MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

ROBERT F. CARLSON AUDITORIUM

LINCOLN PLAZA NORTH

400 P STREET

SACRAMENTO, CALIFORNIA

TUESDAY, AUGUST 20, 2019

2:00 P.M.

JAMES F. PETERS, CSR
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A P P E A R A N C E S

COMMITTEE MEMBERS:

Ms. Rob Feckner, Chairperson

Mr. Ramon Rubalcava, Vice Chairperson

Ms. Margaret Brown

Mr. Henry Jones

Mr. David Miller

Ms. Eraina Ortega

Ms. Mona Pasquil Rogers

Ms. Theresa Taylor

Ms. Betty Yee

BOARD MEMBERS:

Ms. Fiona Ma, represented by Mr. Frank Ruffino

Ms. Lisa Middleton

Ms. Stacie Olivares

Mr. Jason Perez

STAFF:

Ms. Marcie Frost, Chief Executive Officer

Mr. Matt Jacobs, General Counsel

Ms. Donna Lum, Deputy Executive Officer

Dr. Donald Moulds, Chief Health Director

Ms. Liana Bailey-Crimmins, Chief Information Security Officer

A P P E A R A N C E S C O N T I N U E D

STAFF:

Ms. Susanna Bishop, Committee Secretary

Dr. Julia Logan, Chief Medical Officer

ALSO PRESENT:

Mr. Tim Behrens, California State Retirees

Mr. Larry Woodson, California State Retirees

I N D E X

P R O C E E D I N G S

CHAIRPERSON FECKNER: Good afternoon. We're going to call the Pension and Health Benefits Committee meeting to order.

The first order of business is to call the roll.

COMMITTEE SECRETARY BISHOP: Rob Feckner?

CHAIRPERSON FECKNER: Good afternoon.

COMMITTEE SECRETARY BISHOP: Ramon Rubalcava?

VICE CHAIRPERSON RUBALCAVA: Present.

COMMITTEE SECRETARY BISHOP: Margaret Brown?

COMMITTEE MEMBER BROWN: Here.

COMMITTEE SECRETARY BISHOP: Henry Jones?

COMMITTEE MEMBER JONES: Here.

COMMITTEE SECRETARY BISHOP: David Miller?

COMMITTEE MEMBER MILLER: Here.

COMMITTEE SECRETARY BISHOP: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Here.

COMMITTEE SECRETARY BISHOP: Mona Pasquil Rogers?

COMMITTEE MEMBER PASQUIL ROGERS: Here.

COMMITTEE SECRETARY BISHOP: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Here.

COMMITTEE SECRETARY BISHOP: Betty Yee?

COMMITTEE MEMBER YEE: Here.

CHAIRPERSON FECKNER: Thank you. And please note Mr. Perez, Ms. Middleton, Mr. Ruffino, and Ms. Olivares as

joining the Committee today, please.

Second order of business will be to approve the Committee timed agenda. What's the pleasure of the Committee?

COMMITTEE MEMBER TAYLOR: Moved approval.

CHAIRPERSON FECKNER: Moved by Taylor?

COMMITTEE MEMBER BROWN: Second.

CHAIRPERSON FECKNER: Seconded by Brown.

All in favor -- any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Item 3, Executive Report. Ms. Bailey-Crimmins, Ms. Lum, please.

CHIEF EXECUTIVE OFFICER FROST: Chair Feckner, I'd like to start the Committee, if that's okay?

CHAIRPERSON FECKNER: Certainly.

CHIEF EXECUTIVE OFFICER FROST: I'd like to just take a quick moment to welcome Liana Bailey-Crimmins back full time with a clean bill of health. And we're all so happy for her.

CHAIRPERSON FECKNER: Absolutely.

(Applause.)

CHIEF EXECUTIVE OFFICER FROST: I'd also --

CHAIRPERSON FECKNER: Couldn't be better news.

CHIEF EXECUTIVE OFFICER FROST: Yeah, it's great news. We're thrilled and I know she is as well. It's been a one-year battle for her. I think it was a year yesterday, I think is what you said. So a very long year for her. But we were all there championing her fight.

So I want to begin with some introductions, introducing Don Moulds as our new Chief Health Director. I had sent a Board note with his long history of not only working here in Sacramento, but working across the State.

So most recently Don was working with the Commonwealth Fund. And then prior to that he was the Acting Assistant Secretary for Planning and Evaluation for the U.S. Department Health and Human Services, where he was a principal policy advisor.

And I think other notable work for him included leading a work group around Alzheimer's and finding a way to end Alzheimer's disease. He also served as the Vice President for the California Medical Association's Center for Medical and Regulatory Policy. And again, he has very deep roots here in Sacramento, where he also worked as the Director of the Senate Office of Research and as a principal consultant to Senate Pro Tem John Burton. So want to thank Don for joining the team. We're thrilled to

have him.

And then I also want to thank Liana for her leadership of the Health program over the last 2 and a half years and her work with Pension and Health Benefits Committee. There were a number of significant agenda items that came before the PHBC under her leadership, including risk adjustment, and regions, and the development of the Health Beliefs.

Liana will also begin a new role at CalPERS as our Chief of Information Security. And many of you know that Liana started her career in information technology, so this is a bit like going back home for her. And we're excited to see how she will continue to move that program forward. I know it's of particular interest to this Board. We had some discussion at the offsite. We'll have a closed session update on it tomorrow afternoon. But I think you'll find that Liana's leadership and knowledge in this area will meet all of your needs. So with that, congratulations to both of you.

CHAIRPERSON FECKNER: Thank you.

(Applause.)

CHAIRPERSON FECKNER: Please.

DEPUTY EXECUTIVE OFFICER LUM: All right. Good afternoon, Mr. Chair, members of the Committee. Donna Lum, CalPERS team member. Before I get started with my

brief executive report, I'd like to first welcome Ms. Olivares. We hope you are able to join us in future Pension and Health Benefit Committee Meetings as well.

I also wanted to say that it's been a real privilege and honor to have been able to co-lead and share the responsibilities of this Committee with Liana. She and I have worked together for a very long time. And when we talk about her going full circle, I know that our teams in customer service are really going to be benefit from her new role as the Information Security Officer. And so again, congratulations to you, Liana, in your new role.

And then I'd also like to welcome Don in his new role. I'm really looking forward to working with Don on this Committee. And I'm certain that there are many things that you are well aware of that are of great importance in our health program. And I'm very confident that Don is going to do a great job in that role as well. So welcome as well, Don.

So with that, I have a couple of brief updates that I'd like to share with you. The first is centered around an update on our CalPERS Benefit Education Events. And then secondly, just give you another update on what we've been doing with regards to integrating our Lean practices in customer service.

We recently completed the CalPERS Benefit

Education Events, also known as our CBEEs, with three events that were held in July and August. Those events were hold in Ontario, Fresno, and Costa Mesa. And as with all of the CBEEs that we have conducted this year, all three of these did have an increase in attendance. But there is one that is quite notable that I want to share with you, and that is the attendance that we saw at the Costa Mesa CBEE. We had an increase of 35 percent --

CHAIRPERSON FECKNER: Wow.

DEPUTY EXECUTIVE OFFICER LUM: -- of attendees attend that CBEE. And I have to tell you it was very inspiring to see how our teams had to really step up in action when we saw that there were long lines of members who were trying to get into class rooms that were filling up. And so they took very quick action. We found available space there at th CBEE, and we were able to conduct additional classrooms. So it really does represent how committed the teams are and how much we do serve our members at these CBEEs.

We were also visited by several of the Board members. And again, I just want to thank you all for all the support that you give the team when you're attending these CBEEs.

I want to share with you a comment. And it's a very common comment that we receive at the CBEEs. But I

do think that it really does reflect the kind of effort that the team puts into the CBEEs, as well as the level of gratitude and appreciation that our members share with us.

