SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER SENIORS AND PERSONS WITH DISABILITIES (SPD) TECHNICAL WORKGROUP

Meeting #3 – Thursday, March 11, 2010

10:00am – 3:00pm

USC State Capital Center, Room D

The meeting convened at 10:00 AM.

Attendance

Technical Workgroup members attending: Richard Bock, Molina Healthcare of California; Alex Briscoe, Alameda County Health Care Services Agency; Dean Germano, Shasta Community Health Centers; Mary Giammona, Health Plan of San Mateo (by phone); Bradley Gilbert, Inland Empire Health Plan; Michael Humphrey, Sonoma County In-Home Supportive Services Public Authority (by phone); 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; Erica Murray, California Association of Public Hospitals; Chris Perrone, California Healthcare Foundation; 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; Rene Santiago, San Diego Health and Human Services (by phone); Margaret Tatar, CalOptima; Anthony Wright, Health Access California; 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; Luis Rico, DHCS; Bobbie Wunsch, Pacific Health Consulting Group.

Public in Attendance: 24 individuals attended in person, and 42 people called in on the listen-only telephone line.

Welcome and Introduction

Scott Steele, USC School of Policy, Planning and Development welcomed the group to the building and oriented the group to the SPPD.

Bobbie Wunsch, PHCG introduced the agenda, and noted that all presenters had been asked to trim their presentations in order to accommodate full discussion. She directed the Workgroup to the CHCS paper (link) provided to the group by email, which will be the subject of discussion at the next meeting.

The Stakeholder Advisory Committee (SAC) met on March 10, and several key points from their discussion are relevant to the work of the SPD TWG:

- "SPD" does not describe a single group – hundreds of thousands of individuals with varying circumstances fall under that rubric.

- The role of home and community-based services (HCBS) is essential, and the SPD TWG should bear in mind linkages to these services.

Alternative Option to Mandatory Managed Care Enrollment

David Maxwell-Jolly, Director, DHCS presented the Department's current thinking on SPD enrollment in managed care. This proposal is outlined in a memo available at the DHCS Waiver Renewal webpage on the SPD Technical Workgroup tab**.**

The State is proposing to enroll seniors and people with disabilities (SPD), particularly those who are Medi-Cal only (as opposed to dually-eligible), in organized systems of care. DHCS would develop enhanced standards and requirements that existing plans and any other systems would have to meet in order to enroll this population. Enrollment would be mandatory, although individuals would have a choice among available organizations. Enrollment into existing plans would begin in the first year of the waiver. DHCS believes that building on the existing structure makes sense: plans have progressed in their ability to serve these populations, and represent a good resource for delivering care to SPD population.

DHCS's new proposal, outlined in the paper cited above, would allow counties to establish an additional alternative to existing plans in cases where local conditions express a need for such a plan. The alternative would meet the same standards, but would provide an opportunity for local adaptation. Where a county chooses to develop such an alternative, mandatory enrollment in that county would be delayed until the end of first year, so that beneficiaries would have a real choice between the existing plan and the county alternative.

Enrollment of SPD in plans may or may not result in a decrease in their use of the safety net. If this results in loss of revenue, it could be a threat to safety net institutions. At the same time, some county hospitals and other providers have not always actively sought to become part of consolidated delivery systems, though over the past few years public hospitals have been positioning themselves to be comprehensive providers to enrolled populations. Plans and safety net providers need strong relationships. Plans will be required to develop these relationships – not only to have contracts, but to activate them. DHCS intends to use default rules and assignment in such a way as to support safety net institutions, but details remain to be worked through and it has to be done without sacrificing beneficiary choice of plan and provider.

Payment reforms will continue over the life of the waiver with a goal of driving the system toward the outcomes we want. The first level is to decide how much of the service mix will be encompassed in the rate paid to the covering institution. The strategy is to expand the scope of covered services in order to give covering institutions control over a broader range of resources, and to encourage them in turn to set up incentive structures for their providers in order to achieve the right mix of services, including care coordination.

