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, NOVEMBER 19, 2019

9:12 A.M.

JAMES F. PETERS, CSR
CERTIFIED SHORTHAND REPORTER
LICENSE NUMBER 10063

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, represented by Karen Greene-Ross

BOARD MEMBERS:

Ms. Fiona Ma, represented by Mr. Frank Ruffino and Matt Saha

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

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

STAFF:

Ms. Jennifer Jimenez, Committee Secretary

Dr. Julia Logan, Chief Medical Officer

ALSO PRESENT:

Mr. Ryan Beaston, National Union of Healthcare Workers

Mr. Tim Behrens, California State Retirees

Mr. Ernest Goldsmith, Retiree

Dr. Don Mordecai, Kaiser Permanente

Ms. Shelley Rouillard, California Department of Managed Health Care

Mr. Fred Seavey, National Union of Healthcare Workers

Ms. Sarah Soroken, National Union of Healthcare Workers & Kaiser

Mr. Dan Southard, California Department of Managed Health Care

Ms. Cynthia Striegel, Kaiser Permanente

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 morning, everyone. We'd like to call the Pension and Health Benefits Committee meeting to order.

The first order of business will be to call the roll, please.

COMMITTEE SECRETARY JIMENEZ: Rob Feckner?

CHAIRPERSON FECKNER: Good morning.

COMMITTEE SECRETARY JIMENEZ: Ramon Rubalcava?

VICE CHAIRPERSON RUBALCAVA: Present.

COMMITTEE SECRETARY JIMENEZ: Margaret Brown?

COMMITTEE MEMBER BROWN: Present.

COMMITTEE SECRETARY JIMENEZ: Henry Jones?

COMMITTEE MEMBER JONES: Here.

COMMITTEE SECRETARY JIMENEZ: David Miller?

COMMITTEE MEMBER MILLER: Here.

COMMITTEE SECRETARY JIMENEZ: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Here.

COMMITTEE SECRETARY JIMENEZ: Mona Pasquil Rogers?

COMMITTEE MEMBER PASQUIL ROGERS: Here.

COMMITTEE SECRETARY JIMENEZ: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Here.

COMMITTEE SECRETARY JIMENEZ: Karen Greene-Ross for Betty Yee?

ACTING COMMITTEE MEMBER GREENE-ROSS: Here.

CHAIRPERSON FECKNER: Thank you. And please note for the record that Mr. Perez, Ms. Olivares -- who else is down there. I can't see -- Mr. Ruffino, Ms. Middleton are all here at the dais also.

Thank you.

Before we begin our agenda item this morning, I want to take a moment to express our deep sadness at the recent passing of Kaiser Chairman and CEO Bernard Tyson. Bernard was a visionary leader, both at Kaiser and within the American health care system. He was a champion of quality, accessible, and affordable care. And his influence in the marketplace and his passion for improving health outcomes will be sorely missed. We're appreciative of the partnership between CalPERS and Kaiser that thrived during his tenure.

To our Kaiser partners here in the room, I want to extend our condolences. And if there's anything we can do to be helpful to you during this difficult period, please let us know. We also extend our deepest sympathies to Bernard's family and the entire Kaiser community. With that, we'll move back onto our regular agenda, so thank you.

Item 2, approval of the timed agenda. What's the pleasure of the Committee.

VICE CHAIRPERSON RUBALCAVA: Move it.
CHAIRPERSON FECKNER: Moved by Rubalcava.
COMMITTEE MEMBER JONES: Second.
CHAIRPERSON FECKNER: Seconded by Jones.
Any discussion on the motion?
Seeing none. All in favor say aye?
(Ayes.)
CHAIRPERSON FECKNER: Opposed, no?
Motion carries. Thank you.
Item 3, Executive Report. Mr. Moulds, Ms. Lum.
DEPUTY EXECUTIVE OFFICER LUM: Good morning, Mr. Chair, members of the Committee. Donna Lum, CalPERS team member. This morning I have two brief updates for you and they're both related to enhancements that we've made to enhance our customer's experience with CalPERS. The first is related to member self-service responsive changes. I think as many of you know, across service industries, mobile device usage on online transactions continues to grow very rapidly.
And we conducted a survey by our -- with our User Experience Team. And what it revealed is that 86 percent of our members expressed interest in performing myCalPERS transactions on mobile devices. In response to that, the Customer Service team in partnership with the Information Technology teams partnered to optimize the existing

myCalPERS website to ensure full usability across all types of devices, handheld devices, iPads, smartphones.

Our new design is going to launch on November 23rd, and it does have several new features, including streamlined log-in process, a centralized location for messages, as well as simpler navigation and ease of reading across a variety of these different devices.

The new responsive design also enhances our compliance with AB 434, ensuring that all of our self-service offerings are accessible and functional on small form factor screens, as well as smartphones.

So, at this time, I'd like to encourage all customers who currently have a myCalPERS account, post November 23rd, if you have the opportunity, to log into your account and be able to experience these new features. And those customers who currently do not have a myCalPERS account, I also encourage you to go online and establish one. It is an excellent way to perform online transactions with CalPERS.

On an additional note, we've also done some rebranding with the myCalPERS logo. If you recall, it used to have "my" with a horizontal slash, and then "CalPERS". Consistent with other parts of CalPERS branding, we've removed that slash there, the upward slash, and now it's simply just myCalPERS.

So again, what I'd like to also do is thank all of the team members that were a part of this redesign and certainly we anticipate that our customers are also going to be very pleased with the usage of performing transactions on their devices.

The last update that I have is centered around new enhancements related to our survey technology in the regional offices. We recently implemented a new way in which members who have come in for any type of appointment at the regional office is now offered the opportunity to take a service -- a survey at the conclusion of their session with our team member.

Previously, the way that we conducted surveys is we would send random surveys to one in every ten customers that visited the regional office. And with this new technology, we're able to offer the survey to 100 percent of all of the members that come through.

We've had it launched since July. And the feedback that we've gotten so far has been excellent. When we were doing paper surveys, we would get about 13 percent of the surveys returned. With this new handheld device that our members can use right there in the regional office, we're getting about a 56 percent return rate right there.

The other thing is is that we're able to get

immediate feedback as opposed to working through all of the paper that it takes to calculate and analyze surveys when they came in paper form.

One of the nice things about this is it also does support our initiative to reduce paper. These surveys that we are now doing will save us in about $9,500 in printing costs for the surveys that we used to do by paper. But not only do our customers still have the opportunity to use the handheld device, they also have the opportunity, if they wish to, to use -- we do have some paper cards in the lobby, if they want to express additional comments about the service that we -- they received.

So we're really excited about this new offering. And again, it's just one other way for us to be able to attain satisfaction level information from our members. And I am pleased to say that from the period of July to September using this new survey feature, we have achieved about a 99.6 percent high satisfaction rating for all of the services that are being provided.

So, Mr. Chair, that concludes my presentation, and I'm happy to take any questions you may have at this time.

CHAIRPERSON FECKNER: Thank you.

Seeing no requests. Thank you very much.

Microphone.

There you go.

CHIEF HEALTH DIRECTOR MOULDS: There we go. First time.

Good morning, Mr. Chair, members of the Committee. Don Moulds, CalPERS team. It's great to be here. This is my first Committee meeting presenting and I'm very much looking forward to working with all of you.

On our agenda this morning we have two substantive items. The first is a discussion of mental health and the second is an update on our pharmaceutical spending strategy. Our mental health item continues our discussion from the August Committee meeting. As requested by the Committee, we have the Department of Managed Health Care and Kaiser joining us.

Second, our strategy on reference pricing prescription drugs has undergone some pretty significant changes since we've talked about it last. I'm going to walk you through those changes, talk a little bit about the why, and talk about how reference pricing fits in with other initiatives we're going -- that are going to be critical to getting our hands around drug costs.

Before we get going, I wanted to highlight a few items from the last month. I'm excited to share that we've hired a new Chief for our Health Plan Research and

Administration Division, Marta Green. Marta comes to us from the California Department of Managed Health Care, where for the last five years she served as Chief Deputy Director. She has over 20 years of government experience in health care and delivery system reform, public policy, communications, and business operations.

As Chief, Marta will oversee health plan contract management and plan development, clinical programs and appeals, rate development and negotiations, health data analytics, and innovation research.

Marta, can you stand and wave.

(Applause.)

CHIEF HEALTH DIRECTOR MOULDS: I also want to recognize three leaders from within the Health Branch who have stepped over -- stepped up over the last several months. Vanessa Albritton, who served as Acting Chief of the Health Account Management Division; Rob Jarzombek, who led the Health Plan Administration Division, and Kim Malm who led the Health Plan Research Division.

Rob and Vanessa will be returning to HAMD to lead that Division. And I'm excited to announce that Kim will be staying with the Health Branch leadership team.

Finally, I'm happy to report that we've recently completed another successful open enrollment. The new search for a doctor feature within myCalPERS was well

received by our members. We had targeted a ten percent uptake and it turns out that 23 percent of our members who searched for a health plan also searched for a doctor. And 80 percent of our members reported being satisfied with the feature.

We continue to work towards enhancing the new feature to include additional search capabilities, such as medical groups and specialists, which will help improve our member's experience, and make the tool more valuable.

Thank you, Mr. Chair. That concludes my opening remarks. I'm available for questions.

CHAIRPERSON FECKNER: Thank you.

Seeing no requests. Appreciate it. Nice to have you here for your first meeting.

CHIEF HEALTH DIRECTOR MOULDS: Thanks.

CHAIRPERSON FECKNER: I want to take a moment before we move on to Agenda Item 4 to first of all welcome you all, but thank all the folks that gathered with us this morning at the stakeholders meeting. I think that was a great time to be able to mingle, sit and talk about issues that aren't necessarily on the agenda, but to get to know one another on a different level. So thank all the stakeholders that joined the Board and the staff this morning.

And I also want to take a second to introduce a

long time CalPERS staff member who's retired for a few now, brand new grandpa, so he's not awake as he used to be, but Ken Marzion. He was our Interim CEO for a couple of years.

Welcome, Ken.

(Applause.)

CHAIRPERSON FECKNER: That new grandchild slowed down his golf game a little, so a little challenging.

(Laughter.)

CHAIRPERSON FECKNER: All right. Moving on to Agenda Item 4, action items. I have -- what's the pleasure of the Committee?

COMMITTEE MEMBER TAYLOR: Move.

CHAIRPERSON FECKNER: Moved by Taylor.

COMMITTEE MEMBER BROWN: Second.

CHAIRPERSON FECKNER: Seconded by Brown.

Any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Agenda Item 5 is the information consent items. You'll notice that 5a is the annual calendar review. Having no requests to pull anything off the agenda, but I

do want to tell you that there are copies of the agenda there. But yesterday in the Board Governance Committee, the Chair of the Committee, President of the Board, gave direction to both the CEO and the Chair of the Committee to work together to look at whether or not we need to add more meetings next year on top of this agenda item. So just so you know, we're keeping our fingers on the pulse, and if we need that, we will add additional meetings.

So moving on to Agenda Item 6, 6a, Mr. Moulds.

(Thereupon an overhead presentation was Presented as follows.)

CHIEF HEALTH DIRECTOR MOULDS: Great. Thank you, Mr. Chair. Don Moulds, CalPERS team. I want to briefly introduce our agenda item on mental health. Thanks to the Board for their continued interest in the topic.

Mental health is getting more attention these days, but the importance of good mental health is still grossly under valued.

In addition to the obvious connections to well-being, everything we are learning these days makes it clear that there is tight relation between mental and physical health. And every day we learn more about how untreated mental health conditions add to the cost of treating physical health issues, particularly chronic disease.

I'm going to turn it over to Dr. Julia Logan, CalPERS Chief Medical Officer, who will be here talking more about the internal she is leading on mental health. After Dr. Logan, we're going to hear from two guests from the Department of Managed Health Care, Shelley Rouillard, who is the Director at DMHC, and Dan Southard, who is Deputy Director for Plan Monitoring.

After DMHC, you'll hear from two representatives from Kaiser Permanente, Dr. Don Mordecai and Cynthia Striegel.

Before I turn it over, I want to highlight one related bit of work that I'm particularly excited about. Over the last few months, we've been meeting with Covered California to identify common goals and more broadly ways in which we can partner with each other. Together, we serve about three and a half million Californians, so teaming up on common goals can be very powerful.

Our discussions have surfaced a common interest in improving mental health. As a first step, we've agreed in principle that we should have common measures for tracking plan performance on mental health and have started discussions about how we can tackle critical issues like better integration of mental health and primary care.

Together, we've started talking with national

experts on mental health and measurement to review and improve the way we do this. In the coming months, we'll be reporting on how this work is going. With that, let me go ahead and turn it over to Dr. Logan.

CHIEF MEDICAL OFFICER LOGAN: Thank you, Don.

Good morning. Julia Logan, CalPERS team member.