In this particularly survey, we had a member indicate that, "The benefits seminar exceeded my expectations. I had so many questions and concerns before. I have a few now, but I feel like I have access to the resources and the answers to those questions. I feel empowered in my ability to take positive action towards my retirement. I will be making appointments at my local CalPERS office to ensure that I am staying on course. And I want to thank you and all of the CalPERS staff, the speakers and the exhibitors all were very helpful, courteous, professional, they are highly knowledgeable, and very informative".

So as we close the CBEEs for this calendar year, I just wanted to share with you and with the public we do have the 2020 CBEE schedule, which is currently posted on the CalPERS website. And now our education teams and a lot of our customer service resources will be turning our focus over to the Ed Forum, which is coming up in October.

The second update that I would like to share with you is around our Lean practice integration. If you recall, I've updated this Committee on a couple of occasions on some of the areas in customer service where

we've used Lean practices to improve services to our customers. Most notable of those that are centered around disability retirement determinations, as well as pre-retirement death benefits.

Today, I want to give you an update on how we have continued on our journey for looking at continuous improvements and streamlining and improving our customer service.

As a branch, we -- as a Customer Service Branch, we have prioritized adoption of Lean principles, again to streamline our processes and to provide enhanced customer service. And it's impressive to know that over 71 percent of all the customer service team members have been trained in the Lean White Belt Training. And 99 percent of all of our customer service team leaders have been trained. In order to adopt a culture of Lean practices, it's very important that there is education and awareness. And to have a large customer service team that has been trained and has been practicing these consents is really going to take customer service and continue to move it forward.

We did have a couple of very notable improvements in two customer service areas that I wanted to share with you. First of all, we were able to improve our customer service around service credit estimates. We improved the service from 90 days to a turnaround of 60 days. And this

really does allow our members more rapid access to being able to make decisions on a timely basis.

We also used Lean principles to restructure our membership employment review process. And we improved that service level by 20 percent reducing the turnaround from 120 days to 90 days.

And then lastly, we have been making some shifts in the way that we process our work. And we have also empowered our contact center and our regional office team member to also make some new process changes, thereby not having to refer those types of transactions to the back office and delaying responses to our members.

So we will continue, you know, to look at different ways that -- and opportunities to simplify our programs and to streamline our operations. We really do want to continue to focus on providing service to our customers in the most efficient and effective manner.

Mr. Chair, that completes my report, and I'm available for any questions.

CHAIRPERSON FECKNER: Thank you.

Seeing none.

CHIEF INFORMATION SECURITY OFFICER BAILEY-CRIMMINS: Well, good afternoon, Mr. Chair and members of the Committee. Liana Bailey-Crimmins, CalPERS team member.

I am pleased to highlight three areas that have -- we have made significant process. The first is CalPERS is launching two new my|CalPERS member self-service features for our health members.

Second, I'd also like to share some improvements and actions that we have taken to improve member and employer communications regarding open enrollment. And then lastly, provide you an update regarding our reference pricing by therapeutic drug class solicitation.

So the first new my|CalPERS feature is the provider director utility. And I've mentioned this to you in the past. But I am pleased to inform you that we will be able to launch it September for open enrollment and it is three months ahead of schedule. And being a prior CIO, that's very important to have projects ahead of time.

Once a member logs in to the my|CalPERS system or in the open enrollment app, they will search for health plans. And then there will be the new feature that says "Search for my Doctor". They type their physician's name, select that name from the directory, and then they will see the health plans that that physician associates with, and be able to compare monthly premiums.

We believe this is going to be a very beneficial feature and enrich the member's experience. And it will also assist them in making decisions when they are wanting

to make a health plan change, even when it's outside of open enrollment.

As a reminder, CalPERS encourages members to speak with their physicians before making changes to their health plans, because physicians may change which health plans they associate with at any time.

I also want to give a big thank you to the CalPERS Information Technology team and the health plan carriers. Because of them, we were actually able to make this happen for our members.

The second my|CalPERS feature that we are launching is "Health Into Retirement Calculator". It is designed for active members who are nearing retirement. If a member is retiring within the next year, they may want to receive information regarding their health premium estimates, so that it will assist them with their financial planning efforts.

As a member, basically enter a future retirement date, as long as it's within the year period, and they can see how much the vesting percentage will be and how much it affects their share of the health premiums.

We believe this will assist members as that retirement date gets closer. And I am pleased to report that this feature is available right now.

Second category, open enrollment. It is less

than one month away, September 9th to October 4th. The CalPERS website has now been updated with open enrollment information and resources for our members and employers. For members, they can find information on factors to consider when choosing a health plan or making a change. Employers can learn more about processing transactions and also information that they could be sharing with their employees when the open enrollment period begins.

The open enrollment app will be live August 26th. And members can once again use the app to view their health plan statements and perform quick and convenient health plan comparisons.

They will now also have that ability to search for their doctor. And retirees will actually be able to make health enrollment changes, including dependent -- changing their dependent status.

The health plan statements will be mailed out to all of our members August 26th for those members that have elected to receive it by mail. And in an effort to maintain open communications, we wanted to make sure that the Committee was aware, we sent letters to all members that were impacted by health plans that are -- have an increase of approximately 10 percent. So if they chose to stay with their current health plan that we wanted to make sure that they were aware of that via a letter, so they

can make that change during open enrollment.

And lastly, reference pricing solicitation by therapeutic class. It was canceled. But I am pleased to say that it was re-released yesterday as of after August 19th. And as a reminder to the Committee, we are in a no-contact period.

Mr. Chair, I'd like to say it has been an honor to serve this Committee, CalPERS, our -- Ms. Frost, and most importantly, our members and employers making quality affordable health care available to public servants.

Thank you very much. And that concludes my opening remarks.

CHAIRPERSON FECKNER: Well, thank you. And we thank you for a job well done. We know you're going to do even better in your next adventure, so thank you.

All right. That brings us to Agenda Item 4, Action Consent Items, the approval of the June 18th Committee Meeting minutes.

What's the pleasure of the Committee?

COMMITTEE MEMBER MILLER: Move approval.

COMMITTEE MEMBER TAYLOR: Second.

CHAIRPERSON FECKNER: Moved by -- who said that?

Moved by Miller, seconded by Taylor. How is that?

Any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Item 5 is an information consent item. Having had no one request to remove anything, but I do have a request from the public.

Mr. Behrens, would you like to speak on Item 5a?

MR. BEHRENS: Thank you, Chairman Feckner, members of the Committee, members of the Board. Tim Behrens, President of the California State Retirees.

So I'm looking at the agenda item for calendar 2020, the proposal that I'm assuming is going to go to the Board tomorrow. And I'm seeing six real meetings, including the offsites scheduled. So that means there's six less meetings scheduled.

Here's some issues that I have with that schedule. First of all, a couple of years ago, we were limited to three minutes to speak. So now that means we have 36 minutes a year to speak about health benefits issues. Now, you're cutting it down to 18 minutes a year. It doesn't seem reasonable to me.

Your schedule for the approval of the 2021 Health Benefits is in June. Normally, the Board does that behind

closed doors, comes out, gives us a hard copy, we have one hour to review nine pages of changes in the health benefits that are being recommended for 2021. And then there's no meetings after that for four months, which means there's no way or vehicle for us other than to get on a telephone to ask questions about that proposal.

And then finally, customer service. I have a question about when you provide percentages of customer service satisfaction. When you say -- the last one I heard was 0.4 percent complaints about mental health services, for instance. Well, I don't know if that means 4, 40, 400, 4,000. So I'm asking that in the future if you could at least put in parentheses how many stakeholders or members actually were affected by that part that is not going up like we like it.

Thank you.