Brad Gilbert, IEHP, asked several questions about the county alternative:

1. Would county governments (Boards of Supervisors) present the desire for such an alternative?
2. Are these risk-bearing organizations at some level?

3. What would be the scope? Primary care only, primary and specialty care, pharmacy?

David Maxwell-Jolly replied that DHCS would be looking to local political leadership to convene the planning process and make determination. DHCS has not been prescriptive about the model for these alternatives, although it is not interested in cloning Local Initiatives. The county alternatives would likely be less than fully risk-bearing, perhaps operating in an Enhanced Primary Care Case Management (EPCCM) model or some other more limited risk-bearing organization. They might be capitated for a subset of services, for example primary care or primary and specialty care, and provide care management in that context. DHCS will establish standards and parameters, in part to avoid having localities sort people by risk.

Richard Bock, Molina HealthCare, asked whether DHCS anticipated a single alternative system, or multiple systems. He also asked whether California would lose matching funds as a result of the delayed phase-in proposed in counties that choose to develop such an alternative.

David Maxwell-Jolly said that there would be no more than one alternative per county. The case that the state makes to CMS does depend on aggressive enrollment of SPD in organized care systems, and this alternative would delay that enrollment. The alternative would be a choice among others, and it is important not to limit its viability by proceeding too soon with enrollment. He said he would predict an increase in voluntary enrollment in existing managed care plans during the implementation period, but mandatory enrolment would be delayed until all pieces are in place.

Jackie McGrath, Alzheimer's Association, confirmed that in localities with no existing managed care plans, there would be no mandatory enrollment during the first year. She asked whether DHCS would consider initiating a pilot comprehensive care coordination model in a FFS county during this period, in order to test results. David Maxwell-Jolly responded that the roll-out approach is focused on managed care counties, but that the Department is interested in any ideas for non-managed care counties, and that the care coordination pilot sounds like a good suggestion. Jackie McGrath noted that some FFS counties already have care coordination infrastructure, through programs like adult day health centers and MSSP. Bobbie Wunsch noted that the 4th SPD TWG meeting on April 1 focuses on FFS counties.

Elizabeth Landsberg, WCLP, said that the county alternative was a step in the right direction, in her view, good for beneficiary choice and for continuity of care. She suggested a PCMH or care coordination model that works with FFS specialty and the FFS network. While there are lots of details to work out, it will be interesting to see if counties step forward. The phase-in is important if the alternative is to be viable. She agreed that there probably would be an uptick in voluntary enrollment.

Chris Perrone, CHCF, noted that there is an assumption based on the commercial world that there's better access in FFS, but that that might not be the case – any data on this point would be useful. He also asked whether DHCS plans to be prescriptive in defining options for counties.

David Maxwell-Jolly said that the Department does not have a position at this time on what they will prescribe, and do not intend to require a specific model. They will prescribe certain principles and standards.

Margaret Tatar, CalOptima, asked about the January 2012 start, and about how DHCS intended to provide the technical assistance that counties would need in order to implement the alternative plan. David Maxwell-Jolly confirmed that the goal was to enroll new beneficiaries in the first year (2010-11) in those counties that do not choose to develop an alternative and around January 2012 where such an alternative exists. DHCS has a strong presumption that work on the local alternative would be collaborative, with local stakeholder engagement.

Casey Young, AARP, asked about the proposal that plans required to include all elements of an organized delivery system, including HCBS. Would that require putting additional dollars into the rates? David Maxwell-Jolly said that, at this stage of the conversation, "inclusion" could encompass a number of arrangements. The most global would be that the organization takes full responsibility, but another arrangement would be that the MCO has the traditional responsibility but establishes relationships with other providers who help clients transition between institutional and home-based care. This might include a requirement to coordinate with regional centers, for example, so that the physical health provider has access to and understands the developmental plans. The Department does not envision a single approach to rates – it will depend in part on plan capacity.