Today, I'll be providing you an update of our activities around mental health since we last met three months ago. But first, I wanted to take a moment to thank you all for shining a light on this topic and for asking the questions that really matter and that help us understand the opportunities we have to improve mental health for our members and for all Californians.

It has certainly allowed us all to talk openly and frankly about a topic that has too long been in the shadows. I also wanted to thank my colleagues here at CalPERS. After our August meeting, many employees shared with me their own personal stories and expressed validation, and were glad that we were talking about mental health candidly with our Board and with our health plans. To those folks, I appreciate your courage.

--o0o--

CHIEF MEDICAL OFFICER LOGAN: To orient you to our time together this morning, this presentation will have three parts and mirrors many of your requests from

our discussion in August.

First, we will update you on our activities and newly forged partnerships around mental health. And discuss our approach to monitoring quality mental health.

Second, Shelley Rouillard, the Director of the Department of Managed Health Care and Dan Southard, Deputy Director, Office of Plan Monitoring will provide an overview of the Department's role and strategies to increase timely access to mental health services and how they determine network adequacy.

And last, Dr. Don Mordecai and Cynthia Striegel from Kaiser Permanente will provide a mental health and wellness update using a standard set of guidelines that CalPERS team members put together based on your feedback.

These guidelines will be used by plans when presenting to you and are included as an attachment in your agenda item. The guidelines include questions such as explaining strategies that each plan is using to ensure CalPERS members receive the right mental health care at the right time.

Each plan will present on initiatives to address stigma and social drivers of health, which are environmental, socioeconomic, and other factors that affect health and how they're evaluating the impact of these two, and how each plan is integrating mental health

with primary care.

There are so many clinical studies that have shown benefits to the integration of mental health, including improved outcomes, improved access, and decreased stigma. One in five primary care visits involves a mental health issue. And I can certainly attest to that in my own practice, yet, our health care system struggles to integrate the two.

Those are a few of the topics that the plans will address. I am hopeful that it will inform you and our CalPERS members on where we are and where we need to go to improve mental health. Kaiser will be our first plan to present. And the other large health plans will be presenting to you next month using the same set of guidelines. So that's something to look forward to as well.

--o0o--

CHIEF MEDICAL OFFICER LOGAN: This slide reminds us that mental health includes emotional, psychological, and social well-being. It affects how we all think, feel, and act in our personal and work lives. And I know you know this, but I wanted to reiterate how common mental health issues are. Nearly one in six California adults experiences a mental illness of some kind.

And our children are not immune. One in 13

children has an emotional disturbance that limits participation in daily activities.

I'm sorry. I skipped --

--o0o--

CHIEF MEDICAL OFFICER LOGAN: Okay. There can be significant barriers to receiving the right care at the right time. Californians can face fear of rejection about mental health issues. In fact, eight out of ten workers with a mental health condition say shame and stigma prevent them from seeking treatment. Other barriers include workforce limitations, trouble reaching providers far from home, and limited screening and clinical settings for depression, anxiety, and substance use issues. And because of all these, only a third of people with mental health conditions gets treatment.

--o0o--

CHIEF MEDICAL OFFICER LOGAN: In August, we reported on the prevalence of the most common mental health conditions among CalPERS members. And as you remember, depression, anxiety, and neuroses ranked one, two, and three respectively for both basic and Medicare members.

You asked us to report the numbers behind these percentages. As you can see, more than 50,000 basic members and 12,000 Medicare members had a claim for

depression in 2018. And smaller numbers of people had claims for anxiety and neuroses that year.

One of our stakeholders astutely pointed out in our stakeholder meeting last week that these numbers seemed low compared to the prevalence in the general population. And that is true. According to the Let's Get Healthy California Initiative, almost 18 percent of adults reported in 2017 that they had been told they had depressive symptoms.

The difference in our rates versus what is reported elsewhere is in part because our data comes from our data warehouse. It's our claims data and reflects only those people who have a medical claim, such as a visit or treatment for one of these mental health diagnoses. So it's important to keep that in mind. And that's also, in part, why we are looking at other ways of measuring mental health issues. And I'll discuss that in a minute.

--o0o--

CHIEF MEDICAL OFFICER LOGAN: The CalPERS team has been engaging the plans through our quarterly business reviews, ad hoc meetings, and regular meetings with our plan medical directors and other plan leaders. We address strategies to improve mental health care and best practices and programs that we could potentially scale up

across our plans, including how to incorporate effective telebehavioral health into our common set of tools for addressing mental health barriers.

We've also learned from Kaiser about a skills based experiential training program that they've implemented system wide called Mental Health First Aid for the Workplace. It teaches employees how to become aware of and support an individual who may be experiencing a mental health or substance use issue, and help them access appropriate resources.

Seeing the success in their own organization, they are now offering it as part of their community benefit. In fact, a few months ago representatives from 17 CalPERS agencies attended a training. I will also be participating in the course next month to learn firsthand if it could be something to roll out more broadly.

--o0o--

CHIEF MEDICAL OFFICER LOGAN: As Don mentioned, we have been doing a lot of thinking on how to measure high quality mental health care and our approach to ensure our members are receiving the right care at the right time. To do this, we've been reaching out to our partners here in California and experts nationwide to collaborate and leverage our collective impact and voice. We know that our impact will be much stronger and long-lasting, if

we work together.

Between Covered California, CalPERS, and the Department of Health Care Services, we are talking about a really large voice, the purchasing power of more than 17 million Californians with overlapping provider networks and health plans. Covered California is currently undergoing an overhaul of their performance and quality measures in their contracts. So we are participating actively in those discussions and have partnered with Covered California on integrating mental health and primary care as well. We're also learning from other partners and colleagues at the Integrated Health Care Association, the Pacific Business Group on Health, and Smart Care California on what works and what doesn't work.

We are especially interested in measuring how well care is integrated and how mental health care works to improve outcomes rather than just measuring the process, especially, in those who have co-occurring physical conditions that can become so much worse with a mental illness. We will be sure to keep you updated on our progress around measurement.

I'm also pleased to report that we have made changes to the health plan member survey for 2020. This is the annual survey given to a sample of CalPERS members to track experience and access to care. The two previous

questions on mental health were replaced with six new validated mental health questions from a survey called the ECHO survey that provides more details about non-urgent mental health appointment access, urgent mental health service access, and how members perceived improvement after receiving mental health care.

Our goal is to use the results from these questions to evaluate, monitor, and improve the quality of mental health services for our members and to break these results down by health plan when possible.

--o0o--

CHIEF MEDICAL OFFICER LOGAN: We realize the importance of good mental health and wellness in the workplace, so we are taking advantage of this wonderful opportunity to commit to CalPERS team members and are working together with the Statewide Employee Assistance Program, and our own Human Resources colleagues to increase awareness of mental health issues and promote wellness enterprise-wide.

The Employee Assistance Program is such a valuable resource and empowerment tool for not only CalPERS employees, but all State employees. And we've been working to educate our team members about the free and confidential resources available to them.

This includes a new service called Messaging

Therapy, which is therapy through secure text messaging.

--o0o--

CHIEF MEDICAL OFFICER LOGAN: I mentioned in August that our Governor is also prioritizing mental health wellness for our Californians. In his first budget, he allocated almost $11 million to fund a statewide Warm Line, which offers emotional support and resource referrals for people who are experiencing mental health challenges. This California peer-run Warm Line launched last month. And the call center expects to receive about 25,000 calls a year.

This lower level of care can be vital for people who want to talk to someone about their feelings, but don't feel that they need a crisis line. Please feel free to share this valuable resource.

--o0o--

CHIEF MEDICAL OFFICER LOGAN: I will conclude my part of the presentation today by reminding us that overcoming stigma is everyone's responsibility. I truly appreciate the efforts that you have all made to support our CalPERS members.

That ends my portion of this presentation and now I'll turn it over to Shelley and Dan from the Department of Managed Health Care.

CHAIRPERSON FECKNER: Before you go forward, we

do have one question.

Ms. Greene-Ross.

ACTING COMMITTEE MEMBER GREENE-ROSS: Yes. So I just wanted to thank you for the information about the changes to the customer survey. Just wondering, based on what you mentioned prior to that when you had polled us in the stakeholder meeting and mentioned that a lot of people don't report, or complain, or comply because of fear of stigma. And so I'm just curious if we would do anything sort of more -- a little more proactive to poll the stakeholders and/or members to get a better read, because not everybody fills out the survey because of the stigma issue. So just wondering about that issue with the survey results, so we can really get a handle on whether our members are suffering issues with access.

CHIEF MEDICAL OFFICER LOGAN: Yeah, so --

ACTING COMMITTEE MEMBER GREENE-ROSS: Timely access.

CHIEF MEDICAL OFFICER LOGAN: And that's a great question. So we can't always get all of the information we need from one particular data source, like our data warehouse.

ACTING COMMITTEE MEMBER GREENE-ROSS: Claims.

CHIEF MEDICAL OFFICER LOGAN: So we use different -- different sources of information to gather as

much as we can about how our members are using mental health services, and -- or if they're getting the right care at the right time. So the member survey is one tool, but there are different ways to understand that more broadly, such as performance measures, and our data warehouse.

CHIEF HEALTH DIRECTOR MOULDS: I'll just add that part of the -- so as Dr. Logan mentioned, we -- you know, we use a couple of different sources, claims data surveys. Part of the purpose of these calls that we've been having with national experts is to talk about other possibilities, other ways of getting this information, both on questions about access and about quality. So that's part of the work that's ongoing at the moment. The goal is to supplement that information.

ACTING COMMITTEE MEMBER GREENE-ROSS: Thank you. Appreciate that.

CHAIRPERSON FECKNER: Thank you.

MS. ROUILLARD: Okay. Hi. Good morning.

CHAIRPERSON FECKNER: Good morning.

MS. ROUILLARD: I'm Shelley Rouillard. I'm the Director of the Department of Managed Health Care. And I'm really pleased to be here today. I thank you for inviting us to present on how the Department monitors timely access to care and health plan's compliance with

federal and State mental health parity laws.

Before I get started, I just want to comment about your new hire. She's fantastic.

(Laughter.)

MS. ROUILLARD: I miss working with her, but she's going to do a great job for you here at CalPERS and you're lucky to get her, so congratulations to you.

(Laughter.)

MS. ROUILLARD: I did take the opportunity to read the transcript from your August meeting to get a sense of Dr. Logan's presentation. And she did a great job in presenting the over -- the challenges and innovations in addressing mental health concerns. And again, I appreciate your interest in this issue.

As she noted, access to behavioral health care services is a very high priority for our Governor and for the Secretary of the Health and Human Services Agency. The Department has been working hard to ensure health plans comply with all requirements regarding timely access to care and federal and State mental health law -- parity laws.

I thought this morning I would do just a high level overview of the Department's work. And I'll talk about -- a little bit about our monitoring of timely access to care and then Dan will talk about the federal

and State mental health parity compliance work that has -- his team has been doing.

So the mission of the Department of Managed Health Care is to protect consumer's health care rights and ensure a stable health care delivery system. We are a consumer protection agency, first and foremost, and we take that responsibility very seriously. Our authority comes from the Knox-Keene Health Care Service Plan Act of 1975 and all of the amendments after that.

Right now, the Department regulates 125 health plans, including 78 full service health plans, that includes most of the Medi-Cal managed care plans and 47 specialized health plans, and those are like dental, vision, behavioral health plans. Over 26 million Californians are enrolled in health plans regulated by the Department. This represents 96 percent of the commercial and public health plan enrollment in California.

I would note here that the Department regulates seven of the CalPERS health plans. We offer 11 different products to your members. We do not regulate your self-insured PPOs, PERS Choice, PERSCare, or any of the association health plans. Those plans are not subject to the Knox-Keene Act and the Department has no jurisdiction over them.

Similarly, while we license Medicare Advantage

plans, our oversight is limited to monitoring those plans' financial solvency. All other aspects of Medicare Advantage plans, such as covered benefits, utilization management, and provider networks are the purview of CMS.

Importantly, the Department offers a consumer help center, where individuals who are having problems with their health plans can come and get assistance in resolving those problems. This includes anyone who's having problems getting a timely appointment for health or behavioral health care, who's had needed care delayed or denied, or who has received a bill for services that the health plan should have covered.

The help center also administers the independent medical review process, where independent doctors and other providers who are not affiliated with a health plan will review a health plan denial of service to determine if the service was medically necessary. And if the independent reviewer determines the service was medically necessary, then the health plan must provide it. Consumers who file an IMR end up receiving the denied care about 62 percent of the time.

So moving on to an overview of timely access. Under California law, health plans are required to make sure that consumers have ready access to all services covered under their health plan contract. For this to

occur, consumers must be able to see a health plan doctor and other plans providers within a time frame that's appropriate, based on the consumer's clinical condition.

To ensure access to care, health plans must maintain networks of providers who have enough appointment availability to meet the needs of the -- of all plan members. Providing timely access to care is a health -- is a fundamental duty of health plans to their enrollees.