CHAIRPERSON FECKNER: Okay. I just want to point out, Mr. Behrens that there are six scheduled meetings not including the offsites.

MR. BEHRENS: Correct. And normally --

CHAIRPERSON FECKNER: So I understand. It's still a reduction, but it's six not counting. You said including.

MR. BEHRENS: Normally, at the offsites, we aren't allowed to speak. Although I noticed at the last

one a couple people were allowed to speak. Normally, we have to hand a piece of paper to one of our Board members to ask questions on our behalf, so that's why I reported it that way.

CHAIRPERSON FECKNER: Appreciate that.

MR. BEHRENS: Thank you.

CHAIRPERSON FECKNER: Thank you.

Seeing nothing else on Item 5.

It brings us to Item 6, the Mental Health Overview Challenges and Innovations.

Dr. Logan.

(Thereupon an overhead presentation was Presented as follows.)

CHIEF MEDICAL OFFICER LOGAN: Good afternoon. My name is Julia Logan. I'm a CalPERS team member and I have also been a practicing physician in Northern California for the past 15 years. It is my great pleasure to be here today and I'm very grateful to talk about a topic that is very important to me, to my patients, to my family, to CalPERS members, and to all of you.

We're joining -- we're continuing this conversation that started at an offsite in July of 2018 and then a stakeholder meeting in May of this year. And we're also continuing in a statewide dialogue on mental health care. As you know, our Governor has made mental

health a priority in his administration, and is investing in mental health in the State budget. He has also appointed a State Mental Health Czar.

It is my hope that in having this discussion, we can all talk openly about mental health challenges and collectively get to the point where we can talk openly -- as openly about mental health as we can about other health conditions, such as diabetes or heart disease.

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CHIEF MEDICAL OFFICER LOGAN: I wanted to give you an idea of what I'll be talking about today. I'll provide an overview of the mental health landscape in California; I'll talk about how common mental health disorders are in California in general, and then in the CalPERS population; the impacts, both social and financial; the importance of screening and early intervention services; and also a little bit about mental health parity laws and how they fit into this conversation. I'll also be talking about some of the big challenges that we're facing and how the plans are really facing those challenges with some really good interventions.

And then I'll focus on roles and commitments. CalPERS definitely has a role in this, plans have a role, and the Department of Managed Health Care has a unique

role. And I'll talk a little bit about that.

And then finally, I'll wrap it up with how we're working towards the future and what we're thinking about in the next 12 months or so, and how we'll be working with statewide partners and aligning our efforts statewide.

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CHIEF MEDICAL OFFICER LOGAN: So mental health is a person's emotional, psychological, and social well-being. It can be divided up into any mental illness and severe mental illness. Severe mental illness includes things like schizophrenia and bipolar disorder, severe depression. And then mental illness itself can be covered under an umbrella of behavioral health. Behavioral health includes mental health; substance use disorders, such as alcohol disorders or opioid disorders; and then developmental disorders is its own category that includes things like autism.

And today, I will only be focusing on the mental illness and mental health side of things, because everything else it would -- we would be here till 6:00 o'clock.

So mental health includes so many different conditions. It's not a one size fits all for sure. And as we will discuss, because every person is different, their culture, their life experiences, and their

priorities, these all need to be considered when treating a person with mental health challenges.

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CHIEF MEDICAL OFFICER LOGAN: So mental illness does not discriminate or decide to impact certain individuals only. Nearly one in six Californians experiences a mental illness in a given year. And half of us will meet the criteria for a diagnosable mental condition within our own life times. And 1 in 24 Californians has a serious mental illness.

This means that millions of households across California are affected by mental illness in some way. It reaches into every neighborhood in our state. And the needs are great, deep, and plentiful. And we're really all in this together.

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CHIEF MEDICAL OFFICER LOGAN: Mental health issues have a huge economic impact, as you could assume here in California. Not surprisingly, poor mental health care impacts worker productivity, including the inability to complete physical tasks, and it actually decreases your cognitive performance.

In the United States, we lose more than $200 billion a year due to mental illness. And depression is the leading cause of disability among people between the

ages of 15 and 44. And it ranks among the top three workplace issues.

But we know that we have the pow -- we have the power of treatment. We know that treating any mental illness leads to an estimated return of $4 for every $1 spent due to the increase in the ability to work.

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CHIEF MEDICAL OFFICER LOGAN: When we talk about mental health access and treatment, it's really important to understand how mental health parity laws have evolved in the past 20 or so years.

Traditionally, insurers covered for mental health differently than they did for physical health. And limitations of the number of visits were the norm for mental health treatment. This led to greater inequity and limited access.

So in 1996, Congress passed the first federal parity law. This was a great step forward, but it had certain limitations. And realizing these limitations, California passed its own law. But there are also limitations on this, because there are only certain mental health conditions that were covered.

So in 2008, motivated over the gaps of the 1996 law and the California law, Congress passed the Mental Health Parity and Addiction Equity Act, or MHPAEA some

people call it. And this required the copays and treatment limits for mental health and physical health be the same.

And then we made another step forward in 2010 when the ACA defined mental health as one of the essential health benefits. So it went beyond 2008 and mandated coverage rather than just requiring parity.

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CHIEF MEDICAL OFFICER LOGAN: Mental health conditions start early. And with more than one quarter million children that are CalPERS' dependents, this is really important. About three-quarters of serious mental illnesses start before the age of 25. One out of six adults experienced at least four potentially traumatic adverse events during childhood. And this includes abuse, or domestic silence, and things like that. And this greatly increases their risk of depression, anxiety, and PTSD. And it's a large area of focus for our first ever State Surgeon General.

Over the last 10 years, hospitalizations for mental health emergencies spiked 40 percent among young people. So early identification, accurate diagnosis, And effective treatment can alleviate enormous suffering for young people and their families.

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CHIEF MEDICAL OFFICER LOGAN: So as you can plainly see on this slide, suicides have increased dramatically in California and this reflects a national trend. More than 4,300 Californians died by suicide in 2017, a 52 percent increase since 2001. And while this slide is difficult, and jarring, and tragic, I'm showing it because I want to highlight the power of prevention.

We need to do a better job identifying people at risk and utilize screening and early detection. Forty percent of people who attempted suicide visit a doctor the week before. Think how we could change the angle of this line downward, if we improved screening and awareness. It could really be pretty powerful.

And while we're on this slide, we typically think of people with mental illness dying by suicide, or accidents, or overdoses. But what they actually -- the vast majority of people with mental illness die of things that other people die of, common diseases, like diabetes, cancer, heart disease. But there's a difference, these people with serious mental illness die earlier, almost 25 years earlier. And this is well known in the literature and called the mental health mortality gap. And just like the suicide rate, we can decrease that gap.

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CHIEF MEDICAL OFFICER LOGAN: Many studies have

shown that often people with mental health challenges don't receive the proper level of care. Out of the 43.8 million adults annually with mental health disorders, 41 percent receive any care at all, 38 percent -- is it 36 percent - sorry - receive formal care, which could entail going to their primary care physician for care, and then 22 percent receive specialty care, so seeing a psychologist or a counselor, and then 12 percent see a psychiatrist.

And while not everyone needs to receive the higher level of care, we know that the overall numbers are low, and several barriers prevent people from accessing care, which leads me to my next slide.

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CHIEF MEDICAL OFFICER LOGAN: As we just mentioned, there are so many barriers to high quality timely treatment, but I'm going to stick with five, because they're the mos actionable and the most common.

And they're stigma, workforce, screening, geography, and self-perception. I'll start with stigma, because we all have a role in that, and it could really be a game changer, if we all take ownership of it.