Elizabeth Landsberg, WCLP confirmed with David Maxwell-Jolly that it will be incumbent on the counties to step up to the alternative.

Erica Murray, CAPH, said that the public hospitals and counties have been thinking about what possible alternatives to mandatory Medi-Cal managed care for SPD would look like, and the State's proposal mirrors their thinking, which includes a capitated approach for primary and specialty care that does not include inpatient. It is not yet clear how many public hospital counties would be interested in this kind of alternative.

Mary Giammona, HPSM, asked if the State was really focused on capitating only outpatient care, since if the system works on that side, the savings will be on the inpatient side. She also asked if the State had considered phased-in risk. David Maxwell-Jolly said he agreed with the premise that a large part of the savings would be on the inpatient side, and suggested that the State may want to require that any county alternative have some savings sharing structures in it to provide incentives to avoid hospitalization. Alternatively, there are ways to structure a rate that might pool reimbursement only for outpatient services, but track savings on the inpatient side and share those savings across the system.

Mary Giammona raised a concern that to the extent that these alternatives are developed in counties with local initiatives, they will compete with those entities. The playing field should be leveled.

Rene Santiago, San Diego County, asked whether, with so many parts of the proposal dependent on negotiations with CMS, the Department contemplated a September 2010 start, or if the process would be extended into 2011. David Maxwell-Jolly said that DHCS would want to start enrolling as early as possible in the waiver, phased in over the course of the first year in counties where there is no alternative plan.

Alex Briscoe, Alameda County, said that it is no secret that Alameda County is interested in pursuing a COHS, and that Alameda Alliance does a good job with the approximately 11,000 SPD enrolled. However, given that Alameda has just begun construction on new public hospital, the question of loss of revenue has to be considered.

Lisa Kodmur, LA Care, said that if the county alternatives don't include risk, it would be hard to achieve cost savings. David Maxwell-Jolly agreed, saying that putting people at risk for portions of care is a good way to get the right mix. Lisa Kodmur asked how the county alternative would address consumers' difficulties in finding FFS Medi-Cal providers, if it were overlaid on the existing FFS network. David Maxwell-Jolly said that the county alternatives might include a broader provider network than the traditional FFS one. He said that in the case of SPD enrollment, it would be particularly important to pay special attention to network adequacy in existing plans as well, both in terms of quantity and in terms of the range of specialty care needed.

Brenda Premo, Center for Disability and Health Policy, said that the Department should think about care coordination in home the home, and how the transition from inpatient to home works, so that patients don't have to be sent back to the hospital (thus costing additional inpatient dollars). Care coordination will be extremely important.

Jackie McGrath, Alzheimer's Association, agreed, saying that the savings is in inpatient, and the goal is not only getting people out of the hospital as fast as possible, but making sure they don't come back. The capacity of family and other caregivers will require careful assessment. *Brad Gilbert, IEHP,* agreed, expanded that thought, saying that while discharge planning is important, the real goal is avoiding unnecessary hospitalizations altogether.

Margaret Tatar, CalOptima, asked what the Department's next steps are. David Maxwell-Jolly replied that they will take feedback from this group, will discuss these concepts with CMS and work toward an implementation plan, then using that as a core structure to incorporate into the overall plan. That plan will be shared publicly in May.

Consumer Protections

Anthony Wright, Health Access California presented material on consumer protections. These are a work in progress, developed with involvement of several other organizations. The goal is that these would be adopted in *any* organized system of care. The presentation is available at http://www.dhcs.ca.gov/provgovpart/Documents/SPD%201115%20Waiver%20Basic%20Consumer%20Protections.pdf.

Bobbie Wunsch, PHCG, asked whether Health Access had considered how consumer protections could be applied to a non-Knox Keene organization, as in the State's proposed county alternative. Anthony Wright said that some of the areas of importance can be replicated through other means. If the alternative models are taking on risk, then they require more oversight than if they are not risk-bearing. The key issue is patient experience in the issue areas raised in the presentation: continuity of care, network adequacy, disability access, fiscal solvency, public accountability.