So the Department monitors health plans to ensure that all networks have the right types of doctors, including specialists and other types of providers, such as non-physician mental health providers, that would be therapists, psychologists, or qualified autism providers.

We ensure that the networks have enough providers to serve the overall population -- plan population, that providers are located within reasonable distances from where their members live or work, and that providers have enough appointment availability to meet the requirements of the timely access laws and regulation.

As I said before, ensuring access to care is a high priority for the Department. And we use a variety of regulatory oversight tools to ensure consumers have timely access to care. The timely access regulation requires health plans to submit annual reports detailing compliance with the time elapse standards. We are currently

finalizing the timely access report for measurement year 2018 and expect to release it sometime next month.

We also analyze consumer complaints and the independent medical reviews that are filed with the help center and how they are resolved. We track and trend those issues to determine if the are any patterns of particular issues or patterns with a particular plan that need to be addressed.

The Department also evaluates health plan networks to make sure they meet the geographic and provider-to-enrollee ratios -- ratio requirements. We conduct surveys, or audits, of health plans to ensure they're meeting all the requirements of the law and are following their own policies and procedures with respect to timely access and network adequacy. And they do file those with the Department and we approve them.

Last, but not least, we take enforcement action against health plans that violate timely access requirements. And as with all our enforcement actions, the goal is to change plan behavior and bring them into compliance with the law.

Since 2013, the Department has taken a number of enforcement actions that include violations of the timely access regulation with fines totaling almost $7 million. Most enforcement actions also include corrective actions

that the plan must take to address whatever the deficiencies are.

I'd like to reiterate the Department's help center is a resource for anyone having problems with their health plans. Even though we don't have jurisdiction over some of the CalPERS health plans, if a CalPERS member calls us, we can direct them to the appropriate community resources. And we also have a fact sheet on timely access to care that's available on our website for folks who want to know more details about the law.

So I'm going to turn it over to Dan now to talk about mental heath parity and look forward to your questions at the end.

Thank you.

MR. SOUTHARD: Good morning, Mr. Chair and members of the Committee. As Shelley indicated, I'll be talking about how the Department has ensured health plan compliance with mental health parity.

Before I get into the details of how the health -- how the DMHC has ensured health plan compliance, I want to talk generally about mental health parity laws. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 is a federal law that generally prevents group health plans from providing more stringent requirements for mental health or substance use

disorder benefits as compared to medical-surgical benefits.

In 2010, with the passage of the Affordable Care Act, these protections were expanded to enrollees within the individual market. In addition to federal law, there are two applicable California Health and Safety Codes, 1374.72 and 1374.76, which permitted until January 1, 2016, the DHMC Director to issue guidance to the health care service plans regarding compliance with mental health parity.

Now, getting into the details of how we've assessed mental health parity and continue to assess it. We approach this initially through a two-phase approach. The first phase was completed by our Office of Plan Licensing. It required health plans to submit documents to the Department for review and approval. These documents were related to their benefit designs, cost sharing, and utilization management.

Upon multiple back-and-forths with the health plans, we ended up approving these benefit plan design documents and we moved into the phase two review for mental health compliance.

Phase two was completed by my shop in the Division of Plan Surveys, and where we went out on onsite or did desk-level reviews of health plan documents, and --

to determine compliance. Those documents included UM files from the health plans, as well as their delegated medical groups, also cost sharing benefit plan design documents and how those were applied in real-world situations.

The results of those onsite focus surveys were -- we found 11 plans to be compliant with MHPAEA. Fourteen health plans were found to be non-compliant in either the area of non-quantitative treatment limitations or quantitative treatment limitations - those were two plans - or both non-quantitative treatments or quantitative treatments which are five plans.

Now, a little bit more detail on quantitative and non-quantitative. Non-quantitative treatment limitations are specific to the scope and duration of benefits. An example would be that in a -- in a acute care setting that a health plan would authorize services at a lesser duration from medical -- mental health or substance use disorder than they would for a medical-surgical disorder.

So it's applying a more stringent requirement on the medical -- or the mental health substance abuse disorder than compared to the medical-surgical side.

Quantitative treatment limitations are specific to the financial requirements. In increased cost sharing, a copay deductible is applied inappropriately to the

mental health substance use disorder when compared to the medical-surgical benefits.

When the Department found that health plans were non-compliant with a quantitative treatment or the financial requirements, we required the health plan to go back to January 1, 2016 and remediate any claims and reissue -- or issue reimbursements to all enrollees affected. This resulted in 5,099 enrollees affected, and a total reimbursement to enrollees of $517,375.90.

We published these mental health survey reports on our public website. And any plans that were found to be non-compliant at the final report, we are in the process of doing follow-up survey to ensure compliance. Any health plans that are found to be noncompliant at the follow-up survey process will be referred to our office of enforcement for further review and investigation.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests to speak. I thought we were getting a question, but it looks like not. But thank you very much for the presentation.

Oh, there we go. Hold on now.

Mr. Ruffino.

ACTING BOARD MEMBER RUFFINO: Thank you, Director, for your -- am I on?

Thank you for your presentation. Just quickly,

you mention your enforcement actions. And you mentioned, you know, there's fines and you have collected up to seven million with -- and corrective action. Can you comment on the corrective actions in terms of what's typically reasonable? Is it -- for a plan to comply, does it take three years, four years, five years, infinity, or as long as somebody keeps on paying the fine, they can extend a corrective action?

Can you just kind of give us a sense the average corrective action, the expectation of time, and the type of actions that you request or you demand?

MS. ROUILLARD: Okay. Thank you, Mr. Ruffino. There's no kind of average or specific timeframe for the corrective actions. It really depends on what the violations are and how long we think it's going to take the plan to correct them. Sometimes it involves like, in the case of timely access to care, contracting with other providers or making providers that are not contracted available when somebody needs a service that is not readily available in their area.

So we monitor that through the plan survey process that Dan oversees. Our enforcement office also gets regular reports from the plans on how they're making progress. And if they're not making the progress that we feel is important or that has been agreed to, then we can

take additional enforcement action against them. So it's really, you know, a -- it's specific to each particular action and plan, and what the issues are related to that.

ACTING BOARD MEMBER RUFFINO: But it can take six years, or five years?

MS. ROUILLARD: Well, sometimes it takes a long time. So I'll give you the case of Kaiser. Okay. So we had a three-year settlement agreement with them that we entered into in July of 2017. So we're coming up towards the end of that period of time, and we will be assessing -- well, we have been assessing and monitoring their compliance with that. So again, that was a significant violation that they had and so it does sometimes take a while for that to occur.

Most of the corrective actions aren't that kind of time frame. I would say they're probably less than a year. And then, as I said, Dan's shop goes out and checks to make sure that they've done all the things that they said they're going to do.

ACTING BOARD MEMBER RUFFINO: Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Greene-Ross.

ACTING COMMITTEE MEMBER GREENE-ROSS: Yeah, I just had a follow-up question to Frank's question on the -- on this -- the Kaiser outside monitoring process.

You've been in there, as I understand, for about three years now. Can you tell me just a little bit more detail on what the outside monitor does? Do they just hear from Kaiser as to what they're doing or do you guys -- does the monitor actively go in and try to see if the access is there and available for the patients who seek treatment, and are getting it? I mean, how -- just explain how that works, how the monitor is working, and how you're seeing -- are you seeing improvement?

MS. ROUILLARD: The monitor is working with Kaiser on a regular basis. And they are helping Kaiser comply with the terms of the settlement agreement. And that -- if you're interested, that settlement agreement is available on our website. They are working closely with the plan. And I think I'll leave it to Kaiser to tell you how well they're doing with that. But I do get regular updates from them and the plan on how Kaiser is performing.

To date, Kaiser has met all of the benchmarks of the health plan and the -- of the settlement agreement and the milestones that we've set for them. And because it's kind of an ongoing investigation and enforcement action, I can't really get into a lot of detail about what the findings are at this point.

ACTING COMMITTEE MEMBER GREENE-ROSS: And I

appreciate that. I just was trying to understand if it's -- Kaiser is self-reporting or the monitor does their own sort of -- or through a patient investigation. Just because we've been -- our office was reached out by, you know, some groups that have contended that the patients still aren't -- you know, are -- it's still taking too long to get into see somebody. And as you can imagine with, as you know, mental health situations can be very delicate and dangerous for certain people in certain situations. And if they can't get in to see a doctor and the right doctor right away, that's, you know, very, very dangerous, so --

MS. ROUILLARD: Right.

ACTING COMMITTEE MEMBER GREENE-ROSS: So is the monitor just -- is it Kaiser self-reporting or you -- is it actively -- proactively looking at it from the patient perspective?

MS. ROUILLARD: The monitor is actively engaged with Kaiser on these issues. We do also know that there are instances where people aren't getting timely access to care. I will just reiterate again that, you know, our settlement agreement deals with Kaiser's quality assurance program. And so when there's a problem, they need to be able to address it -- to identify it first and address it.

And that is one of the elements of the milestones

and the benchmarks that they're making. So we do get reports from the monitor on how Kaiser is doing with respect to their compliance with the settlement agreement.

I'll just comment, in terms of access to mental health generally, that's an issue across all the plans. I mean, there's not enough providers in the state of California to serve all the needs at every -- at any moment.

But, you know, we're working to try to make sure that the most critical issues are addressed quickly, and that's part of what that settlement agreement is about.

ACTING COMMITTEE MEMBER GREENE-ROSS: Thank you. And then I have one last question. As you mention on the settlement and the claims from the financial end that the reimbursement through the plans, did -- did we -- did CalPERS cross-reference and were we -- were our members impacted and did we get reimbursement for our members under that penalty assessment process? That's more like for Don or somebody in the CalPERS Health Benefits office.

CHIEF HEALTH DIRECTOR MOULDS: We can -- we can get back to you with numbers on that.

ACTING COMMITTEE MEMBER GREENE-ROSS: Thank you.

MR. SOUTHARD: Yeah, we didn't break that out by who the membership was from. We could go back and take a closer look at that work with Dr. Logan and Mr. Moulds on

that to determine, of that 517,000 how much of that was specific to CalPERS members.

ACTING COMMITTEE MEMBER GREENE-ROSS: That would be great to know. Thank you. Thanks, Rob.

CHAIRPERSON FECKNER: Thank you. Seeing no other requests.

CHIEF MEDICAL OFFICER LOGAN: Thank you, Mr. Chair. I'll -- now, I'll pass it over to the Kaiser team.

CHAIRPERSON FECKNER: Just a second, we have one more question.

Mr. Ruffino.

ACTING BOARD MEMBER RUFFINO: Thank you, Mr. Chair. Before we go there, a quick question for CalPERS staff. Last month, the CDC issued a report indicating that suicide rates among teenagers has tripled since 2007. Furthermore, we see more evidence that there's a significant danger between mental illness and medical illness. So is the CalPERS staff tracking these patterns among youths and adults in California? What pattern do you see? And lastly, have the contractor health plans provided sufficient treatment to address mental illness at an early stage?

CHIEF MEDICAL OFFICER LOGAN: Yes. Thank you for that question. At our August Board meeting, we did present about suicide rates climbing in California and

specifically among younger people. And we are certainly concerned about that. And that is one reason why we think it's really important to integrate primary care and mental health, and why early intervention and treatment, and also screening is incredibly important.

So those are the things that we're working -- as Dr. Molds mentioned, that we are working on with experts and our partners with Covered California and Integrated Health Care Association to be able to understand that throughout California and then to be able to monitor and improve it within our population.

ACTING BOARD MEMBER RUFFINO: Can I just do a quick follow-up, Mr. Chair?

CHAIRPERSON FECKNER: Yes.

ACTING BOARD MEMBER RUFFINO: If these patterns continue into the future, what cost implications will they have for CalPERS, and what implications will they have for the health outcomes of CalPERS members?

CHIEF MEDICAL OFFICER LOGAN: They could have very significant negative impacts for sure. We know that people with serious mental illness die earlier, up to 25 years earlier. So that is something that we are continuing to track and to try to better understand, so that we can improve. But, yes, I agree. It's a very serious problem.

ACTING BOARD MEMBER RUFFINO: Thank you, Dr. Logan.

CHAIRPERSON FECKNER: Thank you.

Please continue.

CHIEF MEDICAL OFFICER LOGAN: Thank you, Mr. Chair. Now, we'll go ahead and turn it over to the Kaiser team.

CHAIRPERSON FECKNER: Than you.

MS. STRIEGEL: On my mic --

CHAIRPERSON FECKNER: It was not it's off.

There you go.

MS. STRIEGEL: All right. Good morning.

CHAIRPERSON FECKNER: Good morning.

MS. STRIEGEL: So thank you, Mr. Chair and members of the Board. My name is Cindy Striegel. I'm Vice President at Kaiser Permanente. It's to be with you again today. I also have along with me Dr. Mordecai to co-present with us today.

We're here today as a follow-up to the August Board meeting. We deeply appreciate the time today to engage on this important topic.

