both sides in concluding the waiver negotiations before the end of August, that DHCS has been impressed by the work of CMS staff work and that he is optimistic that the process will be concluded quickly. The Implementation Plan and the legislation will have to be adjusted to conform to CMS discussions, and the Waiver Proposal will have to reflect the final form of the California legislation, so the process is complex, with many moving parts, but a rapid and successful conclusion to the waiver process is a high priority for CMS and for DHCS, and the Department is highly optimistic.

Bobbie Wunsch, PHCG, opened the Webinar to questions from SAC members.

Marty Lynch, LifeLong Medical Care, asked for clarification about who would be covered under the HCCI expansion. David Maxwell-Jolly said that DHCS proposes to offer eligibility for Medi-Cal to childless adults up to 133% FPL within the context of the waiver. The Waiver Proposal asks for authority to limit enrollment on a county-by-county basis based on limitations in county funds for that purpose. The HCCI benefit package will be expected to become more comprehensive over time, so that by 2014 it meets the benchmark for Medi-Cal expansion. DHCS expects to ask both existing and new HCCIs to offer a more comprehensive set of benefits, and this will be a point of discussion.

Sharon Rapport, Corporation for Supportive Housing, asked for clarification on the definition of care coordination, and specifically whether it could be provided telephonically or only

face-to-face, or at different levels for different populations? David Maxwell-Jolly said that DHCS has been working internally on a process to develop more specific guidelines for care coordination. Although it is not finalized, it will be based on an evaluation of the relative needs of the individual, with people with more intense needs receiving a higher level of coordination. DHCS has not specified whether care management must be delivered face-to-face, but want to ensure good access around the clock and coordination with other delivery systems – including mental health, CCS, and regional centers – so that when a client needs services that are beyond the scope of the medical care plan those can be well-coordinated. DHCS will be reaching out to stakeholders to help with the care coordination definition; the Implementation Plan proposed that the state issue direction to health care plans by October 2010.

Elizabeth Landsberg, WCLP, asked for additional detail on the comprehensive benefits package to be developed by HCCIs. What would the benchmark look like, and what standards for access and network adequacy apply? In some counties, there are long delays and/or wait lists for primary care, so standards and evaluation are critical. David Maxwell-Jolly responded that the Waiver Proposal discussed the benefits offered under current HCCIs in detail, finding that while there is broad access to inpatient and outpatient services, as well as DME and pharmacy, there is significant variation in the HCCIs' ability to provide rehabilitation, home health, and mental health services, among others. DHCS will work closely with CMS to lay out a more specific set of benchmarks and a timeline for progress on this issue, but the details have not yet been developed.

Elizabeth Landsberg asked whether DHCS is assuming that the benefits package for Medi-Cal expansion in 2014 will resemble a commercial benchmark package. She noted that the State can provide a Medi-Cal benefit to this population, and that there are good reasons to do so, including administrative simplicity. She said that she hopes that policy discussion is still open. David Maxwell-Jolly said that he is aware of the concern, and understands that there will be an opportunity to define benchmark plans for the expansion population. California will look at federal guidance before deciding what to do, and will investigate the funding implications of going beyond the benefit package defined by the Secretary.

Stuart Seigel, CHLA, asked what had happened with respect to comments submitted on the Implementation Plan. David Maxwell-Jolly said that those comments are being considered. The Implementation Plan has not been revised, but comments on that document may be included in Waiver Proposal updates.

Chris Perrone, CHCF, asked when the Waiver Proposal would be shared with the public, and *Bobbie Wunsch, PHCG*, said it would be posted on the website on June 10th, and transmitted to all SAC and TWG members.

Anne McLeod, CHA, asked whether the Waiver Proposal included investments for safety net hospitals other than public hospitals. DHCS recognizes that the network is broader than just public hospitals, and that all are important in providing access and care. David Maxwell-Jolly said that several elements of the waiver will be important to non-public safety net hospitals, including the HCCI expansion, which provides substantial new support for a currently uninsured population, relieving some of hospitals' uncompensated care burden, and the requirement in the SPD restructuring that plans establish coordinated care arrangements with private providers. Anne McLeod said she would follow up with DHCS to understand more about these proposals.