Jackie Ritacco, AltaMed, asked how the recommendations envisioned monitoring for the following: network adequacy, medical group solvency, and SPD grievances. Anthony Wright said that DMHC already monitors for network adequacy and for medical group solvency, and that while the standard might be higher for SPD, the protocol would be the same. DHCS should and DMHC should coordinate on the review of these plans, but DMHC would continue its existing functions. Elizabeth Landsberg added that given that the patient cap is applied separately to each plan with which a provider contracts, she would recommend additional monitoring – mapping, secret shoppers, etc. – to assess network adequacy.

Cheryl Phillips, On Lok Lifeways, took issue with the recommendation that PCPs should accept no more than 1200 patients from any source. Primary care access is at a crisis, and most primary care doctors have panels over 2500. While supporting the intent – that the primary care infrastructure be there for SPD – she suggested ways to achieve this other than panel limits, including after-hours access, 24-hour call lines, and other access points. Several other Workgroup members supported this point. *Anthony Wright* responded that if the current standard is meaningless, we need to make sure that the benefit is not illusory, and that PCPs actually serve the patients in their panels.

Brad Gilbert, IEHP, spoke to the issue of DMHC enforcement, saying that the agency has become much more engaged. He also noted that while the 2-plan model did begin by enrolling women and children, Medi-Cal plans, and COHS in particular, have undergone a major shift, and already serve significant numbers of 3N individuals and people in SPD codes.

Regarding transition, Brad said that he would rather contract with a specialist who is already serving a patient but not yet in the IEHP network than have that person remain in FFS. Regarding rates, he said that they wished they were paid at 95% FFS (as the presentation said), and that plans do a better job when they have financial responsibility and the ability to coordinate care.

Elizabeth Landsberg, WCLP gave a presentation on consumer protections in enrollment, transition, and disenrollment. The presentation is available at http://www.dhcs.ca.gov/provgovpart/Documents/SPD%20WCLP%20Readiness%20Standards%20E.%20Landsberg.pdf.

Deb Roth, SEIU, asked whether, given that those who don't choose a plan may be among the most vulnerable, it would be worth looking at who currently gets defaulted. Tanya Homman responded that DHCS currently doesn't default SPDs at all, since their enrollment is voluntary. While they do know something about current defaults, the population is so different that it may not be relevant. DHCS recognizes that the SPD population may require additional outreach and other attention, though they cannot commit to all the WCLP recommendations.

Mary Giammona, HPSM, said that, based on the COHS experience, DHCS should look at the lack of risk adjustment in the SPD rates. It might be a good time to consider how funding is developed for serving SPDs, and to look at Medicare risk-adjustment scoring. She also noted that the Health Access and WCLP examples seem to describe delegated situations and private plans, and that they are not representative of every kind of plan serving the disabled. These populations do deserve special attention, but there are some good models already in operation.

Brenda Premo, CDIHP, said that the SPD aid codes are not uniform in the enrollment assistance they need. Some people who are deaf need only interpretation, while others need additional help. Some things are the same as the general population, as far as non-response. She also suggested that provider panels be defined not in terms of individual physicians but in terms of the full medical team, including midlevel providers.

Margaret Tatar, CalOptima, said that from the COHS perspective, public accountability is imperative, and addresses many of the other issues that have been raised. When a plan is accountable to local committees and a publicly meeting board that's appointed by local elected officials, it affects the plan's processes. CalOptima delegates to medical groups and has a lot of the protections mentioned in the WCLP presentation. A cross-cutting issue in that presentation is the difference between and among Knox-Keene and Medi-Cal obligations. It is important for DMHC and DHCS to enhance audits and work toward better coordination, particularly in terms of beneficiary rights.

Richard Bock, Molina, took issue with some of the characterizations of managed care plans, saying that managed care is not the enemy. For fragile potential members, plans and advocates should work together to make sure that what plans provide makes sense for individuals.