This particular topic is of great importance to our organization and our leadership. It was also a passion of our late CEO Bernard Tyson. I would like to express my gratitude for the thoughts and condolences

we've received as our organization grieves and transitions with the significant loss, especially with your comments in the opening today. Greatly appreciated.

Our objective today is to answer the questions provided by the CalPERS staff and those asked during the August Board meeting. As has been the case for the past year, we are currently in contract negotiations with one of our union partners. We will did our very best to answer questions based on this situation.

To begin with, I'd like to have Dr. Mordecai introduce himself and begin the presentation.

--o0o--

DR. MORDECAI: Good morning.

CHAIRPERSON FECKNER: There you go.

DR. MORDECAI: Good morning. I'm Don Mordecai. I'm the national leader for mental health and wellness for Kaiser Permanent. I'm a child and adolescent psychiatrist and adjunct clinical professor at Stanford University. And I see patients at the Kaiser Permanente San Jose Medical Center.

I'm going to hand that you, Cindy.

MS. STRIEGEL: Yes, please.

DR. MORDECAI: I also wanted to thank the Chair for his words about Bernard Tyson. It is indeed a great loss to our organization and really to the nation. Mr.

Tyson consistently talked about things that maybe health care CEOs don't talk enough about equity and health outside of the walls of hospitals in communities. And he cared a lot about mental health and wellness, so I will -- I will miss him particularly.

As has already been referred to, we're facing a crisis in our nation with respect to mental health and addiction care, with ever increasing demand and a workforce that is not growing fast enough. As the Board probably knows a recent California Health Care Workforce Commission found that if demand keeps up as it's going, by 2030 California will only half the number of psychiatrists estimated to be needed and a third less -- or approximately a third less of the therapists estimated to be needed.

Kaiser Permanente has been working to address this situation on behalf of our members through large-scale hiring, creating new approaches to provide rapid access, training hundreds of M.D. and therapist, mental health, and addition care specialists every year with plans to greatly expand that number. And, of course, some of those specialists do come to work for us, but many go out into the California community to serve -- to serve other citizens.

And we have been contracting for external

services and we're building quite a bit of office space to the tune of several hundred million dollars worth, so that our new providers have places to see patients.

We have an integrated system, which allows us to address mental health and addiction issues for our members across the continuum from primary care through specialty care. And as this slide illustrates, we provide an extraordinary range of integrated care for our members.

MS. STRIEGEL: In the August Board meeting one of the questions that I think fits in this slide that was raised was the number of -- the growth of our therapists in relationship to the growth of our membership growth.

And today, when we've pulled the latest information, so we've grown our therapists since -- and specifically the question was since 2015. So we've grown our therapists collectively about 30 percent, a little over 1,200 full-time therapists or clinical care providers, in that time frame, at the same time as our membership growth has been about 20 percent -- slightly over 20 percent, 1.5 million members or so. So it was a question asked in the August Board meeting.

We've also continued to actively recruit for additional behavioral health staff and currently have 300 positions posted and in the hiring process -- recruiting process, I should say, across the state of California.

--o0o--

DR. MORDECAI: So Cindy was referring to hiring for specialty providers, but we don't believe that the situation facing our country can be solved in traditional ways, depending just on specialty mental health and addiction care system capacity. We do believe there's a solution. Our strategy is to invest in our whole continuum of integrated care for mental health and addiction, because the demand cannot be met solely in specialty care.

We're also making investments upstream - and I'll talk more about this in a bit - to try and prevent the emergence of mental health and addiction conditions by decreasing adverse childhood experiences and making schools trauma informed. We hope to reduce the stigma attached to these conditions, which prevent people from seeking care.

In the area of care delivery, there needs to be a tightly coordinated set of services across the continuum to get people to the right level of care at the right time.

These services include:

Rapid assessment and the ability to start people quickly on the right care path based on their diagnosis and treatment plans created by physicians and therapists;

Expanded capacity for collaborative care and primary care. This is an evidence-based approach to population care for mild to moderate depression and anxiety; expanded capacity in specialty care, as we were just discussing, and use of measurement based care to ensure measurable and meaningful outcomes to our members; use of intensive outpatient programs and case management for the most severely ill; use of evidence-based digital tools and telehealth, which can expand care options for members; the ability to move seamlessly along this continuum is important as needed, so that you can intensify or moderate the level of care based on a patient's specific needs; and finally, expanded training of mental health and addiction care professionals, as I referred to earlier. Across the state, we train hundreds of mental health professionals every year.

As an integrated care system, we are uniquely capable of building this tightly coordinated system of care, which we believe is necessary to actually address the issues facing our nation in mental health and addiction care. It is worth noting that KP Northern California and KP Southern California are the only plans in the state to receive the highest rating for behavioral and mental health care, five stars, from the California Office of the Patient Advocate.

However, we are not perfect and we have much more to do making investments and improvements, and we intend to do that.

MS. STRIEGEL: An additional question that was asked of us in August was a -- was the number of days between visits after the first initial. So an insight around the follow-up care and the averages as such. It's difficult in these scenarios, because our approach to mental health care is similar to our approach to specialty care.

So there is not a one-size-fits-all on how a follow-up visit would be obtained. Our approach is to follow a treatment plan. So just as you would with your cardiologist or OB/GYN, there is a need based on your specific care. And so our focus is on following the treatment plans that are developed by those clinicians working directly with the -- with the member.

Each patient would -- their course of diagnosis and need would be different. Their follow-up needs would be different. And so our focus is primarily on following the treatment plan.

--o0o--

DR. MORDECAI: I'd just add that when I'm seeing patients at San Jose, I have some patients that when I see them for the first time might need to go right into an

intensive outpatient program. And therefore, I need access to that kind of program, which I have.

I have some patients who I might start on a medication say for depression or anxiety, and I need to check in with them in a week or two weeks. And I say to them, how do you want to do this? Do you want to do this by phone? Do you want to do it by email? If they need to come in, I'll find a way to bring them in. Most often, they're happy to do it remotely, so make it more convenient for the members.

And then sometimes I have very stable patients that I might see once every several months, because they're fine. They know how to reach me and I know that they'll reach out to me if they're having difficulty, so...

MS. STRIEGEL: Thank you.

DR. MORDECAI: Should I go on?

MS. STRIEGEL: Um-hmm.

DR. MORDECAI: So specifically about specialty services, we are expanding access, as you've already heard. So along with developing this integrated continuum, of which specialty is a part, we are hiring many more mental health providers as Cindy detailed. We are contracting with external providers. We are opening new offices. So we are accelerating a multi-hundred

million dollar building project to make sure that we have appropriate treatment facilities.

So, for example, we are opening a new outpatient mental health and wellness center in San Leandro and Fremont, adding a hundred new offices where mental health providers will treat patients, as well as an 18-bed med-psych inpatient facility in San Leandro. And that's a shortage -- there's a general shortage of beds in California for inpatient facility, but med-psych is sort of a super specialized area, where we were finding that there weren't enough beds for us to contract out for, and so we're building our own.

In 2018, we opened a new mental health treatment center in downtown Sacramento. As I mentioned, we're developing ways to accelerate patient access to their initial treatment through programs that more quickly connect members to clinicians. We're expanding our telehealth services. We did I believe it was about 400,000 telehealth mental health visits in 2018 and we're continuing to expand that.

We have developed a mental health service line to help members address issues related to mental health appointments non-urgently. If there's urgent, they need to call into their local clinic or go to the emergency room, where we're -- we're happy to see them. But for

non-urgent issues, we've developed a mental health service line.

And then as I said about training, we're investing tens of millions of dollars to expand our training programs and expand training opportunities for our current staff.

--o0o--

DR. MORDECAI: There have been -- there were questions about primary care, so I wanted to address that somewhat. In primary care, we proactively screen high-risk groups, like those with chronic illnesses, pregnant women, and those where there's a high index of suspicion for mental health or substance use condition. Mental health professionals are readily available to primary care providers for consultation. That's one of the advantages of our integration.

Primary care doctors are equipped to care for mild to moderate depression and anxiety, and can easily refer to specialty mental health and addiction care when needed.

A shared electronic medical record allows primary and specialty care physicians to communicate easily about care for a patient. And that's something I particularly value about practicing within Kaiser Permanente is when I have patients with comorbidities - and they can be quite

complicated sometimes - it is quite easy for me to communicate with their endocrinologist, or nephrologist, or cardiologist about their medical situation, so that we can coordinate their care.

We track data, such as access, satisfaction, outcomes, and quality related to our primary care services.

--o0o--

DR. MORDECAI: All right. So switching gears a little bit. There were questions about the social drivers of health or social determinants of health. We sort of like the word "drivers", because it's a little less determinative. We don't want to communicate that if you had these situations in your life, you're definitely going to have negative outcomes, so we call them social drivers.

This is part of what I mentioned before about how we're working upstream, in terms of not waiting for people to develop mental health conditions, but actually trying to prevent them. And this is something that Bernard cared quite a bit about, I would say.

So for the past 70 years, part of our mission has always been to improve the health of our members and the communities we serve. As part of our community health strategy, we're committed to addressing the social drivers of health, which are the conditions where people live,

grow, play that impact their health outcomes.

Some of our efforts include a community -- community investments. In May of 2018, we announced a $200 million impact investment to address homelessness and create affordable housing. We committed to housing over 500 Oakland residents who were over the age of 55 and had some kind of chronic condition.

In October of 2019, we announced a $2.75 million commitment to fund new research to help prevent and mitigate the health effects of Adverse Childhood Experiences, or ACEs.

We're currently building out a national solution called Thrive Local to connect our members to community resources to help them meet needs such as food, housing, child care, and other needs.

We've developed a Social Drivers of Health report to help employers understand the connection between where employees live and their health outcomes. So I think we've come to understand in our society a very important issue, which is that environmental factors actually have a bigger effect on health, probably substantially bigger, than health care itself. And so Kaiser Permanente is endeavoring to engage that truth and understand how we can develop efforts to promote things like food security, housing security, health care security, decreasing Adverse

Childhood Experiences, and efforts like that.

--o0o--

DR. MORDECAI: You asked about stigma. We are committed to helping people understand the importance of creating a culture of acceptance and support for mental health. That's why we launched our public health awareness effort Find Your Words in 2016. And you can find it at findyourwords.org. Findyourwords is one word.

We're joining forces with others in the field to spark a national conversation about depression and other mental health conditions. Our intent is to reduce the stigma that can be a barrier to reaching out for help or support.

We continue to invest in expanding content in Spanish and English, adding information about resilience in childhood mental health to the site just last month. We have multiple other initiatives on stigma. We have a partnership with the National Basketball Association focused on reducing sigma, improving resilience, and creating healthier generations.

We have a groundbreaking initiative called Resilience in School Environments, expanding to 225 schools nationwide, which is really focused not on the kids, as much as the staff, understanding that the staff are there every day with children who may have been

traumatized and need to understand issues of trauma and how to work with children like that. So that effort is ongoing.

We recently launched an online mental health and wellness training for KP employees and managers designed to help everyone at KP understand and identify the signs and symptoms of mental health conditions and to be able to assist someone, a co-worker, colleague, community member, or loved one. And as you heard from Dr. Logan, we're making mental health first aid widely available to our staff.

--o0o--

MS. STRIEGEL: Several questions were around our compliance with mental health parity laws. And so I'm going to spend a few minutes on this slide. The three areas that we're focused on around this are that we've reviewed all of our benefits pursuant to the -- to the Act. We are in compliance and we continue to monitor that as we develop benefit plans in the future to ensure that they're also in compliance.

The second piece of this compliance work is operationalizing and understanding our utilization management to ensure that we meet the requirements of the law.

And then last in this area, in 2014, Kaiser

Permanente complied with the DMHC requirement to participate in the routine mental health parity, which includes worksheets. We've responded to all the requests. And most recent DMHC survey was issued in July of 2018. And as you heard previously, the next version would -- should be out in the next month or so.

This last item I think is appropriately connected to the question -- not this slide yet. Sorry.

DR. MORDECAI: Apologies.

MS. STRIEGEL: That's okay -- connected to the questions we received in August about the DMHC findings and the timely access to patient care for Kaiser Permanente, which we take seriously.

The DMHC produces the Timely Access Report, which is intended to provide this information on all health plans. They use the provider appointment availability survey methodology. This includes having the survey conducted by an approved third-party surveyor called Mazars. They publish an annual report that covers all health plans and we are a part of that application and participation in that survey.

We also look to external entities, like NCQA, HEDIS, and the Office of Patient Advocate where Dr. Mordecai shared the recent summary of our successful rating with their most recent report.

While we're pleased to see those results, we continue to constantly work on improving mental health, both reducing the stigma, improving access and care, ensuring that our primary care physicians have the tools and resources they need as a front-line defense to assisting our members and your employees.

You also asked specifically about our approach in approving the deficiencies identified by the DMHC. So we did have deficiencies identified in 2012. They consisted of insufficient oversight and monitoring of access for non-urgent care. They did not find fault with the quality of care provided or the difficulty in assessing urgent or emergent care.