So what really is stigma? It's really negative stereotypes about mental illness that persist in all aspects of our society. People with mental health

challenges face rejection, discrimination, bullying in their personal and their work lives. Because mental health is unfortunately often not considered the same as physical health, the public perception of depression or bipolar disorders is often seen differently from diabetes or cancer.

Eight out of ten workers with mental health conditions say that shame and stigma prevent them from seeking treatment. And self-perception certainly plays a role in all of this. People may not know the extent of their illness, or be shamed of their emotions, or fear retaliation.

And so next, I'll talk a little bit about workforce and geography together, because they're so inextricably linked. And really it's a supply and demand issue with workforce shortages. The supply is limited not only because we have limitations on the number of providers, but because mental health appointments take much longer. Typically, therapy sessions are almost an hour long, so the average therapist only has about six to eight appointments per day.

And with our anticipated population growth in California, the aging of our population, the increased diversity, and increased utilization of mental health services, our State is facing some serious shortage

issues.

Over the next decade, it's projected that California will have 40 percent fewer psychiatrists and 10 percent fewer psychologists and family therapists. And age is a factor too. Half of our psychiatrists are over the age of 60.

And geography, certainly compounds the effects of workforce challenges, with much of the workforce concentrated in certain areas. The Bay Area, for example, has over three times more psychiatrists than those in the Inland Empire and San Joaquin Valley, which are both facing shortages. And as you are probably already aware, the northern and Sierra regions are about 40 percent of the state average.

The final report of the California Future Health Workforce Commission was published in February of this career. And it's worth looking at, if you're interested in learning more about the specifics and details. You can check it out at futurehealthworkforce.org.

Some of the solutions proposed in the report were taken up by our Governor and are reflected in our State budget. In total, $300 million was allocated to increasing the overall workforce with much of it focusing on the Medi-Cal program, where many of the most dire shortages are seen. And in terms of mental health

funding, the budget allocated more tan $70 million of general fund to hire trained behavioral health counselors in the emergency department and to increase the training of our workforce.

And finally, I wanted to talk about screening on this slide. Screening for certain mental health disorders, like depression, is recommended by several leading national organizations for children and adults. And it's a covered benefit for CalPERS members. But we know that screening is under-utilized. In fact, in a national study, rates in primary care settings are below ten percent. It's really a missed opportunity to identify patients and link them to care.

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CHIEF MEDICAL OFFICER LOGAN: So what does mental health look like among our CalPERS members? We've taken a look at our data warehouse and have been able to look at the prevalence of common mental health disorders in our members. The most common condition is depression with a prevalence of 4.7 percent in 2018, which is actually lower than the prevalence of the general population, which is between seven and eight percent.

Anxiety disorder and neuroses followed close behind with 3.5 percent and two percent respectively. And I wanted to take a moment to explain what neuroses is,

because some people may not be as familiar with it. It's a relatively mild mental illness that involves symptoms of stress or anxiety. And it's kind of a clinical term that physicians use.

And in terms of cost, depression is far and away the biggest cost driver for CalPERS for mental health. We spent more than $102 million on depression alone in 2018 and anxiety came in second with 36 million.

Although, not on this side, I did want to give you the total amount spent on behavioral health services in 2018. It was $349 million. And this cost trajectory has been generally increasing over the past six years or so. In 2012, for example, CalPERS spent approximately $209 million on behavioral health services.

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CHIEF MEDICAL OFFICER LOGAN: So I wanted to shift gears a little bit and talk about our roles. First, CalPERS' role, and then the Department of Managed Health Care, and finally I'll end with the plan's role.

CalPERS is guided by our strategic plan, which serves as our guide to transform health care purchasing and delivery. CalPERS monitors and administers health benefits. And through our contracts, we hold our plans accountable.

We also routinely track grievances and appeals.

And recently, we tracked plan level grievances and appeals related to mental health access. We're pleased to report that less than 0.08 percent of members have filed a grievance or an appeal with their health plan regarding mental health access in 2017 and 2018, and we found no significant difference between the plans.

And I certainly realize that not everyone files a complaint and certainly not people with mental health challenges. And that's why we have other ways of measuring the quality of mental health services. This includes our population health dashboard, which has certain mental health measures on it, our member satisfaction survey, and other measures.

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CHIEF MEDICAL OFFICER LOGAN: And I wanted to also talk about the Department of Managed Health Care's role. They have a unique role in measuring access and provider network adequacy. Guided by the Knox-Keene Act, plans are required to provide timely access to appointments. This is 48 hours for an urgent appointment -- mental health appointment, ten days for a non-urgent mental health appointment, and 15 days for a non-urgent specialist appointment.

And DMHC has the authority to enforce these through a corrective action plan or other sanctions. They

also require an annual network review from their plans. And so both timely access reports and annual network reviews are provided -- reports are provided on their website, as well as the raw data behind the reports.

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CHIEF MEDICAL OFFICER LOGAN: I wanted to take a minute or two to talk about the contracts and the role of the plans. Through the contracts, we take a multi-disciplinary and multi-pronged approach to ensuring that members receive high quality mental health services. This includes the provision of health benefits, preventive services and tracking, and evaluating quality care.

The plans are required to maintain an accredited behavioral health program. And through this program, plans cover inpatient and outpatient mental health services without a referral. They're required to meet all mental health parity requirements, which I discussed a little bit earlier. And they're also required to provide case management and care integration services.

And this is to support our high-risk high-touch members. It improves lives, decrease costs, and decreases utilization, and effectively streamlines care.

And in terms of ensuring quality tea, we hold plans accountable for several mental health clinical quality measures.

And finally, plans are required to maintain a wellness program, which is focused on the well-being of its members.

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CHIEF MEDICAL OFFICER LOGAN: Okay. So we recently surveyed and spoke with our health plans to better understand some of their own challenges and how they were overcoming them. What they reported back was really rich with innovation. And rather than give you a long laundry list of what each plan is doing, we thought it may be helpful to frame them around some of the most common barriers.

As you remember, the barriers I mentioned earlier, and they're on your -- this slide are stigma, workforce screening, geography, and self-perception. It was clear from ongoing discussions with the health plans that they have a deep and thorough understanding of these barriers and are continuing to find innovative approaches to overcome them.

So starting with stigma and self-perception. Thankfully, all of our plans are focusing on eliminating stigma and improving member's perception of themselves.

Blue Shield has take on a person-first approach designed to actively alleviate the perceived stigma associated using mental health benefits. Other plans are

using apps and social media, like YouTube, to reach out to members to educate them about stigma. And several plans have taken the National Association of Mental Illness's Stigma Free Pledge, while many plans have realized that supporting and educating primary care physicians about proper counseling techniques helps address stigma and can have a profound, positive impact on their patient's self-perception of their own mental heath challenges.

And moving forward, workforce and geography. There are several different innovations that plans are using to approach this statewide problem. And they're very -- very inclusive. So it's telehealth, the use of non-physician clinicians, the use of care managers, increasing the integration of mental health into primary care, and even training -- creating training programs, such as psychiatry residency programs.

Kaiser now has two psychiatry residency programs, one in Northern California and one in Southern California. So telehealth is increasingly used by all of our CalPERS plans to overcome shortages and geographic challenges. And for good reason really, there's a growing body of evidence that telehealth increases access to care and improves health outcomes, including mental health outcomes and reduces health care costs.

UnitedHealthcare is rolling out a text-based

therapy program that will increase access to more than 4,000 more providers, while Anthem is using video visits with in-network licensed psychologists, therapists, and psychiatrists. Patients are able to schedule their own appointments themselves seven days a week, via access through their phone or tablet.

Health Net is using text messages to ensure patients have a follow-up visit after a mental health hospitalization. And other plans, as I mentioned before, are using physician extenders. So a health care provider, who's not a physician, but has the credentials to diagnose and treat, it's mostly a nurse practitioner or a physician assistant. And these extenders are used most commonly in rural areas to help with that need.