Dick Thorp, CMA, noted that Medi-Cal participation by physicians and mid-levels is at an all-time low. How does DHCS propose to increase provider participation, particularly of solo practitioners and small groups, and what funding is available for infrastructure development? David Maxwell-Jolly said that the fact that California already has the lowest Medicaid cost per enrollee in the nation makes it extremely difficult to face a world where available revenues are growing even more slowly than the underfunded program. The goal of the waiver is to put in place systems of care that have the promise of mitigating the rate of growth in the overall system, so that the program can live within the state's means and savings can be reinvested. Medi-Cal's existing managed care structures offer better and more efficient care than FFS, often with better rates for providers. Using the existing money more effectively is the foundation of the state's strategy.

Catherine Douglas, PEACH, said that her organization would reserve comments until they have reviewed the Waiver Proposal, but said that while she applauds the provisions for public hospitals, she is astounded that there is no similar provision for private safety-net hospitals. All prior waivers relative to hospital financing and the uninsured, as well as ABx4 6, require a balance of funding for public and private hospitals, so that both have predictable and sustainable funding. That does not appear to be extended in this Proposal.

Regarding HCCI, while David Maxwell-Jolly's argument regarding the benefit to private hospitals may be true for some that currently don't receive any reimbursement for this population, if the HCCIs don't include private safety net providers in their networks those providers will be further isolated and damaged. In the context of SPD coverage, PEACH appreciates that private providers will be authorized as active participants, but if rates are something like 90% FFS, and 15% is allowable administrative charges, the potential payment to private hospitals could then be 75% of the 75% of actual costs that these hospitals *currently* recover through FFS. While the Waiver Proposal may be a good bridge for California's public hospitals, it represents a cliff that private safety-net hospitals may fall off before 2014, in contradiction of the goals of HCR. She said that she hopes the Waiver Proposal can be amended to do something for these providers. David Maxwell-Jolly replied

that the waiver is not the only thing in the works: DHCS is looking at a potential resolution of the hospital fee proposal, which would address some of these issues.

Bobbie Wunsch, PHCG, recognized the participation of Supervisor Liz Kniss of Santa Clara County, who is representing CSAC while Kelly Brooks is on maternity leave.

May Revise Budget Elements Related to 1115 Waiver Renewal

Gregory Franklin, Deputy Director, DHCS, discussed the status of waiver-related budget elements in the May Revise.

- DHCS' initial request was for 53 positions and approximately \$3 million, reflecting the fact that proposals under the waiver affect the entire Department. Positions are needed not only for CCS, LTC, MMCD, but also in support areas such as HR and budget. Resources are also required for contracted pieces such as rate analysis, quality, and outreach and enrollment.
- The request was denied in the Assembly in May, and advanced in the Senate at approximately 50% of the initially requested level.
- DHCS hopes to prevail in Conference Committee with at least a portion of what the Senate advanced.
- The lack of funding approval has not slowed DHCS' work to date, but may require that they develop a "Plan B" in the event that necessary funding is not forthcoming.

1115 Waiver Implementation Steps Taken So Far: Update on Waiver Implementation Activities

Greg Franklin, DHCS, provided updates on waiver implementation activities:

- Readiness capacity assessment for SPD:
 - Staff have looked at performance measures for this population.
 - Care management definition work is ongoing in MMCD
 - DHCS has contracted with the Center for Disability Issues and the Health Professions (CDHP) at Western University for a site facilities review tool and plan training tool.
 - A provider crosswalk comparing plan networks and FFS providers will be completed within the next few months.
- Continuing to develop various methodologies for auto-assignment, to improve the current default algorithm.
- Contracting with UCB for an outreach campaign directed at SPD.

Elizabeth Landsberg, WCLP, asked what network adequacy standards DHCS is applying and to what extent they are collaborating with DMHC in this work. Greg Franklin replied that DHCS has started with the provider crosswalk, looking at the numbers of providers in plan networks and in the FFS environment, and their relative experience with service to SPD individuals. DHCS expects to begin with the essential standards discussed in the third SPD TWG meeting, but may add additional standards. DHCS is keeping DMHC apprised of its efforts, and the two Departments are negotiating how much DMHC can take on and how much will remain with DHCS. They are driving toward better monitoring of plan activities and better understanding of plan capacity prior to enrollment.