We have made tremendous progress working collaboratively with the DMHC and their external consultant. Progress reports are reported on a quarterly basis with them. And we're meeting the needed deliverables by the following activities:

In the first area around improved quality oversight, such as exceeding the established regulatory standard for first appointments; expanding internal capacity by increasing therapists and expanding recruiting efforts and focus, which I did spend a minute on earlier; investing in treatment facilities, as Dr. Mordecai has outlined, by expanding and enhancing our treatment

facilities, including the medical-psychiatric unit at Fremont Medical Center and others that he outlined.

The fourth area is by expanding our external provider network by contracting with qualified community providers when and where necessary to meet our access expectations and standards.

On innovation options, we have a program we call Connect 2 Care in our telehealth, which has the ability for patients to communicate with our therapists from the privacy and comfort of their own homes; embedding behavioral health professionals in our primary care clinics and our Emergency room departments for immediate access. Building a pipeline has been important in our ability to meet these heeds around training opportunities statewide with over 300 trainees each year. We provide tuition assistance and grants to help train up to a thousand new therapists across California over the next six years.

And the last area of focus to meet these corrective action plans has been around reducing the stigma. And Dr. Mordecai spent a few minutes on the 2016 campaign that we launched.

--o0o--

MS. STRIEGEL: And the next slide, the last area was specifically around prevalence and utilization. So

this slide will show all of the inpatient and outpatient services categories with paid claims between April of 2018 through March of 2019. So we're showing a 12-month period of time. CalPERS results are closely aligned with our overall book of business for the entire state of California. We've listed out the top five mental health diagnoses by prevalence and the overall number. And this matches exactly the book of business for Kaiser for California.

We also outlined the top five mental health diagnoses by cost, which also four out of the five match the Cal -- our California book of business. The one that doesn't is in your prevalence, just not in your top cost. We want to thank you for your time today and we're happy to answer any further questions.

CHAIRPERSON FECKNER: Very good. Thank you for the presentation. We do have a number of questions.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Yes. Thank you for the reports. So it looks like you -- you've made some progress here. I'm not -- I think that all of our health plans have issues with mental health.

Well, number one, I had a question. You said you opened a mental health treatment center in downtown Sacramento. Is that an inpatient or outpatient?

DR. MORDECAI: That's an outpatient.

COMMITTEE MEMBER TAYLOR: Outpatient. Okay.

And then I just wondered we had a lot of questions for you, but I also kind of wondered on slide number eight, where you're working to help the social drivers of health care.

MS. STRIEGEL: Um-hmm.

COMMITTEE MEMBER TAYLOR: I think -- I'm wondering -- I see housing, insecurity -- food insecurity. Are you guys -- do you guys have a program to address the upswing in gun violence in schools and kids now having to do active shooter training for -- I assume that would be a social driver as well. I wouldn't know. I'm not a mental health professional, but...

DR. MORDECAI: So we don't have a specific focus on children and gun violence, although that's a reasonable suggestion. We have made substantial commitment to gun violence search to the tune of, I think, $2 million. So that's one way that we're tying to get a better understanding of the implications of that.

COMMITTEE MEMBER TAYLOR: Is it overall gun violence, or children and gun violence, or all of it?

DR. MORDECAI: It's overall.

COMMITTEE MEMBER TAYLOR: It's overall. Okay.

And then I -- so you've done a lot to bring in

more health professionals. I heard you talk about actually providing money for schooling for folks to --

MS. STRIEGEL: Yep.

COMMITTEE MEMBER TAYLOR: I know that's a big problem.

MS. STRIEGEL: Yes.

COMMITTEE MEMBER TAYLOR: So I don't have Kaiser anymore, but --

MS. STRIEGEL: Right.

COMMITTEE MEMBER TAYLOR: -- one of the problems is when you call for health care -- or mental health care, nobody can take you.

MS. STRIEGEL: Um-hmm.

COMMITTEE MEMBER TAYLOR: So I don't know if that was a problem that was occurring with Kaiser as well.

MS. STRIEGEL: Sure. Sure. So the 2012 findings were around being able to provide timely non-urgent appointments. So our emergent and urgent met the standard. So it was the I need to call today and I need an appointment, and it was taking longer than the 14 days, the 10 days, et cetera.

And so much of the focus of many of the tools that Dr. Mordecai laid out was a full package of addressing that. So it can't just be addressed by hiring over 1,200, you know, therapists or building more offices.

It's around making sure our primary care physicians have the resources to manage the member when they first present in their office, expanding the capacity of the telehealth services to allow more clinician activity to happen without having to, you know, be present.

And so it's a full spectrum of work to meet not only the increasing demand. Thankfully the increasing demand, quite frankly, of our members seeking that guidance, but also being able to manage it within those guidelines. And so that is the tremendous amount of work that we've been doing.

Anything, you want to add?

DR. MORDECAI: (Shakes head.)

COMMITTEE MEMBER TAYLOR: Okay. So as -- another question I have --

MS. STRIEGEL: Yeah.

COMMITTEE MEMBER TAYLOR: -- that I've had members talk to me about is --

MS. STRIEGEL: Sure.

COMMITTEE MEMBER TAYLOR: -- so they go into their primary care physicians --

MS. STRIEGEL: Yeah.

COMMITTEE MEMBER TAYLOR: -- talk about, hey, I've been depressed. I need to see somebody.

MS. STRIEGEL: Right. Right.

COMMITTEE MEMBER TAYLOR: I'd say a couple of years ago.

MS. STRIEGEL: Um-hmm.

COMMITTEE MEMBER TAYLOR: I haven't talked to this person for a while.

MS. STRIEGEL: Um-hmm.

COMMITTEE MEMBER TAYLOR: They had said that basically their primary care physician was directing -- directing them, hey, go call --

MS. STRIEGEL: Um-hmm.

COMMITTEE MEMBER TAYLOR: -- our mental health.

MS. STRIEGEL: Um-hmm.

COMMITTEE MEMBER TAYLOR: And then it was, like you said, how long to get in.

MS. STRIEGEL: Right, a challenge. Sure.

COMMITTEE MEMBER TAYLOR: Who had an opening, because there was a lot of that. There was no openings.

MS. STRIEGEL: Sure. Sure.

COMMITTEE MEMBER TAYLOR: But it wasn't -- it was sort of a detachment.

MS. STRIEGEL: Yeah.

COMMITTEE MEMBER TAYLOR: But you still had to go through your primary care. So it felt like my -- I think --

MS. STRIEGEL: Sure.

COMMITTEE MEMBER TAYLOR: -- people were telling me they felt like why should I go through primary care. Why can't I just talk to mental health.

MS. STRIEGEL: Right. Yeah, so to that -- and I'll have Dr. Mordecai talk a little bit about the primary care and the mental health. Our mental health is you go direct.

COMMITTEE MEMBER TAYLOR: Okay.

MS. STRIEGEL: You do not need to go through your primary care physician. We find that many of our members will present themselves -- they -- they don't want to say I need help --

COMMITTEE MEMBER TAYLOR: Right.

MS. STRIEGEL: -- so they won't call mental health directly. They may go into their primary care. And as an example, I had a doctor's appointment yesterday, you know, for medical stuff. My physician asked me how I was doing and I said, well, my mother in-law fell and hurt herself and is living with me now, not while I was there. I have the support I need, but she sat down and had a ten-minute conversation with me about the stress and anxiety of that approach.

I was there for a completely different reason. That happens a lot. And so having the primary care physician understand the tools and resources available to

members from the mental health perspective is really important. But our members call directly to mental health. There's not a need for them to go to their primary care physician.

COMMITTEE MEMBER TAYLOR: Okay.

MS. STRIEGEL: Do you want to --

DR. MORDECAI: And that's not new, so I --

COMMITTEE MEMBER TAYLOR: Maybe the person who was -- maybe they felt like they --

DR. MORDECAI: There may have been a misunderstanding.

COMMITTEE MEMBER TAYLOR: -- had to.

MS. STRIEGEL: Right, they need to, yeah.

COMMITTEE MEMBER TAYLOR: Okay. Thank you.

MS. STRIEGEL: Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Rubalcava.

VICE CHAIRPERSON RUBALCAVA: Thank you, Mr. Chair. Thank you for the presentation. I appreciate you addressing a lot of the questions that were raised and issues.

In the presentation, Dr. Mordecai, you spoke a lot about it's an integrated system, which we know Kaiser is. And I want to follow up on Ms. Taylor's question. Sort of -- it's what you responded, Cindy, which was

primary care physicians have -- in one of the slides said it has been identified as a gateway for the first -- especially with chronic diseases, when there's comorbidity, we know that the mental illness coexists there too. But you mentioned they were trained. How are they trained to identify the need for mental health services and how -- what is the -- what is -- what is the training and what is the next step? How are they referred or how are they addressed? Can you explain that process in more detail, please?

DR. MORDECAI: Sure. Thanks for the question. So I do want to be clear so primary care is not a gateway for us. So as we said to the last question, people can self-refer into mental health care.

VICE CHAIRPERSON RUBALCAVA: I didn't mean gatekeeper, but --

DR. MORDECAI: Oh, okay. I just --

VICE CHAIRPERSON RUBALCAVA: -- it means, for many people who -- some of the presentation was about how it's underreported perhaps or undiagnosed. So many members perhaps go to the primary care for one reason.

DR. MORDECAI: Right. Right.

VICE CHAIRPERSON RUBALCAVA: And one of your slides in your presentation spoke about how they're trained -- primary care physicians are trained to be, I

guess, a first -- not first responder but the first point of contact.

DR. MORDECAI: Right or a first line. And --

VICE CHAIRPERSON RUBALCAVA: So how are they trained and what is the next steps that they're trained to do?

DR. MORDECAI: Sure. So primary care doctors, like all physicians, are continuously retraining. There's -- for the positions on this panel, we all know that we have to go through any number of hours of continuing medical education to maintain our license.

Part of that training would be mental health training, if they choose to take it. But then Kaiser Permanente specifically trains its primary care providers, in terms of how it wants them to manage mental health conditions.

And one thing I didn't go into a lot, but I mentioned, is what's called collaborative care. So collaborative care is not just, oh, make your primary care doctors into psychiatrists, right?

Primary care is actually a system of care that the primary care doctor can refer to, so that people can get appropriate care and follow up, mostly for depression and anxiety. So there would be a team of specialists on the collaborative care team to whom the primary care

doctor can refer. And that team knows how to track the patients, knows how to prescribe medication, knows how to do therapy type interventions. So by way of saying part of the training is to say understand the resources that are available to you and use them when you detect that somebody is depressed.

For direct training, we would say to them, you know that, as Dr. Logan said, 20 percent, some people would say 30 percent, of people coming into your primary care practice have mental health issues. So these are not foreign issues to primary care docs. They see them every single day.

And so working with them to help them understand, you know, here are your first steps in terms of treating somebody who maybe they are open to a medication and that would be appropriate or maybe they're not open to a medication. What are the steps you take for that?

So I think trying to describe what it's like to be a Kaiser Permanente provider, you're tightly integrated into the care system and have opportunities to train and collaborate with your fellow docs continuously essentially.

VICE CHAIRPERSON RUBALCAVA: I have a follow up question.

CHAIRPERSON FECKNER: Um-hmm.

VICE CHAIRPERSON RUBALCAVA: So does Kaiser keep any matrix or any reporting as to from that primary care physician visit, how many are referred to further care for mental health illness or systems, and how many actually follow through? What is the follow up that Kaiser does to ensure that people who identified -- say they're presenting for diabetes, for example, you mentioned the term comorbidity. So some people always have other symptoms in there. How do we follow up -- how does Kaiser follow up to make sure they get the attention that's necessary?

DR. MORDECAI: So one of the keys to collaborative care is that it's a population-based approach, meaning you don't -- you assign people into a population and you say, these are -- this is our population of adults with depression in primary care and we're going to follow them as a population. So much as we do with blood pressure treatment, right, you bring somebody in, you make a diagnosis that they have hypertension, you apply a treatment, and then you don't sort of let them walk out and see how they do. You follow up, right? You take their blood pressure again.

So similarly, with depression, anxiety, things like that, it's a matter of measuring somebody, making a diagnosis, making an intervention, and then reassessing.

And if that intervention is not working, then you need to do something different.

So again, this collaborative care is a population-based approach in primary care. And it's proven quite effective. And I think when my fellow physicians talk about the importance of bringing mental health into primary care, often they're talking specifically about this approach.

MS. STRIEGEL: And I would just add, Mr. Rubalcava, that many of the reports that we produce now will show things like compliance with antidepressant medications and things that are in, what we call, our Chronic Conditions Report are around those diagnoses as depression. So there's HEDIS metrics that are followed that are reported based on that population care that Dr. Mordecai spoke about.

VICE CHAIRPERSON RUBALCAVA: Thank you, Cindy. Thank you, Doctor.