And the integration of mental health services into primary care is another way that plans are really addressing the need to coordinate care, while also addressing workforce issues.

This model allows patients to see their primary care doctor, their therapist or psychiatrist, their care manager, and other support staff within the same four walls at the same time -- well, sequentially. It allows better communication for the clinical staff and improved access for patients, and it's been shown to really improve outcomes and lower costs. And Sharp and Kaiser are among

the plans integrating care in this way.

And I also -- finally, I wanted to touch on screening. Earlier, I mentioned that screening is underutilized in primary care clinics. Even though it's recommended, it's a covered benefit and it's important for prevention. Well, plans do realize the value of screening for its members. Western Health Advantage has been using -- utilizing a pay-for-performance program to incentivize its providers to improve an increased screening in the primary care setting, and has paid special attention to screening for those at risk for depression after a hospitalization. And they found great success with this program.

And Health Net has developed a toolkit for primary care physicians to manage mental health conditions in primary care and to increase the rate of screening.

Kaiser has a maternal screening program, which screens women during their pregnancy and after delivery, a time when they are at highest risk for depression. And both their obstetrician doctors and their pediatricians work collaboratively to screen pregnant and -- pregnant and new moms to ensure that they have proper protocols in place to support a mom at risk for depression. This program was started on a very small scale and has been scaled up, and has really shown positive outcomes for mom

and babies throughout the Kaiser system.

And plans are monitoring access to ensure that all their efforts are actually working. They do this through member satisfaction surveys, onsite audits, secret shopper surveys, and medical record reviews.

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CHIEF MEDICAL OFFICER LOGAN: Okay. You've heard a lot today about mental health, how it impacts California and CalPERS, some of its challenge, and some really promising innovations. I want to ensure you that we are committed to providing high-quality, high-value mental health care for our members and to working with our plans continuously to continuously further refine our mental health care services.

We are looking to scale up some of the promising interventions, like depression screening, and maternity care, and integrating primary care and mental health care. We're also looking to increase and improve telehealth. And we've reached out to the Department of Health Care Services and Covered California to learn about their experiences.

I also wanted to mention that we're taking a closer look at transgender health, in terms of access and prevalence. And we've been in contact with other state -- statewide stakeholders about this issue.

And we are also increasing and advancing our partnership with Smart Care California, including its focus on depression and depression treatment, given its high prevalence in the general population and in our population. And finally, we're working on alignment with other purchasers and State partners as we feel it's essential for our success.

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CHIEF MEDICAL OFFICER LOGAN: So this is my final slide and I wanted to leave you with some final thoughts about stigma. So through powerful words and actions, we can shift the social and systemic barriers for those living with mental health conditions. Together, we can encourage acceptance and understanding. Together, we can advocate for a better world. And I just wanted to end with a quote from former President Clinton who once said, "Mental illness is nothing to be shamed of, but stigma and bias shame us all".

I thank you for your time and attention and I welcome any questions.

CHAIRPERSON FECKNER: Thank you very much for a very nice presentation. We do have a number of questions.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Mr. Chair. Thank you, Dr. Logan for the overview of mental

health.

I was looking at page eight, suicide rates and looking at the decline in suicide rates from 2000 -- it appears to be from 2003 to 2005. And so then it began to spike back up. So what occurred during that time that couldn't be continued to avoid this return to this rapid increase?

CHIEF MEDICAL OFFICER LOGAN: You know, I'm not exactly sure what happened in that period. That's why we look at trends over many years, because there can be kind of ebbs and flows that we're not -- we can't really, really track and say that's the cause, but that's why we look at many years at a time. And so we can see this general trend upward.

COMMITTEE MEMBER JONES: So there's some kind of annual reports that are provided to kind of provide an overview of what occurred during those years?

CHIEF MEDICAL OFFICER LOGAN: The Centers for Disease Control and Prevention, the CDC, provides reports, and also our California Department of Public Health could probably provide further insight about those specifics.

COMMITTEE MEMBER JONES: Okay. Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Yes. Thank you,

Doctor.

So there was a couple of things that stuck out to me. I appreciate the report. One was the hospitalization of young people. And then you said that has increased. Suicide rates have increased. Yet, in 10, years we're going to have a decline of psychologists and psychiatrists, 40 percent fewer and 10 percent fewer. And I understand this talked about our partnership and working with our plans to work through some of the kinks of this.

And I know that Kaiser is working on it. You said Sharp. It looked like Health Net is using some different ways. I think my concern is how are we actually verifying that they're implementing these programs? Is there a tracking system? I think you also talked about following through with people who are hospitalized after they get out of the hospital when they're at highest risk.

I have a family friend who committed suicide not more than a week or oh after he got discharged from the hospital. So, I mean, how is -- how are we -- how are we tracking this? It sounds nice, but it seems like we're hitting our heads against a wall, and I don't know what that wall is.

CHIEF MEDICAL OFFICER LOGAN: Thank you for the question. You're exactly right. There are a lot of things working against us, so it seems like we are kind of

pushing against a wall.

I think our new Governor's interest in -- and commitment to mental health will really make a difference in terms of increasing our workforce. There are a lot of things that I did not mention about substance use that also is kind of happening in the background in terms of substance use treatment. So I think the substance use rates have a lot to do with the 40 percent increase in hospitalizations and things like that.

In terms of what CalPERS is doing to track, as I mentioned, we require the plans to have -- maintain a behavioral health program. And the behavioral health program is accredited, either by URAC or NCQA, which are two accrediting bodies. So they have to do a lot of maintenance of their records in terms of tracking grievances, and appeals, and timely access, and a lot of different things.

In addition to that, they have to provide a behavioral health report every year to us. And so we use that behavioral health report. We also use queries that we -- like recently, we asked the plans about things that they were doing that may not come up in our meetings with the plans. But it kind of helps us understand the broader -- the broader things that they're doing to improve mental health.

And in addition to the tracking and the behavioral health program reports, we always look at outcomes. Because you can do all kinds of different things, but the proof is really in the pudding. So that's where we have our performance measures. And we focus our performance measures mostly on the highest prevalence. So mental disorders, so we have several measures on depression, and depression treatment, and maintenance of depression treatment.

COMMITTEE MEMBER TAYLOR: Thank you.

CHIEF MEDICAL OFFICER LOGAN: And then follow up after hospitalization is another measure that we -- that we follow.

CHAIRPERSON FECKNER: Thank you.

Ms. Brown.

COMMITTEE MEMBER BROWN: Thank you. Thank you for the presentation. It's very insightful.

And I will just say that I noticed that you used the term "substance use". And I've always heard it called "substance abuse". So thank you for that new dialogue.

And I want to piggyback on something Ms. Taylor said, which is about do we have the ability to track what our providers are doing? And I wanted to know specifically you talked about our plans -- our providers have a requirement -- or maybe it's California has a

requirement that they get an appointment within two days, if it's serious, and then you said ten days and 15 days. Do we know how well our providers are doing? I mean, are 50 percent of the patients getting help within two days and is that in that behavioral report you get? I'm just curious about that.

CHIEF MEDICAL OFFICER LOGAN: Yes. So that information is actually produced by the Department of Managed Health Care. And so they provide timely access reports. And they don't break it down by provider. They break it down by plan. So we know that, for instance, 80 percent of plan A has timely access.

One thing -- because we've had some conversations recently with the Department of Managed Health Care about this, and one thing is that they're trying to develop standards around this, because we don't have any idea of what good is. I mean, of course, we want 100 percent, but we're not going to get 100 percent. So where do we hold plans accountable? And that line has not been drawn yet. So the Department of Managed Health Care is working on drawing that.