Jackie McGrath, Alzheimer's Association, said that she was sorry that David Maxwell-Jolly's presentation on the Waiver Proposal did not include discussion of coordination with HCBS. Greg Franklin replied that coordination for the entire continuum of care was an expected element of SPD enrollment in managed care plans, as had been discussed in a number of Workgroup meetings.

Liz Kniss, CSAC, asked whether DHCS knows how well prepared individual physician offices are to meet the Department's managed care standards. Greg Franklin replied that DHCS' expectation is that health care plans will share those expectations with providers, and assess their readiness before they contract with them. Liz Kniss said that some of the requirements will take a while to implement, and that the timeline for enrollment is aggressive. It may be a problem for those providers who already care for the SPD population, but are not yet part of managed care networks. Greg Franklin said that the SPD TWG discussed this issue in detail, and was clear that where providers are not ready they should not be enrolled. This is a conundrum, because the current FFS provider community is important, but DHCS and plans have to make a business decision about when and how SPD are enrolled. DHCS does not yet know how well they meet the standards.

Stuart Seigel, CHLA, asked whether there would be specific accommodations for pediatric providers related to SPD enrollment, given that some children are included in those categories. Greg Franklin said that the assessment includes a piece on specialty providers, and that he would check on whether pediatric specialists are specifically called out.

Catherine Douglas, PEACH, asked for clarification on how the enhanced medical home concept will be implemented in non-clinics, given that in Los Angeles County, the SPD population is seen mostly by solo practitioners and small offices. She asked how the proposal ensures access, continuity of care, and choice but also includes current providers who currently don't have the capacity to serve as medical homes or care coordinators. Greg Franklin said that DHCS recognizes that there will be a learning curve for everyone. If providers have not previously been part of an organized system or met certain standards,

then DHCS intends to engage in an effort to get them there. To begin with, DHCS intends to build on existing plans, which have done a good job with the SPD population to date.

Catherine Douglas also asked what DHCS' plans for safety net default mechanisms for the SPD population are. Greg Franklin said that the methodology for Medi-Cal managed care default enrollment has changed over time, with the current system based on quality scoring. Given the special needs of the SPD population, DHCS is looking to refine the system again.

Diana Dooley, CCHA, said that her organization and others have previously asked that children in the SPD category who are not eligible for CCS be carved out of mandatory managed care, at least initially. She asked about the status of this proposal. David Maxwell-Jolly said that DHCS is not inclined to carve out additional subcategories of people, but intend to provide for continuity of care to the extent possible, and to include requirements for graceful transitions for those people who need to change providers. The crosswalk numbers, when available, will provide information on the overlap between managed care networks and FFS providers.

Juno Duenas, Family Voices, asked how consumers and advocates will be able to participate in monitoring and quality improvement activities. Greg Franklin said that MMCD currently convenes a group of advocates quarterly to address issues including quality, and that that group may meet more frequently as part of this transition.

Al Senella, CAADP, asked how the Waiver Proposal will ensure that substance use and mental health disorders are adequately addressed by all plans and providers. Greg Franklin said that the last BHI TWG discussed the need to improve integration and coordination between medical and behavioral health services. There is significant energy within the health plan community to include stronger requirements around BH integration, and DHCS is looking at including additional requirements within current managed care contracts.

Regarding other aspects of the waiver proposal implementation, Greg Franklin reported that:

- CSHCN pilot proposal development is moving on schedule through DHCS' internal process. A meeting was held on June 9, convened by LPFCH, to discuss children's health evaluation methodologies, and these discussions will inform the RFA evaluation component.
- DHCS has engaged Stanford to look at cost, utilization and quality data for the current CCS population.
- Behavioral health integration is being discussed as part of the efforts toward pilot projects for dual-eligibles and CCS-enrolled children, as well as in the SPD enrollment.