MS. STRIEGEL: Yep. Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. Thank you for the presentation. I'm really heartened to hear the attention, the resources, the effort, because clearly some of the challenges and shortcomings are pretty obvious. So

I don't really want to focus so much there, as kind of a couple bigger picture comments and questions.

One, the kind of adverse childhood events, the trauma, the prevalence and the need for trauma specific mental health professionals, I'd be interested in how you're addressing that. I recently was on jury duty for a little while. And it was potentially a trial involving some pretty severe crimes against children. We started off with a pool of about 160 jurors. And every time we got to the voir dire questions about have you been a victim of childhood trauma --

MS. STRIEGEL: Um-hmm.

COMMITTEE MEMBER MILLER: -- abuse, sexual abuse, domestic silence, it was incredible how many people had to raise their hand and were ultimately kicked out of that jury box.

MS. STRIEGEL: Yeah.

COMMITTEE MEMBER MILLER: And after three days, we finally got down to the --

MS. STRIEGEL: Right.

COMMITTEE MEMBER MILLER: -- last few of us who were left --

MS. STRIEGEL: Right.

COMMITTEE MEMBER MILLER: -- and the case settled out. But it just reminded me that it's a lot more

prevalent even than the numbers we have show, particularly in various populations. So that's my first question is how are you grappling with getting trauma-specific people? Because we -- they hit the workforce --

MS. STRIEGEL: Um-hmm.

COMMITTEE MEMBER MILLER: -- but the underlying traumas are often as well established as children.

DR. MORDECAI: Well, we're certainly interested in hiring people who have trauma experience. Not all therapists do, but many more do now. I think the awareness has come up such that the training programs that we hire out of often have elements of that.

And then as I mentioned, we're doing the Resilience in School Environments is about making schools trauma informed. Our own training programs have trauma modules in them, like I said, where we train over 300 providers every year. And you're right, I mean, as society has become aware, you recognize, and I certainly recognize, probably most of my patients have had some kind of trauma.

And just general statistics say that only about 30 percent of people had no identifiable trauma in their childhood, based on the Adverse Childhood Experiences study. And in some populations, some communities, it's far, far higher. So among the mental health issues our

society is grappling with, that's a big one. And we know also that trauma contributes to incidents of suicide attempts, and substance use disorder, and depression, and on, and on, and on, so...

COMMITTEE MEMBER MILLER: Yeah. My second and kind of final comment and question is it seems to me when I looked at your chart on social determinants and everything, the one thing that seemed to be a real -- really conspicuous by its absence was toxic workplaces and workplace environments. Our members have been public employees. And when I came to State government here in California way back during the Deukmejian administration, one of the first things that struck me is almost all of our approaches to human resource management, particularly when it comes to anything related to performance or behavior were based on discredited 40 years old, at that time, models of behavior and models of using aversives, which, you know, society has figured out don't really work. Our prisons are now our mental health system. We now have wised up to, you know, beating children is not the way to get them to be healthy adults and well behaved children.

Yet, in our workplace is we still have these old models of how you organize work, how you manage work, how you discipline and punish people to modify their behavior.

And so many of the patients -- I think so many of our members who have mental health challenges between the stigma and the practice in the workplace that actually exacerbate their anxiety, their depression, their behavioral issues. And yet, the employers and the unions - I'm a long-time union official - don't really seem to be as interested in this as kind of fundamental -- you know, it's not the immediate root cause, if you go deep enough, but it's where things really play out in the workplace.

And we're still -- and so it seems to me that there may be a real potential for mental health professionals to help us, as labor folks and human resources professionals to say, you know, yeah, we can do better than these, you, know old-school approaches to, you know, like, we do an 80-hour supervisor training for all our new supervisors in State government.

MS. STRIEGEL: Um-hmm.

COMMITTEE MEMBER MILLER: And I've got to tell you, it's like, oh. It's wow. More harm than good in many respects in terms of how we teach people that they're supposed to address behavior.

MS. STRIEGEL: Um-hmm.

COMMITTEE MEMBER MILLER: So any thoughts on that as part of a bigger program to help our employers, our

members, your patients, you know, make our workplaces less of a contributor to the -- to the problem?

DR. MORDECAI: I think it's an important comment, Mr. Miller. And I could see how that -- there could be another puzzle piece in there in our display. And you're bringing to mind many patients that I've seen who were in toxic work environments, that were essentially making them have mental health problems. And it's a real challenge for them to sort of make their way through it. Often, I was just trying to stick with them, so that they knew they had an advocate, but there wasn't so much I could do to change their boss who was harassing --

MS. STRIEGEL: Their situation.

DR. MORDECAI: -- them or things like that.

MS. STRIEGEL: Well, and the two things that I would add for Kaiser as an employer, so the mental health first aid program that they put many of the employees through really helped. You know, it wasn't addressing toxic work environment, but really making you mindful that your colleagues are in a -- in a -- their own mental state that day. You know, they don't -- they're not all walking around thinking like you, or in a good mood, or a bad mood, or in distress or not, but to really think about them, you know, first as a human and then, you know, potentially that their behavior means something bigger.

And so that's at least a step in the direction. I certainly know personally after that, I engage with my employees differently. I mean, I hope I don't have a toxic work environment. But, you know, I engage with them very differently after those trainings.

And then the second was also, you know, reminded me of another passion of Bernard's was he launched an initiative called Speaking Up. And it took some time to really take off, because it wasn't are you sure that you really mean you want is to speak up? And it was about having a voice within your work if things weren't going right, or there wasn't something that was fair, or equitable, or productive, that you were encouraged to speak up. And the organization provided guidance, and training, and insight for leaders and others on how to instill that in their employees and support it when it happens, because there's going to be varying degrees of who's going to speak up and what they're going to say.

But, you know, those are two initiatives that we've launched internally as an employer that I think would help in those situations.

Thank you. That was a great question.

CHAIRPERSON FECKNER: Thank you.

Ms. Middleton.

BOARD MEMBER MIDDLETON: Okay. Well, first, I

want to thank everyone who's a part of this panel and all of my colleagues as you all identified stigma as one of the issues that we confront. And by holding forums, such as this, and bringing attention to these issues, I think we make steps forward in eliminating some of the stigma that exists and it's something that we need to continue to do.

I was struck as I listened to the work that you're trying to do as to what are the issues around adequacy of staffing --

MS. STRIEGEL: Um-hmm.

BOARD MEMBER MIDDLETON: -- that you have, in order to be able to address those issues? And I suppose I will start with the folks from Kaiser, but I think it is a much larger issue in staffing not only of M.D.s, but of support staff that would be able to help the M.D.s.

MS. STRIEGEL: Um-hmm. Yes, I think -- it was a great question. I think it really goes to the beginning of our presentation around just the severity of the needs versus the availability of therapists. And so our comprehensive approach has really been about dividing out what are all of the barriers to making more clinicians -- the wide spectrum of clinicians available, you know, from first providing, you know, the funding in order to hire people, then how do you find them, how do you recruit

appropriately when the demand is high and the supply is quite low?

And so working upstream as we've outlined around, you know, supporting tuition reimbursement if that is a barrier for someone in order to get their, you know, training, and focus, and building facilities. And there's a full spectrum of that approach. That takes time and is difficult and challenging, and requires a lot of things to work in -- you know, in a coordinated fashion.

And our ability in a fairly short period of time for this type of work to be able to hire in a couple of years, several years, you know, 1,200 more clinicians and then to tap into our primary care physicians and emergency room physicians to shore up some of that need, as well as right now we are currently contracting with outside providers to ensure that we are able to provide, you know, the access that's needed.

Would you add anything?

DR. MORDECAI: No.

MS. STRIEGEL: Okay. Did that answer your question?

BOARD MEMBER MIDDLETON: That's a good start.

MS. STRIEGEL: Okay. Okay.

BOARD MEMBER MIDDLETON: I want to turn to the Department of Manage Care. Do we have staffing models

that have been defined for health care organizations, in terms of what number of mental health clinicians they should have for a given population?

MS. ROUILLARD: There are no specific standards with respect to numbers of mental health providers per enrollee population. In our authority, there are standards for physician-to-enrollee ratios, but not specifically to mental health.

But on your issue of workforce development, one of the things the Department has done over the last several years and some of the mergers that we have approved, is to direct the health plans to provide money for workforce development, primarily through the Office of Statewide Health Planning and Department and their Health Professions Education Foundation.

So there's money available similar to what other groups have been doing for loan forgiveness, or scholarships for both mental health, as well as the physician assistants, nurse practitioners, and the non-physician providers.

So we are trying to support that work as well. And the Governor also has put a lot of money into the budget this year for that same kind of activity.

BOARD MEMBER MIDDLETON: And to complete the circle, are there things that we need to be doing here at

CalPERS to ensure that there is adequate staff to provide the access to care that we want?

CHIEF HEALTH DIRECTOR MOULDS: Sure. And I'll let Dr. Logan jump in also, if she wants to. You know, some of the questions that we're -- we've been asking the external experts, as we've been talking about this, are novel ways of addressing some of these staffing issues. So one of the things that comes up often in mental health is -- is telehealth. It is not a cure, because at the end of the day, you have to have a provider on the other end of whatever technology you're using to have it be effective, but it cuts down on the amount of time that's not spent treating. Its's also a venue for getting care that some people prefer over in-person. It addresses the access issue in a different way. And for people who are really reluctant to come forward, it makes it easier.

You know, in terms of access we're -- we are looking at a lot of different tools outside of the standard NCQA and HEDIS measures that typically are used to make these kinds of assessments.

There's some novel ideas that have emerged that we are exploring as -- or looking at as possible ways of getting a better read on access. But certainly, it's an issue that's really critical.

BOARD MEMBER MIDDLETON: Thank you, Mr. Chair.

CHAIRPERSON FECKNER: Thank you.

Ms. Greene-Ross.

ACTING COMMITTEE MEMBER GREENE-ROSS: Yes. So Kaiser, I'm, you know, pleased to hear all the things you're doing to be addressing the increased demand going forward and the increased demand hopefully is related to the efforts to lower the stigma and get more attention on this issue.

MS. STRIEGEL: Um-hmm.

ACTING COMMITTEE MEMBER GREENE-ROSS: So my question then is a lot this stuff is in the works, and it, as you noted, is going to take awhile to get the number of actual staff that you need to have the ideal situation. What are you doing about the mental health needs of your existing mental health providers? Because since the demand sounds so excessive and all the things you're doing are pretty innovative but will take awhile to implement, I'm guessing the strain on your current --

MS. STRIEGEL: Sure.

ACTING COMMITTEE MEMBER GREENE-ROSS: -- crew of providers is pretty excessive. I've heard anecdotally from friends who work in Kaiser, and that -- you know, they're very stressed, so they can't spend enough -- you know, enough time with patients.

MS. STRIEGEL: Um-hmm.

ACTING COMMITTEE MEMBER GREENE-ROSS: And it's -- so I'm just curious about you're handling and supporting your existing -- the existing staff who --

MS. STRIEGEL: Sure.

ACTING COMMITTEE MEMBER GREENE-ROSS: -- sound very strained, like we would have -- like we have in State government, where we can't get enough people.

MS. STRIEGEL: Yeah.

ACTING COMMITTEE MEMBER GREENE-ROSS: We have more work thrown at us.

MS. STRIEGEL: Well, it sounds familiar from our --

ACTING COMMITTEE MEMBER GREENE-ROSS: Yeah.

MS. STRIEGEL: -- from primary care physicians and --

ACTING COMMITTEE MEMBER STRIEGEL: Yeah.

MS. STRIEGEL: -- you know, especially physicians. Do you want -- no.

So I actually really appreciate the question, because it's not one that I often get around -- around this. We sort of forget about the providers that are -- are really paving the way for innovative, you know, care and treatment. So as an employer, just in general, there are a number of resources that are available to me. I'm not a care provider, so the stress on them is -- is

significant.

As part of our engagement with that segment of employees, there's a lot around getting them actively involved on innovating care and how best we can meet that. So I think getting them actively involved in what that feature care looks like. And I don't mean ten years from now. It could be a year from now, months from now on getting them actively involved in those guidelines.

I think also I feel that the significant - and I really do mean significant - effort around getting them the support the members that they need to have additional clinicians reduces that volume of feel of workload and that they're in it alone. And particularly building facilities that are dedicated to treating those members is making them first and foremost -- forefront of what you provide to this organization and to our members really matters, and so having the space to be able to see clinicians.

I know several years ago they were needing to share offices and rotate, because the demand was so great. And so filling those availability for them to have dedicated space that are -- is welcoming and that members enjoy, you know, coming to evaluates that. And I would also say that we've encouraged them to have a dialogue with their leaders, their managers, if there's something

going on in their space that it isn't sustainable.

If they don't feel like they have the resources they need to care for the members that are coming to see them, whether that's return time, or office space, or ability to connect with other providers, that they have -- their managers have been guided by the organization, and supported by both the medical groups in both Northern and Southern California to really help those clinicians figure out how to manage this need.