COMMITTEE MEMBER BROWN: And I recently read in I think it's the State Auditor's report of the rural counties access to regular health care. I think it may be Medicaid or Medi-Cal here. And what they did is while

they had a target of what they wanted to do, they looked for outliers.

So if three of the plans were able to be outsourced so it's like 81 percent, and then somebody was at 30 percent, then they were the outlier. So I assume that's what we would be doing to say why is it that two plans can meet the requirements and the third plan can't? And so I would assume we would look at -- sorry, I'm a little nerd about when it comes to data. But I would assume we would look at the outliers and say, why is it that maybe Kaiser can succeed and somebody else can't, you know?

CHIEF MEDICAL OFFICER LOGAN: You're exactly right. That's -- it's my understanding that that's what the Department of Managed Health Care does in absence of not having that line drawn in the sand. They do look at outliers.

COMMITTEE MEMBER BROWN: It might be helpful for some of us nerds to share that information with us about our providers or plans -- the plans. Thank you.

CHIEF MEDICAL OFFICER LOGAN: Sure.

CHAIRPERSON FECKNER: Thank you.

Mr. Ruffino.

ACTING BOARD MEMBER RUFFINO: Thank you, Mr. Chair, and thank you for your presentation, Dr. Logan.

That was very informative.

We definitely appreciate the staff commitment, your commitment to ensure that CalPERS beneficiaries have access to quality, timely behavioral health care through their chosen health plan.

Treasurer Fiona Ma wrote CEO Marcie Frost recently, as you may be aware, regarding some concerns with Kaiser Permanente's ability to deliver timely and appropriate behavioral health services to CalPERS members, and asked quote, "Whether Kaiser has been, is currently, or will be in compliance with all, all, the terms of its CalPERS contract", unquote.

Kaiser's response to staff's request for details for the most part reference only self-reported aggregated data, and didn't speak to the specific experiences of CalPERS beneficiaries or -- or addressed the specific shortcomings for which the Department of Managed Health Care has cited the plan.

The Treasurer, in her letter, was that the DHMC, the Department of Managed Health Care, has cited Kaiser repeatedly for its violations of State mental health laws, including, which you referenced to the California Mental Health Parity Act, timely access rules, network adequacy standards, and clinical appropriateness standards.

It is the substance of these violations and how

they may impact Kaiser's contract with CalPERS that the Treasurer is interested in, not only in the self-reported data.

Let me give you some examples of the kind of things that the Treasurer would have hoped to have learned specifically about Kaiser, but ultimately about other plans as well, as part of our broader program to hold our plans accountable for providing the behavioral health care CalPERS beneficiaries need and have paid to receive.

So one quick question. What percentage of the plan's premium dollar is allocated to behavioral health care services?

Second question, for both the plans internal and external provider networks, what is the average number of days, both in calendar and business days, between patient's second and third appointments with a non-physician behavioral health therapist?

It would particularly valuable to have that data both on a statewide basis and broken out on the regional and medical center level.

Third, what is the percentage increase since 2015 in the number of non-physician mental health clinicians employed by Kaiser expressed in full-time equivalents not -- not as a number of individual.

And a follow up. Given that Kaiser California

enrollment has grown by over 20 percent since 2015, what was the ratio of non-physician mental health clinician FTEs to Kaiser members in 2015 and how has that ratio changed since then?

Now, Kaiser mental health clinician claim, and that's their claim, that they must schedule their patient's follow-up appointments further into the future than is clinically appropriate. But Kaiser claims to be providing timely access to its patient for both initial and follow-up appointments. The Treasurer quite simply would welcome a chance to review data - which has been also expressed by other Board member - data supporting this claim that Kaiser makes. And I would imagine that everyone in the Board will welcome that as well.

The Treasurer would ask that staff direct Kaiser to come to this committee meeting later prepared to present and discuss in detail their member's access to follow-up appointments and to provide a full presentation of all the relevant data.

Finally, what data is available regarding the timeliness of appointments for the CalPERS patients whose behavioral health care services Kaiser outsources? To what degree were these members who directed to an outside provider successfully in gaining needed care in a timely manner?

Thank you, Mr. Chair, for the opportunity.

CHAIRPERSON FECKNER: Thank you.

Ms. Yee.

COMMITTEE MEMBER YEE: Thank you, Mr. Chairman.

Let me follow on, if I could, a little bit more broadly to Mr. Ruffino's comments. First of all, Dr. Logan, thank you for the presentation. And I actually really want to applaud CalPERS leadership on its sustained focus on mental health. I was very moved by many of the presentations -- well, the presentations at the July offsite, which I think really gave us a lot of food for thought about where we can head in the future. And obviously a lot of attention focused on this. I'm also happy to learn that in some ways, you know, the issue of stigma seems to be improving.

And so -- but I'm always concerned when we have -- when we're talking about mental health issues, when we -- and particularly with the -- still the amount of stigma that's associated with it, whether the numbers that we're seeing really are, in fact, increases in the numbers who are experiencing mental health conditions or whether it is just that more are presenting, because they feel comfortable presenting and coming forward with their conditions.

So I wanted to just kind of explore a little bit,

and I did also submit a letter to Ms. Frost, but I was actually interested in kind of more broadly looking at the plans, because we have obviously an ability to engage the plans as we're, you know, working with them every year in the rate setting process, and engaging them with respect to this particular area of care.

And I think really teeing off of the presentation from the July offsite, looking at the status of how the plans are implementing, you know, some of the strategies that were described during that offsite and maybe getting a report back on that. And I appreciate Ms. Frost's letter in response to me that we've gotten some information from the plans to that effect. And so I would like probably more granular presentation with respect to what each of the plans are doing.

But I also think there's probably more tools within, I guess, our authority, if you will about how to explore more of, you know, just kind of getting to a place of where we can deal with some of the challenges that you mentioned.

And so first, just looking at whether -- you talked about kind of the -- the percentage of the members that are experiencing mental health conditions. And can you tie hard numbers to those percentages just to give us an order of magnitude? Do you have those numbers?

CHIEF MEDICAL OFFICER LOGAN: Oh, you mean, the --

COMMITTEE MEMBER YEE: Like the 4.7 percent for depression, and 3.5 percent anxiety disorder, two percent neuroses.

CHIEF MEDICAL OFFICER LOGAN: I don't have that at my finger types, but we could provide that to you.

COMMITTEE MEMBER YEE: Okay. Okay.

CHIEF MEDICAL OFFICER LOGAN: We have that. We got those numbers from our data warehouse. We can --

COMMITTEE MEMBER YEE: Right. Right. Okay.

And then I wanted to -- and then to Ms. Frost I know you've probably got a whole -- some rich information from the plans. And so to really begin to have the responses back to us -- and I like the fact that we're looking at it across plans. And certainly, there's a very focused look at Kaiser, but related to obviously delivery, access, coordination, quality of mental health care services, I mean, all the things that we've referenced so far, but I was actually interested in our customer service and beneficiary survey, because those tend to be very general.

And I think the growing concern over timely access. Is there a way that maybe we could improve upon that survey to where we could either have elaboration on

questions to better understand that beneficiaries are feeling like they're getting into the type of care that they need, including specialized care, and, you know, just how quickly and easily that is -- is their experience? And then can we track the responses by plan to determine if we're having any issues with any particular plan? And so just some suggestions there.

And then I think when we look at our health plan contract quality measures, obviously, they require compliance with federal and State mental health parity requirements. And I didn't know whether in our contract negotiations we posed questions like requiring the plans to disclose any litigation, or claims, or citations as it relates to compliance with State or federal mental health parity laws. So maybe a question there. And if we currently require that, what do we do with that information? Does it help us in terms of furthering our discussion on this front?

And then again just with respect to the access, because I'm trying to look at the tools that we currently have and how we can really enhance them to kind of get to, you know, I think what we could establish as maybe our own baseline about how we make improvements. And so a customer survey, health plan contract quality measures, and then obviously hearing from the plans themselves.