Dean Germano, Shasta Community Health Centers, raised the issue of adequate primary care capacity, particularly with the aging of the primary care workforce. In his non-managed care community, panels are huge, but they can't shut them. Nurses and non-clinical case managers must pay a bigger role, with care management aligned along a team of support. Financial and regulatory systems need to back that up. Savings will come from the inpatient side, but only if the front end of primary care is adequately supported financially and in regulation.

Access and Enrollment – DHCS Perspective

Tanya Homman, DHCS provided an overview of DHCS's current work regarding access and enrollment.

Jackie McGrath, Alzheimer's Association, asked about the nature of notices to potential managed care enrollees, mentioning that a previous notice regarding adult day health care was difficult to understand. Tanya Homman said that DHCS aims for a sixth-grade reading level, but has trouble achieving that with its more technical documents. David Maxwell-Jolly acknowledged the problems with the ADHC letter, but said that it is the exception and not the rule, and that most MMCD and enrollment materials are much more successful. *Elizabeth Landsberg* offered the assistance of legal advocates in the preparation of notices and other materials.

Dan McCord, Chief, Health Care Options Branch, Fiscal Intermediary & Contracts Oversight Division, DHCS explained HCO's goals and procedures. His presentation is available at http://www.dhcs.ca.gov/provgovpart/Documents/SPD%20HCO%20Program%20Overview.pdf.

He described the enrollment packet and mailing, the Member Services offered, outstationing in communities, and the HCO website, which includes a link to the Provider Information Network (PIN) which allows users to find a PCP within 10 miles.

Elizabeth Landsberg, WCLP, asked whether the Provider Information Network allowed users to see which hospitals and other entities a physician contracts with. Dan McCord said that was not yet possible, but that they are working to improve the PIN system.

Elizabeth Landsberg asked about the percentage of applicants that go to presentation sites. Dan McCord said he would supply that information.

Lisa Kodmur, LA Care said that she had trained local HCO employees in 2009 regarding the needs of people with disabilities in enrollment, and that it had been very well received.

Tanya Homman noted that plans' EOC also explain assistance options (from plans) to members.

Consumer Experience

Shelly Martin and Beccah Rothschild, Health Research for Action, UCB, discussed the *Medi-Cal Access Project*, a four-year effort focused on promoting Medi-Cal Managed Care for seniors and people with disabilities. A summary of year one of the project is available at http://www.dhcs.ca.gov/provgovpart/Documents/SPD%20UCB%20Medi-Cal%20Access%20Project%20SummaryRpt.pdf, and a summary report on year two is at http://healthresearchforaction.org/evaluation/medicaid-guide-medi-cal-access-project-report-2008.pdf.

Focus groups with SPD individuals, held in 2007, found the following:

- Many people mistrust managed care organizations and Medi-Cal, sometimes based on their experience, but not always
- Many people feared that if they moved to a Medi-Cal managed care plan they could never go back
- Many wanted specific information – especially with regard to providers and prescriptions – in order to make a choice. Names of plans, contact information, and side-by-side charts with information on copays, prescriptions, participating hospitals, quality measures were all important.
- Prescription coverage is a major concern – people want to know which medications are covered, what to do if something is *not* covered, how much the copays will be, etc.
- Language access was another concern – people do not want to supply their own interpreters, and want to find a doctor who speaks their language

Leila Saadat, Alameda Alliance, said that an Alameda Alliance evaluation from 2010 similarly found that SPD members were concerned about prescriptions and wanted clear information.

Chris Perrone, CHCF, noted that when Brenda Premo did focus groups with PWD, there were significant differences in the health access of people with physical disabilities versus those with mental illness. People with physical disabilities had usual sources of care and relationships with providers, but people with SMI did not. Beccah Rothschild said that due to the mental health carve-out, they heard these concerns more from people with physical disabilities, who were concerned that if they switched to managed care they would never find another specialist.