So those are a few areas. I really -- it's a unique question I haven't been asked before, so appreciate that.

ACTING COMMITTEE MEMBER GREENE-ROSS: Sure. Okay. Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Ruffino.

ACTING BOARD MEMBER RUFFINO: Thank you, Mr. Chair. And thank you, Ms. Striegel and Dr. Mordecai --

MS. STRIEGEL: Yeah.

ACTING BOARD MEMBER RUFFINO: -- for being here --

MS. STRIEGEL: Yeah.

ACTING BOARD MEMBER RUFFINO: -- and answering some of the questions, especially from our office.

Kaiser gets great marks, you know, does great

work for a number of its medical services. Why are its behavioral health services so vastly inferior? Is it due to lack of resources or and inadequate model for delivering mental health services? What do you think?

MS. STRIEGEL: Do you want me to start?

DR. MORDECAI: If you want to start.

MS. STRIEGEL: No, go ahead.

DR. MORDECAI: I don't accept the premise that it's -- that our services are inferior. I mean, as I said, and we're not trying to crow about it, but we're the only two plans with five stars from the Office of the Patient Advocate. There's one plan with four stars.

So are we challenged by the issues facing all the plans? Absolutely. Are we moving towards a new model that we think can actually address the increasing demand in our society and the lack of providers? Yes. And that's what I tried to layout for you.

MS. STRIEGEL: What I would add, in general -- so I've thought quite a bit about this. I -- you know, we spend -- we have spent quite a bit of time talking about mental health services with many employers. Very different than diabetes care or cancer care. I think the topic is emotional. It's mental, but it's emotional. I think there are a number of factors that influence more intense structure and focus around it.

And where I come around to on a regular basis is that, you know, I see as your objective, the Board's objective and CalPERS objective, is for their employees and ultimately our members to have, you know, the best possible care around all medical conditions, including mental health, and have access and service that meets their needs.

And where I come around to is, yeah, I can honestly sit here, and so would Dr. Mordecai, and say our objectives are aligned, that we are deeply interested in meeting and, quite frankly, exceeding the needs of our members around mental health. And everything we're doing is in order to get there. And it is a journey.

It is not reflective of our lack of commitment, or desire, or interest in actually leading the nation in how to best care for members who are in need of mental health. There's a lot of factors around, you know, demand, and provider availability, and stigma that comes into -- into account, that makes this work even more challenging than say diabetes or cancer care. But we're as committed to mental health as we are to those.

ACTING BOARD MEMBER RUFFINO: One quick follow-up.

MS. STRIEGEL: Yeah.

ACTING BOARD MEMBER RUFFINO: I mean, we --

obviously, we all know, we've heard that, we understand that you were cited for violating, you know --

MS. STRIEGEL: Um-hmm.

ACTING BOARD MEMBER RUFFINO: -- a variety of State mental health laws that -- back in 2013, but have not yet successfully corrected all of those violations. Why has it taken so long to remedy these violations?

MS. STRIEGEL: Yeah. No, that's a great questioning. There were four specific findings. Two of them were corrected. And I apologize, I don't know the timing, but they were -- they were corrected, relatively soon after.

The last two were around -- you know, continued effort around access and service on making sure that employees/members can get it in a timely manner. So that's going to require system changes, which have happened. It's going to require hiring of staff, which has happened, but certainly, there's, you know, more to do. And so they're -- particularly, around staffing up and beefing up the system to support it and will take some time to get there.

We feel -- we feel very confident that we will be there and are working closely with -- with the external consultant to ensure that we're meeting milestones, and as was shared earlier, that we have been. This is not an

issue or an area that we can solve over night. We can't just throw more money at it. We can't throw more effort at it. We're doing the things that we feel are the most important. They just take some time to implement.

ACTING BOARD MEMBER RUFFINO: One other quick to the Department of Health. I know that you guys hire, I think I understood, an outside monitor in 2017 to monitor that work. Thus far, have they gone a day -- meaning Kaiser, have they done a DHMC[SIC] investigation that documents that he has successfully resolved or all the violations committed, or -- can you comment on that or if -- not the specific, but in general, can we be assured?

MS. ROUILLARD: Certainly. The Department, as part of the settlement agreement, required Kaiser to contract with the external experts to help the plan address the deficiencies around their quality assurance program and to be able to effectively identify and address issues.

That monitor has -- or consultant, really, has been working closely with Kaiser and reporting to the Department on a quarterly basis on their progress. And as I said earlier, they are meeting all the benchmarks and milestones of the settlement agreement.

And then Dan's shop will be doing a follow-up -- or a routine survey next -- next year or this year?

MR. SOUTHARD: It's in its current process. We have finished our onsite portion of the survey.

MS. ROUILLARD: Yeah. Just to -- you know, just do our own due diligence on how that is all working, so...

ACTING BOARD MEMBER RUFFINO: Thank you.

Thank you, Mr. Chair.

CHAIRPERSON FECKNER: Thank you.

Ms. Pasquil Rogers.

COMMITTEE MEMBER PASQUIL ROGERS: Thank you, Mr. Chairman. Thank you very much for your presentation today. The collaboration and partnership is encouraging. And, you know, the additional staff --

MS. STRIEGEL: Um-hmm.

COMMITTEE MEMBER PASQUIL ROGERS: -- that you'll be hiring is encouraging. What I'd like to hear is are you working with different statewide groups or local groups to identify -- that reflect the great mosaic and need of our state in trying to build your applicant pool? Because as an Asian-American, you know, when -- I know when I was growing up, if I went into the mental health area, my parents would be like, you're not a lawyer? You're not going to be a lawyer.

(Laughter.)

COMMITTEE MEMBER PASQUIL ROGERS: So -- but what I -- I know that the needs of our state are very

different.

MS. STRIEGEL: Yea, and very diverse.

COMMITTEE MEMBER PASQUIL ROGERS: And so what are you -- very diverse. What are you doing to encourage a strong applicant pool that reflects our great mosaic?

DR. MORDECAI: So thank you for that question. As part of our efforts to increase the training that we're already doing, we are working with a number of the school -- the professional schools out in our state. And we are always interested in the diversity of our workforce. I mean, as you probably know, Kaiser Permanente has one many awards for being one of the more diverse health care entities.

But so we're actively going out and meeting with those schools. I think, you know, behind your question is an important thought about, well, how do we go even further? You know, are there ways to get into the high schools, for instance, and get people interested, even if they have to tell their parents that they're not going to be a lawyer.

(Laughter.)

DR. MORDECAI: So -- and I think that's -- that's territory we haven't gone into yet, but probably should.

And then, of course, in -- we've devoted, as we said, tens of million of dollars to allow our own

employees who want to become mental health providers to do that, so that they're not facing, you know, a huge tuition burden when they're wanting to become something that we would like them to become, and to hire them. And we certainly hope that we will draw from the very diverse pool of talent that we have internally as well.

COMMITTEE MEMBER PASQUIL ROGERS: Mr. Chairman, I have a follow-up.

CHAIRPERSON FECKNER: Um-hmm.

COMMITTEE MEMBER PASQUIL ROGERS: Thank you. So I believe that children don't know what they can become unless they see it.

DR. MORDECAI: Um-hmm.

COMMITTEE MEMBER PASQUIL ROGERS: So I do see you in the communities a lot. I would encourage you though --

MS. STRIEGEL: Um-hmm.

COMMITTEE MEMBER PASQUIL ROGERS: -- you know, to go to the schools, because if there's a kindergartner out there --

MS. STRIEGEL: Um-hmm.

COMMITTEE MEMBER PASQUIL ROGERS: -- who is seeing what you do --

MS. STRIEGEL: Right.

COMMITTEE MEMBER PASQUIL ROGERS: -- and you're saying it in their language in ways that they can

associate help --

MS. STRIEGEL: Right.

COMMITTEE MEMBER PASQUIL ROGERS: -- you are encouraging people.

MR. STRIEGEL: Right.

COMMITTEE MEMBER PASQUIL ROGERS: So it's great to sponsor community events. It's super when you can actually be very thoughtful --

MS. STRIEGEL: Yeah.

COMMITTEE MEMBER PASQUIL ROGERS: -- about where you're putting those resources and how you're helping the community.

MS. STRIEGEL: Yeah, that's great.

COMMITTEE MEMBER PASQUIL ROGERS: Thank you.

Thank you, Mr. Chairman.

CHAIRPERSON FECKNER: Thank you.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Thank you, Mr. Chair.

I want to thank you for both coming and answering our questions.

MS. STRIEGEL: Um-hmm.

COMMITTEE MEMBER TAYLOR: And I really appreciate DMHC and our staff for putting this together. This was a great presentation.

MS. STRIEGEL: Um-hmm.

COMMITTEE MEMBER TAYLOR: So one of my concerns is Kaiser is an inte -- integrated health system --

MS. STRIEGEL: Um-hmm.

COMMITTEE MEMBER TAYLOR: -- so these questions are for our staff. As a user of one of our other HMOs, I find that while there may not be complaints about these other health systems, our other providers and our other insurance carriers are also lacking when it comes to mental health. What -- I'm wondering if Dr. Logan and Mr. Moulds, what we are looking at in terms of that. I know the only complaint that came in was about Kaiser.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. So we have queued up for next month similar presentations and discussions with the three other large health plans that we contract with, United, Anthem, and Blue Shield of California. So we're -- this isn't a Kaiser-unique exercise. We're doing this across the board.

One of the things that you're going to run into when we start having those discussions is the models are very different as you pointed.

COMMITTEE MEMBER TAYLOR: Right, that's my issue.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. And in particular, one of the things we'll be talking about when we start talking to some of the other provide -- some of the other carriers are the challenges that come with --

with carve-out mental health plans and integration. So again, Kaiser's model very different.

The carve-outs, in a lot of ways, make MHPAEA compliance, mental health parity compliance, easier, but they create other challenges having to do with referrals and the seamless integration of behavioral and physical health. So we'll be talking about that more with those plans next month.

COMMITTEE MEMBER TAYLOR: Okay. So that's good, because I didn't know we were going to do that. Because my concern is that carve-out situation, where the provider -- I'm sorry, the insurance carrier is okaying you to go to mental health, but the access is not there. There's just not enough health care -- mental health care providers. And you can go through lists, and lists, and lists before you find one with an opening.

CHIEF HEALTH DIRECTOR MOULDS: Yeah.

COMMITTEE MEMBER TAYLOR: And then if you're looking for any kind of urgent care, even if your insurance covers a portion of that, which is completely different from an integrated system, you're paying for a large portion of that outpatient and/or inpatient care, because they're private institutions.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. Sure. I can -- I can -- I can kick part of this to DMHC, because

the part of MHPAEA is supposed to be parity along, you know, financial, copays, cost sharing, and so forth. So that shouldn't be happening in theory. They can maybe comment on that in practice.

MR. SOUTHARD: Right. So as we were discussing earlier, quantitative treatment limitations require health plans to not apply more stringent cost sharing to mental health benefits, when compared to medical-surgical. So that would be an issue I'd like to know about if --

COMMITTEE MEMBER TAYLOR: Okay.

MR. SOUTHARD: -- that we may not be aware.

We did find, like I said, seven health plans that were non-compliant in this area. We required them to go back and re-review claims and reimburse enrollees appropriately. We will continue to assess their compliance through our routine survey process as we move forward. But if you have a specific instance where that's occurred, I'd like to know about that, so we can look at that as well on the urgent side.

COMMITTEE MEMBER TAYLOR: We can talk later, but --

(Laughter.)

COMMITTEE MEMBER TAYLOR: -- I think one of my concerns is a lot of people would, rather than go ahead and pay for the health care, not take it. And that's --

that can be a problem. And I know that that's not supposed to be the case, but it was the case. And maybe it was before the Affordable Care Act. I'm not -- I can't remember, but it prevents people from seeking mental health care, because of that.

MR. SOUTHARD: So I think you're speaking to access specifically.

COMMITTEE MEMBER TAYLOR: Yes. Access, yes.

MR. SOUTHARD: So access, as Shelley was alluding to earlier, we review that on a -- in a couple different ways. Our annual network review process, each health plan is required to submit their entire network's providers to us on a yearly basis. We assess those against the current laws to determine if they're adequate. And Shelley also was speaking about the capacity is only specific to -- for ratios only specific to PCPs. And in the physician world, it's one physician as a group to every 1,200 enrollees.

So we don't have specific capacity ratios for mental health providers. We assess the health plan's annual network data, and we apply it across all health plan data to see if we find them to be an outlier. And we push that health plan to come more into the norm of the other providers without having those specific laws. Many health plans have responded by adding more providers in whatever specialty type it might be.

MS. ROUILLARD: Could I just add something to Dan's comments?

COMMITTEE MEMBER TAYLOR: Sure.

MS. ROUILLARD: Even though a health plan may contract with a behavioral health plan to provide mental health and other behavioral health services, the health plan is still responsible for all the actions and activities of its delegates. So you're still going to hold Blue Shield accountable for whatever its delegated, you know, behavioral health plan is doing.