And, Mr. Chairman, I know I, for one, would be very interested in having all the plans come before this Committee, because this is a problem that's not going away. In fact, we'll probably hear more about more numbers of our members and beneficiaries presenting with mental health conditions. And I just want to be prepared in terms of how we look at being sure they're served well going forward.

CHAIRPERSON FECKNER: Thank you, Ms. Yee.

Mr. Rubalcava and I spoke about that earlier, and we're going to agendize having the committees come in -- I mean, the plans come in maybe once a month until we can get through them all, instead of doing them all at once, because it will be a little overwhelming.

COMMITTEE MEMBER YEE: Okay.

CHAIRPERSON FECKNER: All right. Mr. --

COMMITTEE MEMBER YEE: Oh, Mr. Chairman, on that, could we -- will there be kind of an established set of issues that we want them to address just so we're kind of hearing the same thing?

CHAIRPERSON FECKNER: We'll set up some guidelines --

COMMITTEE MEMBER YEE: Okay. All right.

CHAIRPERSON FECKNER: -- so they'll know ahead of time what they're coming in for.

COMMITTEE MEMBER YEE: All right. Thank you.

CHIEF EXECUTIVE OFFICER FROST: And we'll take your comments today to prepare those agenda items.

COMMITTEE MEMBER YEE: Okay. Thank you.

CHAIRPERSON FECKNER: Mr. Rubalcava.

VICE CHAIRPERSON RUBALCAVA: Thank you, Mr. Chair. I, too, want to thank Dr. Logan for your presentation, and also the staff for being responsive both from the Education Forum, but also the State Treasurer and the Controller for taking the initiative and moving this forward.

Dr. Logan, in your presentation in your cover letter, you talked about some of the barriers. And one of them that you mentioned was screening. And you -- twice you admitted is was being underutilized. And you also mentioned how those with chronic illness tend to die earlier. There was one of the bullets, and in you letter, was the whole thing about coordinating care through the primary -- because, you know, people tend to go to their primary care physician perhaps more than they do to their mental health services.

So I was curious as to -- as we ask the health plans to show their commitment, and as CalPERS pushes for accountability, what kind of performance measures or standards do we have in our contract to sort of promote

that identification of comorbidity when -- you know, when people have chronic disease, they also tend to have mental care issues. They may or may not be identified or treated.

So I was wondering what is in their -- in our contracts to push that, and incentivize and the plans to do that? And if that could also be one of the issues that's addressed when they do come and address us to this body.

Thank you, Doctor.

Thank you, Mr. Chair.

CHAIRPERSON FECKNER: Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: Thank you, Dr. Logan.

CHAIRPERSON FECKNER: Hold on.

There you go.

COMMITTEE MEMBER MILLER: Oh. Thank you, Dr. Logan. I appreciate the presentation. And I'll try not to ramble on too much as I'm one to do.

But I think it's important that we recognize too that kind of the point you made, that this is bigger than CalPERS. I mean, I mediate over in civil harassment court regularly. And I can tell you the lack of mental health resources in our communities is a burden on law enforcement, it's a burden on our courts, it's a huge,

huge challenge.

But when it comes to our providers and our members, for years, I've been hearing the challenges and problems our members have. And they relate to the scope, not just access, but the scope of the practice when it comes to mental health resources, and the availability of timely and appropriate care from physicians, from psychiatrists, from Ph.Ds. psychologists.

And I guess I will just pile on to the discussion about Kaiser. My experiences talking to members and with personal experience has been getting to see a psychiatrist, getting to see a Ph.D. psychologist, getting to anything much beyond a canned, sixth grade level, one-size-fits-all cognitive behavioral therapy approach is really challenging.

And the limitation, particularly with psychiatrists, is typically you've got this little slot, this much of it is going to be with a paraprofessional, a non-physician, and then you get your three minutes where they want to write you prescriptions.

The confluence of that kind of cookie-cutter approach to mental health services, when you get into the mental health issues being comorbidities with other conditions. You mentioned diabetes, other things, but particularly chronic pain conditions, any type of nerve

pain, neuralgias, fibromyalgia, et cetera, it just exacerbates the whole mess, because then you've got -- you typically will not have a psychiatrist involved with trying to deal with pain, and these mental health issue comorbidities, and off-label prescriptions of a whole range of, you know, serotonin uptake reinhibitors, or whatever it may be that you're cycling through.

And so, no one ever says to patients in my experience, there are real limitations on our scope of practice, and what we can do, and you're going to have to just go out of network or switch providers. No, you learn that -- our members learn that the hard way over time.

And so I think beyond just what we see in their presentations to us or surveys where so many percent that respond to it say they got good service. They like their provider.

But the real-world implications for those of our members who have had a hard time, and are having a hard time, and who are, in some cases, no longer with us, is something we need to be able to get under the hood, just like we do when we look at cost structures, and try to get to what's really going on, and what can be done, because the whole integrated care team model that everyone touts is not working for our members who have mental health issues in the system.

Thanks.

CHAIRPERSON FECKNER: Thank you.

Ms. Brown.

COMMITTEE MEMBER BROWN: I have one additional comment. I actually have a former colleague who is watching on the web and wants to know if all of our providers are required to deliver the same behavioral health services, because she finds herself having to go out of network and pay out of pocket in order to get the services she needs? And so I just would pose that to you? I would assume it's yes, but...

CHIEF MEDICAL OFFICER LOGAN: The answer is yes. I'm not familiar with her particular situation, of course, but the services for the behavioral health program itself are the same.

COMMITTEE MEMBER BROWN: Okay. Great. Thank you.

CHAIRPERSON FECKNER: Mr. Perez.

BOARD MEMBER PEREZ: Mr. Chair, I see that there's some health care professionals in the audience. I don't know if Kaiser is represented here. But if they are, can we call them up and make sure they understand the requests that the Treasurer has for them and --

CHAIRPERSON FECKNER: They are here. Somebody from Kaiser want to acknowledge the fact that you

understand the request.

You can just wave, we'll get you.

(Kaiser representatives waved.)

CHAIRPERSON FECKNER: They got it.

BOARD MEMBER PEREZ: So there's no -- it's pretty clear, huh?

Okay.

CHAIRPERSON FECKNER: Pretty clear. Thank you.

Ms. Pasquil Rogers.

COMMITTEE MEMBER PASQUIL ROGERS: Thank you, Mr. Chairman. I'd like to -- and thank you, Dr. Logan, for this. It's really important.

One of the things -- I do agree that it's a good idea to have the -- all of the providers here. But I would like to ask if we could also have someone from DMHC come before all of this to kind of set the tone. Everybody is working on this issue. And I believe most, if not all, of the providers are actually working with, you know, the Governor, and this task force. But it would be nice to get the overall picture of kind of what's going on. And so that, you know, we don't -- we're not -- you know, we're dealing with all of the information.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Middleton.

BOARD MEMBER MIDDLETON: Thank you, Mr. Chair.

I think -- I appreciate all of the comments from my colleagues, in terms of our obligation to make sure that the health plans understand their obligations.

But beyond that, calling attention to what they need to do, what are other things that we should be doing as an organization and as a Board to diminish stigma and to increase the opportunities that individuals have to access care when it's needed?

CHIEF MEDICAL OFFICER LOGAN: Is that a question for me?

BOARD MEMBER MIDDLETON: Um-hmm.

CHIEF MEDICAL OFFICER LOGAN: Thank you.

Yes. Certainly, as I mentioned, we all have a role. We -- I think that as you mentioned, Ms. Rogers, working with other departments is essential. There's so much going on with the Governor's office, and DMHC, and the Office of Statewide Health Planning and Development in terms of workforce. So making sure that we're on the same page, that we're aligned, and we move forward together I think that's incredibly important.