Sharon Rapport, CSH, asked how DHCS defined “enhanced medical home” and how it differs from a regular medical home. Greg Franklin said that this has been discussed internally at DHCS, and that an enhanced medical home is one that is based at a specialist’s office, a hospital, or anywhere other than a primary care provider office. Sharon Rapport asked whether it therefore had less to do with services than location, and Greg Franklin replied that the two are related, since a specialist or hospital would typically provide a greater intensity of services.

Bob Prath, AARP, asked what evaluative results would be available to the public as SPD enrollment proceeds. David Maxwell-Jolly said that over the course of the waiver implementation, within the context of CMS’ terms and conditions, DHCS intends to make an active set of data – including enrollment, expenditures and utilization data – widely available via the DHCS website and other means. Continued stakeholder work is an ongoing requirement of the waiver implementation, so meetings will also continue. David Maxwell-Jolly said he has been pleased with engagement and interest of stakeholders and hopes to continue to get feedback from the SAC in order to calibrate the Department’s efforts according to evolving needs.

Richard Chambers, CalOptima, asked about next steps regarding BHI. Greg Franklin said that the Proposal does not expand on the Implementation Plan regarding BHI, but that DHCS wants to ensure integration with existing structures and systems of care to make BHI commonplace within the HCCIs. David Maxwell-Jolly said that the conversations regarding BHI are not sufficiently mature to be included in the Waiver Proposal at this point, but that when concrete proposals exist DHCS will go back to CMS with them. CMS is very receptive to these ideas, and DHCS hopes to get feedback from local conversations and to take these forward.

Richard Thomason, Blue Shield Foundation, asked whether the Waiver Proposal proposes an amount of federal funds to be invested in HCCI. David Maxwell-Jolly said that DHCS proposes to dedicate the existing \$180 million annually for the needs of individuals in the 133-200% FPL group, and to draw down an increasing amount of money for individuals under 133% FPL. That amount is proposed at \$900 million in the first year, increasing to \$1.5 billion in the third year. Overall spending will depend on the availability of local funds to match the federal investment.

David Maxwell-Jolly, DHCS, said that he had been talking to a number of counties about HCCI expansion, as well as to the health and welfare committee of CSAC, and was hearing very positive responses to the expansion proposal. DHCS is engaged in making sure that counties understand the opportunities, and that they will be in a position to respond.

Bobbie Wunsch, PHCG, introduced the public comment period of the meeting, conducted according to the Bagley-Keene Act.

No other public comment was forthcoming, but several SAC members had comments:

Brenda Premo, CDHP, asked what tool was being used to determine provider standards for SPD enrollment and who is reviewing the access and auxiliary standards that are important to SPD? David Maxwell-Jolly said that the Department has traditionally done readiness assessments using one tool, and that this will be used again within the context of plan readiness with respect to the SPD mandatory enrollment population. In addition, DHCS will request that plans implement facilities site reviews to allow detailed information to be shared with prospective enrollees regarding site accessibility.

Marilyn Holle, DRC, asked how DHCS is looking at the special classes of providers needed by SPD, including rehab providers, orthotics providers, and others, in determining network adequacy. Greg Franklin replied that part of the crosswalk project involves identifying any gaps in current managed care networks. Marilyn Holle asked about GHPP (Genetically Handicapped Persons Program) providers, who are important not only to people covered under that program but to other SPD individuals. David Maxwell-Jolly said that DHCS is investigating potential network adequacy standards related to specialty care, and will be trying to operationalize those with respect to specialty groups to extent that such standards exist.

Marilyn Holle also asked whether Stanford researchers will be able to evaluate plans' performance to date in those counties where CCS is semi-carved in, as part of their CCS evaluation work. Luis Rico, DHCS, said that the Stanford work will include retrospective cost, utilization and quality data, and that DHCS hopes it will be sufficiently comprehensive to allow that analysis.

Bobbie Wunsch, PHCG, thanked the participants, David Maxwell-Jolly and Greg Franklin, DHCS technical staff, and legislative staff presenters, and announced upcoming meetings:

- July 22, 2010, Sacramento Convention Center
- September 29, 2010, Sacramento Convention Center

The webinar was adjourned at 11:15 AM.