Anthony Wright, Health Access, suggested that language access might have improved due to the adoption of language standards in commercial plans during the period of the study, and Shelly Martin said the study found that language access is better in managed care.

Anthony Wright mentioned video medical interpretation, which brings the interpreter onto the screen at the time of the appointment, reducing the wait time. IT should be used to help facilitate language access and get around the scheduling and other complications of three-way appointments. *Erica Murray, CAPH,* said that several public hospitals (ACMC and SFGH) are using video medical interpretation and sharing interpreters, as part of the Health Care Interpretation Network (HCIN).

Lisa Kodmur, LA Care, asked whether there was evidence of the impact of a guide to Medi-Cal managed care produced by the project, and Beccah Rothschild said that a randomized controlled trial showed increases in understanding and reductions in stigma. A 6-month follow-up found a slight (but statistically significant) increase in the number of people joining plans after receiving the guide. They are currently engaged in a second evaluation.

Transitioning from FFS to Managed Care

Michael Humphrey, Sonoma County In-Home Support Services Public Authority, described his county's planning process as it prepared to move the vast majority of Medi-Cal beneficiaries from FFS to managed care, a transition that happened in 2009 with a move to Partnership Health Plan (PHP). A Sonoma County planning group report from 2006 is at http://www.dhcs.ca.gov/provgovpart/Documents/SPD%20Sonoma%20County-Report%20of%20the%20Planning%20Group%20on%20Medi-Cal%20Managed-Care.pdf.

Bobbie Wunsch, PHCG, asked what IHSS members were saying about the transition. Mike Humphrey said that with only 5 months of enrollment, it is too early to say. He noted that Sonoma requested and got a Partnership Health Plan (PHP) regional office and regional director, and set up a local Consumer Advisory Committee. He noted that many enrollees are dual eligibles, and that adds some confusion.

Michael Humphrey said that community clinics had been closely involved with the planning group, and were very active in educating their patients regarding enrollment provisions and choice. As a result, Sonoma's auto-assignment rate has been very low.

Elizabeth Landsberg, WCLP, said she was glad that so many people were engaged in the enrollment process, and wondered what lessons Sonoma could provide on outreach strategies. Michael Humphrey reiterated the importance of the clinics, as well as of community groups connected to children and SPD.

Access for Persons with Physical Disabilities

Brenda Premo, CDHP, facilitated a discussion about ADA access for persons with disabilities, and the process of development of a facility site review (FSR) tool for disabled access. Brenda noted that for SPD, access means what it means for the population at large – language access, network adequacy, etc. – but also means being able to reach an office without needing to negotiate stairs.

Development of FSR

Brad Gilbert, IEHP, discussed the development of a new facility site review (FSR) tool. The tool is available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/FEB24/ADA%20Tool_IEHP_LACare_HealthNet_Molina.pdf.

When IEHP began working with the Center for Health and Disability, the draft FSR had 300 questions, including 37 related to bathroom access. Eventually, it was edited to 55 questions, which take only about 20 additional minutes beyond the standard FSR. Development of the tool was a collaborative effort between LA Care, HealthNet and Molina. Leila Saadat said that the Alameda Alliance has incorporated the tool in their site reviews, and is working with DREDF to expand its use to additional providers.

Carol Spencer, HealthNet, which uses the tool in every location with Medi-Cal business, said the goal was to answer the question: what do you need for a member to go independently from the parking lot to the exam room – including using restroom facilities. HealthNet has trained all its review nurses to use the tool, in an experiential training which involves the nurses sitting in wheelchairs, and going through a facility in order to get the perspective of a person in a wheelchair. Brenda said that the goal is not to punish doctors, but rather to get members the information they need to make an informed choice.

June Isaacson Kailes, CDHP, noted that the tool was essential because many existing criteria for evaluating site access and safety do not go far enough – it is possible to meet them and have a facility that still is not accessible to someone who uses a wheelchair. The ADA accessibility tool addresses 13 areas with 55 criteria in all. Of these 25 are critical for getting from the parking lot to the exam room, and any break in those 25 means that the office is classified as “limited access.”