Alignment, as I mentioned, is important and decreasing the stigma. The National Association of Mental Illness has a pledge. And I mentioned that some of the plans take a pledge. And you, too, can take the pledge.

It's on the website. I know it does seem like kind of a small act, and maybe a drop in the bucket, but it takes you, and you, and you, and everybody to have a voice.

And I think that's really important for eliminating stigma, not just decreasing, but eliminating.

BOARD MEMBER MIDDLETON: All right. And I want to make a personal comment. It's been over 25 years since I, as a transgender woman, needed the assistance of someone, and I received that assistance from physicians at Kaiser Permanente in Northern California. And I have to say it took a while to get in, but they were absolutely outstanding at a time the law was very different than it is today.

CHIEF MEDICAL OFFICER LOGAN: I appreciate your comment.

CHAIRPERSON FECKNER: Thank you.

Ms. Pasquil Rogers.

COMMITTEE MEMBER PASQUIL ROGERS: Yes, Mr. Chairman, I'm sorry. Should I have made a request to you to put this on the agenda for a meeting. I wasn't sure if I was supposed to do that or if I was --

CHAIRPERSON FECKNER: I think we got the message.

COMMITTEE MEMBER PASQUIL ROGERS: Okay. Thank you.

(Laughter.)

CHAIRPERSON FECKNER: Ms. Yee.

COMMITTEE MEMBER YEE: Thank you, Mr. Chairman.

I wanted to just add on to Ms. Middleton's observation about what more can we do. And I think just as we place emphasis on obviously protecting our pension benefits, and certainly our ability to administer the fund in a sound fiduciary way, I would say probably the same in terms of upping our advocacy efforts on the health benefits side as well. I know Liana, Donna and others, the team -- our health team has been doing that with respect to federal legislation. As to whether it's at the federal or the State level, I think to the extent that there is a role for to us play as advocates, I would say we should step up.

CHAIRPERSON FECKNER: Very good. Thank you.

Seeing no other requests to speak. Thank you very much. Great presentation.

Anything else on this item?

CHIEF INFORMATION SECURITY OFFICER BAILEY-CRIMMINS: No.

CHAIRPERSON FECKNER: All right. Seeing none. I have one request from the audience

Larry Woodson, please come forward. You have up to three minutes for your comments. Please identify yourself for the record.

MR. WOODSON: Good afternoon. Larry Woodson, California State Retirees.

Chairman of the Board, I thank you for the opportunity to comment. And first on behalf of CSR, I'd like to welcome Dr. Moulds as the new Director of Health Benefits. I look forward to meeting with you and working with you. As Chair of CSR's Health Benefits Committee for the last four years, I can tell you that you're inheriting a skill and dedicated staff, so -- and I'd also like to thank Liana Bailey-Crimmins for her service, leadership, accessibility, and responsiveness to stakeholders over the last two years. So best of luck to you in your new endeavor.

Now, you can start my three minute clock.

(Laughter.)

MR. WOODSON: Mental health. CSR appreciates CalPERS recent focus on mental health as an important issue, as exemplified by Dr. Logan's presentation, a special stakeholder session in May where all CalPERS health plans provided detailed information on their efforts to address covered member's mental health needs.

I've got to say we only had 15 minutes for questions at that meeting, which wasn't enough. So I'm glad to hear that there will be more discussion hopefully in open session, so that we can all take advantage and

learn.

We also heard a staff overview Thursday at stakeholders of this topic, a summary of Dr. Logan's presentation. In that, I raised an issue of concern in that meeting that I now have learned, after the May meeting presentations, that -- and Mr. Ruffino and now many of the Board members have stolen my thunder, I was going to say a carrier, but I'll say Kaiser was fined $4 million for -- by DMHC six years ago for multiple violations of California Mental Health Parity Act for insured members with mental health conditions being forced to wait weeks and sometimes months for treatment.

And again, in 2017, then DMHC found that the carrier had not yet remedied all of those access issues. And currently, it's under a three-year monitoring program. And I'm sure they've made significant improvements, but we will be looking forward to a final report as to how they're doing. And I fully endorse the request from Mr. Ruffino and others for more detailed accountability.

I asked staff on Thursday that since CalPERS identified one of their roles, it is holding carriers accountable for shortcomings in mental health services, how do they do so? And the response that I got was really -- at that time, was really not satisfactory. They said that they had received a very low percentage of

appeals. I think Mr. Behrens said 0.04 percent, which again we don't know what the number is in delays or lack of service.

And the implication was that CalPERS doesn't view that as much of a problem. And I pointed out that using appeals as a barometer to measure shortcomings is really questionable, especially in the subset of mental health problems where stigma is really in play.

And I have many members talk to me after my meetings about denials of services and not even realizing they had appeal rights.

So in conclusion, I hope CalPERS will take a closer look at this issue, not rely on -- solely on appeals as a barometer of plan shortcomings.

Thank you.

CHAIRPERSON FECKNER: Thank you very much.

Seeing no other requests.

Item 6b, summary -- do we have any summary direction, other than we all caught a lot of that. But, yes, what do you have, Ms. Bailey-Crimmins?

CHIEF INFORMATION SECURITY OFFICER BAILEY-CRIMMINS: In addition to each pan presenting to this Committee regarding behavioral using the same guidelines including DMHC, I have provide detailed numbers for the percentages that were listed in the presentation

today. So we will be providing that. And I also heard from Controller Yee that to evaluate our satisfaction survey, and specifically regarding mental health, and see if there's some improvements that can be made there, and maybe bring that back to the Committee.

CHAIRPERSON FECKNER: Very good.

What was that?

COMMITTEE MEMBER YEE: I think Liana on the -- what we're currently doing in terms of requiring compliance with the parity laws --

CHIEF INFORMATION SECURITY OFFICER BAILEY-CRIMMINS: Oh, that's right.

COMMITTEE MEMBER YEE: -- with our health plan contract quality measures. Yeah. Thank you.

CHIEF INFORMATION SECURITY OFFICER BAILEY-CRIMMINS: Thank you.

CHAIRPERSON FECKNER: Thank you.

VICE CHAIRPERSON RUBALCAVA: Mr. Chair.

CHAIRPERSON FECKNER: Turn on your light.

There you go.

Mr. Rubalcava.

VICE CHAIRPERSON RUBALCAVA: Yeah, that's what I requested that we identify how the contracts, performance measures, those standards speak to coordination of care comorbidities.

Thank you.

CHAIRPERSON FECKNER: Okay. Mr. Ruffino.

ACTING BOARD MEMBER RUFFINO: Thank you, Mr. Chair, just to be clear, and in the interests of time, I'm not going to repeat the questions, but they're on the record.

CHAIRPERSON FECKNER: Thank you.

Now, seeing no other requests.

No other public comment.

This meeting is adjourned.

(Thereupon California Public Employees' Retirement System, Pension and Health Benefits Committee meeting adjourned at 3:20 p.m.)

C E R T I F I C A T E O F R E P O R T E R

I, JAMES F. PETERS, a Certified Shorthand Reporter of the State of California, do hereby certify:

That I am a disinterested person herein; that the foregoing California Public Employees' Retirement System, Board of Administration, Pension and Health Benefits Committee meeting was reported in shorthand by me, James F. Peters, a Certified Shorthand Reporter of the State of California, and was thereafter transcribed, under my direction, by computer-assisted transcription;

I further certify that I am not of counsel or attorney for any of the parties to said meeting nor in any way interested in the outcome of said meeting.

IN WITNESS WHEREOF, I have hereunto set my hand this 25th day of August, 2019.

JAMES F. PETERS, CSR
Certified Shorthand Reporter
License No. 10063