Richard Bock, Molina, said that 6 of the 15 staff-model primary care centers that Molina operates have done FACE lifts (Fully Accessible Centers of Excellence) and now include the following accessibility enhancements:

- Exam table that goes down to 17”
- Wheelchair weight scale

- New Hoyer lift
- Accessible restrooms
- Accessible waiting areas
- Face to face interpreters
- Lowered counters
- Automated entry doors
- Materials in alternate formats
- Assistive listening device
- Video interpreting pilot
- Insta-med Rx dispensing –to avoid trips to the pharmacy
- Cisco telemedicine pilot

Lisa Kodmur, LA Care, talked about what LA Care has done to get the word about more- and less-accessible offices and facilities out to consumers.

- The six collaborating plans now share their FSRs using the Tool for those providers that are in more than one plan network
- A tablet PC transmits FSR results wirelessly to LA Care and populates database. (This project took LA Care's IT team 6 months to design, and then another 3 months to put results online)
- Results are publicized through the call-center/member services representatives, through publication in the paper provider directory, and on the website. It remains a challenge to let consumers know that they have all this information.
- Collaborating plans exchange data monthly, and meet quarterly
- Nurses receive 8 hours of training, including experiential training

Lisa Kodmur said there had been no resistance from providers, perhaps because there is no corrective action plan for providers who do not pass the audit.

The collaborative has now done more than 1580 reviews. Compliance rate range from 90% for the waiting room to 50% for the walkways to a mere 3% for the height adjustable exam table.

Bobbie Wunsch asked Brenda Premo and June Isaacson Kailes to identify the essential ingredients for disability access.

Brenda Premo, CDIHP, said that regardless of the system or the site, it needs to be accessible for everyone. It is impossible to give people the care they need without this. Everyone, including consumers, needs training.

June Isaacson Kailes, CDIHP, said that the details are important. It takes work up front and negotiation along the way, but it's doable.

Brad Gilbert, IEHP, said that the ADA tool did not initially have strong support from providers. However, they have come to see it not as a punitive measure but as a QI tell. IEHP has told providers that they can be re-reviewed if they fix things. HealthNet manages its FSRs similarly, and uses the tool for provider education.

Brad Gilbert said he would propose the following:

1. There should be a negotiated, agree-upon tool that should be used at all primary care sites, including Ob/GYN; and
2. Data should be accessible at minimum in directory and member services.

Dean Germano said that his clinic has prepared providers to go out and look at Board and Care homes' accessibility.

Brenda Premo, CDIHP, said that the current tax incentive should be modified to help reduce the cost of tables and other specialized equipment, or that providers will have to see patients at the public hospital. *Brad Gilbert, IEHP,* agreed, saying said that it's difficult to impose these requirements on solo practitioners in outlying areas, and that policies should either make it cheaper for them to upgrade their equipment, or be prepared to transport patients.

Christina Mills, CILC asked whether the tool had been used in LTC facilities or hospitals. Both IEHP and HealthNet said no, that they only audit primary care offices at this point.

Conclusion

Bobbie Wunsch thanked the presenters, and reminded the group of the next meeting:

- April 1, 10-3, Convention Center Room 103

She asked the group what they thought remained to be discussed at that meeting, besides the scheduled discussion of counties without managed care plans. Responses included:

- Dual eligibles (Greg Franklin reminded the Workgroup of the paper on dual-eligibles prepared by CHCS, and announced an in-audience webinar on it to be held on March 29 at DHCS, time TBA)
- Home and community-based services (Bobbie Wunsch said that would be added to the April 1 agenda)
- Opportunities for plans to have direct responsibility for HCBS
- DHCS thinking re: consumer protection ideas presented at this meeting
- Wrap-up from DHCS on where we are and how to move forward

The meeting was adjourned at 2:55 PM.