The other thing I just mentioned again is that if somebody -- you or somebody is having problems getting access to care, that they should call the help center, and we can help facilitate a resolution to that problem. And we do get good results, so...

COMMITTEE MEMBER TAYLOR: All right. Thank you.

CHAIRPERSON FECKNER: Very good.

Thank you. Seeing no other requests. Thank you, all, for a great presentation. Very enlightening. We do have a number of requests from audience on this item. So as soon as you take your seats, we'll bring them up. Thank you again for being here.

So we have a number of requests to speak. The first two I'll call down are Sarah Soroken and Fred Seavey. Please come down to your right, my left. The

microphones will be on for you. You'll have up to three minutes for your comments and please identify yourselves for the record.

MS. SOROKEN: Hi. My name is Sarah Soroken. And I'm a Marriage and Family Therapist working in Kaiser's Napa/Solano region. At Kaiser's -- at Kaiser clinics across the state, we're routinely unable to deliver timely, clinically-appropriate care. Patients in my region typically wait one to two months between individual psychotherapy treatment appointments for depression, anxiety disorders, PTSD, bipolar disorders, and other conditions. These wait times are completely inconsistent with professionally recognized standards of care, which is weekly or biweekly reappointments at the beginning of treatment.

As a result, patients experience prolonged or worsening symptoms, some needing to access emergency or inpatient care. The root problem is the understaffing of Kaiser's mental health services and the inadequacy of Kaiser's external networks of contracted therapists.

In response to understaffing, Kaiser has cut in half the time spent on initial diagnostic assessments. And instead of conducting them in person, Kaiser has begun doing thousands of these shortcut assessments by phone. Therapists must try to diagnose whether a first-time

patient has a major depressive disorder, or PTSD, or bipolar disorder during a 30-minute telephone call with someone they've never met and cannot even see.

This is not an appropriate use of telemedicine and psychiatry, and can lead to misdiagnoses and improper treatment plans. Many clinicians are especially concerned about our adolescent patients, many who wait four to eight weeks before they're actually first seen by a therapist.

This is because Kaiser directs therapists to do a 30-minute telephone call with adolescent's parents within ten business days of the appointment request and counts this call as meeting the State's timely access requirement, even though the adolescents were not -- were often not even talked to.

Given the tripling of the suicide rate among youth across the U.S. reported last month by the CDC, this is risky. We've raised these concerns with Kaiser and the DMHC, but it appears that neither have taken substantive action.

In closing, I'd like to say I support your efforts to investigate the adequacy of Kaiser's mental health services. Patient's well-being and lives are in the balance. I and my colleagues would be happy to assist you however we can.

Thank you.

CHAIRPERSON FECKNER: Thank you.

MR. SEAVEY: Good morning. My name is Fred Seavey. I'm the Research Director at the National Union of Healthcare Workers. Our members include 3,500 psychologists, licensed clinical social workers, marriage and family therapists, addiction medicine counselors, psychiatric RNs, and other therapists who deliver care to Kaiser's members at more than 100 clinic sites, emergency rooms, call centers, and other facilities across the state.

During the past nine years, I've worked with our therapists, patients, patient's family members, the DMHC, advocacy organizations to try to improve Kaiser's health services. You know, we're delighted that the Committee is examining more carefully the behavioral health services provided by Kaiser and other health contractors of CalPERS. And similarly, we're pleased to see Kaiser and the DMHC here.

You know, although Kaiser is well known for providing many top quality medical services, historically, it's understaffed and underresourced its behavioral health services, which lead to outcomes that Sarah described, care that falls beneath professionally recognized standards and often violates State law.

Our experience over these last years -- these

nine years calls on us to caution you against relying on the DMHC, in terms of its capacity to adequately evaluate, and monitor, and enforce laws. This grows out of our experience. You know, there's been references here today, in 2013, the DMHC cited Kaiser for quote serious and quote systemic violations of State law.

Those violations have still not been remedied. And these were very serious violations of depriving thousands of patients of timely access to care, violations of clinical appropriateness standards, quality assurance protocols, the provider network adequacy requirements, et cetera. We're very concerned that the -- this is our state's regulator, our state's largest provider of mental health services. Why haven't these violations been corrected?

Secondly, we have concerns about the DMHC's lack of transparency. The three-year oversight process, we've requested records through the Public Records Act regarding the monitor. They've refused to provide any of those documents during this three-year oversight process.

Thirdly, we're concerned about the lack of accountability of the DMHC to the public. During the past year, we filed 13 additional complaints. Each of these is documented by internal records, including some emails from Kaiser top officials describing and admitting about their

inadequacy of their own care.

The DMHC has failed to even indicate to us whether it's investigating these complaints, whether it's resolved them, what is the disposition of the complaints. So finally, I just want to reinforce, you know, again our support for this effort to probe into the behavioral health services delivered by your health plan contractors, including Kaiser, and secondly caution against relying on the DMHC. We urge you to develop your own rigorous systems of audits, plan monitoring, and enforcement mechanisms of your health plans.

Thank you.

CHAIRPERSON FECKNER: Thank you.

The next two are Ryan Beaston and Larry Woodson.

MR. BEASTON: Good morning. I'm Ryan Beaston with the National Union of Healthcare Workers. I'm the Legislative Coordinator.

I would just like to make a quick point of clarification around the Office of Patient Advocate's scorecard. The methodology is flawed, in that it only considers six performance metrics related to behavioral health care. None of these metrics measure patients' wait times for routine mental health treatment appointments, which are the services received by the vast majority of mental health patients.

The only appointment wait times considered by the OPA are for a very small population of patients, namely those who have been discharged from a psychiatric hospital. Further, the more OPA bases its scores on HMO self-reported administrative records. Whereas, the DMHC performs the in-person investigations, a random sampling of patient charts, an agency initiated data collection.

You have the handout which lists the six criteria and you can see that they don't reflect the ongoing challenges at Kaiser.

Thank you.

CHAIRPERSON FECKNER: Thank you.

MR. WOODSON: Larry Woodson, California State Retirees, Chair of the Health Benefits Committee. Thank you, Mr. Chair, for the opportunity to comment.

On behalf of CSR, I'd like to thank the CalPERS Board and staff that have been -- and particularly Dr. Logan for shining the light on this topic on mental health needs and services, and creating public dialogue. I think it's meaning -- or it will benefit our members and help reduce stigma.

I gave public comments in August regarding -- and drew attention to Kaiser's violations of the Mental Health Parity Act, timeliness of access issues. It's encouraging to hear some of their progress. It's also discouraging to

hear from some of the public commenters of the actual therapists, that it sounds like there is still a real divide. And I hope that both sides can reach agreement in this labor strife, because that is a huge factor and will impact the provision of effective services.

And then lastly, I'd like to -- and we're looking forward to the DMHC report when it comes out in 2020.

Finally, regarding -- Dr. Mordecai acknowledged the impacts and social -- of social and medical conditions on -- that it can -- that it can have on mental health. And to that end, and this may be a little off topic, but it's something that CSR has been very concerned about over the last year and a half, we would encourage Kaiser to begin to provide supplemental and personal services pursuant to the CHRONIC Care Act and regulations that were adopted by CMS -- federal CMS for the Medicare Advantage plans. The most recent information I just got from all three plans that are our carriers, they're really not stepping up.

There will be more on that later. But, you know, modifications to the home are something they could provide that's preventive, you know, handrails. There's limited in-home support services. They're not stepping up on any of those. And we'll be continuing to push. We've had some discussions already with Dr. Moulds and we'll

probably be discussing them in the annual stakeholder review -- meeting.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Okay. Before we move on to the next agenda item, we need to take a ten-minute comfort break for the court reporter and the rest of us. So we will reconvene at 11:30.

(Off record: 11:19 a.m.)

(Thereupon a recess was taken.)

(On record: 11:31 a.m.)

CHAIRPERSON FECKNER: If we could please take our seats, we'd like to reconvene the meeting.

We're now on Item 6b, Outpatient Prescription Drug Reference Pricing.

Mr. Moulds.

You got it.

CHIEF HEALTH DIRECTOR MOULDS: There we go.

Thank you, Mr. Chair. Don Moulds CalPERS team. This item is an update on the reference pricing for prescription drugs program this Committee approved last year. Before we talk about reference pricing, I want to take a minute to do a little stage setting. I don't need to remind any of you that the single Larges threat to our ability to provide high quality health benefits to our

members is cost.

Last year, CalPERS spent $9.2 billion on health care for our members. 2.2 billion of that was on retail pharmaceuticals. That works out to about 24 percent of our health care spend.

For reference, large group purchasers in the U.S. average between 19 and 21 percent of their health care spend on retail drugs. So we're on the higher end, but not a complete outlier. But in contrast, Kaiser commits about ten percent of its health care spend to retail pharmacy. So when we compare our total spend to what they've been able to achieve, we know there's a lot of room for improvement.

In 2018, this Committee approved a reference pricing program for pharmaceuticals. As a refresher, reference pricing expands on our current member pays the difference benefit for brand drags with generic equivalents. Specifically, it applies to therapeutic equivalents within selected drug classes.

Reference pricing is not a silver bullet. It won't do much to address the fastest growing driver of pharmaceutical spending, which is specialty drugs. In general, reference pricing works best in mature therapeutic drug classes, classes where there's a good mix of generic and brand name drugs and lots of price

differentiation.

In the coming months, we're going to talk more about what we can do about some of those other cost drivers. There are a lot of classes of drugs for which reference pricing can be a powerful cost reduction tool and there are examples where reference pricing has produced powerful results. Reference pricing is at the core of several of the best European drug purchasing systems. Closer to home Reta Trust and Safeway embarked on a successful reference pricing program back in 2013. An evaluation of that program identified cost savings at about 14 percent.

When I was at the Commonwealth Fund, we supported research related to reference pricing that included translating the successful German referencing pricing experience for U.S. policymakers and purchasers, as well as research looking at practical implementation considerations.

In our efforts to implement reference pricing, we had a couple of starts and stops. In June of this year, we moved forward with request for proposals for a program that failed to surface the right partner. On August 19th, we put out a second request for proposals, but I had some concerns with that RFP, specifically about the scope of the project, the target population, and the project's

timeline. The RFP would have created a reference pricing program for the 575,000 CalPERS members who received drugs through OptumRx, our pharmaceutical benefit manager, starting in January of 2020. Most of those members are in our PPO plans.

Research and common sense tells us that one of the keys to any successful drug formulary related intervention is successful outreach to the health care professionals who write prescriptions. In the case of reference pricing, successful communication with doctors and other prescribers is critical to transitioning patients away from high-cost drugs to low-cost therapeutic equivalents.

When it works, patients move seamlessly from one to another. When it doesn't, our members first experience a reference pricing program is likely to be at the pharmacy, where their prescription may be much more expensive than it used to be without an explanation as to why.

In order to ensure a smooth transition to reference pricing, we need to be able to know with confidence that we can reach the health care professionals who write prescriptions so they have information about patient costs. We also need to educate members about the program and have protocols in place for pharmacists.

After extensive discussion, both internally and with outside experts, we're proposing to move forward with a phased reference pricing program. In its first phase, we would introduce a reference pricing scheme as part of the Blue Shield Trio health plan. Trio is a narrow network HMO and a new plan offering for CalPERS.

For phase one, CalPERS and Shield have settled on four classes of drugs to reference price, statins, proton pump inhibitors, topical acne medications, and nasal steroids.

In a second phase, Blue Shield and CalPERS would add additional classes of drugs to expand from Blue Shield's Trio plan to include Access+, Blue Shield's larger CalPERS HMO.

In a third phase, CalPERS would transition the population that is now served by OptumRx to full reference pricing.

For phases one and two, Blue Shield would transition members from high cost to reference priced drugs using a carrot and stick approach. The price difference between a 30-day supply of the high-cost drug and the reference drug will accrue to the member at the time he or she makes a switch. This will act as carrot for members who make the switch.

Members who have a medical reason for staying on

a high-priced drug would continue to pay a lower copay. Members who choose to stay on a high-priced drug without a medical reason for doing so would be subject to a copay that would be tied to the full price of the drug.

We will work closely with Shield to ensure comprehensive communications with providers and members and will be supplementing that communication by reaching out to our own members with a coordinated message. There are a number of key reasons for this new phased approach. The first is that reference pricing is novel. It's never been done in the U.S. at the scale that we are considering. A phased approach allows us to integrate reference pricing gradually in a far more controlled environment and progress iteratively.

Second, the OptumRx population will be the most challenging for reference pricing. It's largely, as I mention, a PPO population, which makes it difficult to conduct meaningful outreach to prescribers in the timeline that was originally contemplated by the RFP. This would have likely created the undesirable scenario that I mentioned earlier, where members would be learning that they were subject to reference pricing at the time they try to fill their prescription creating a lot of member disruption.

In Trio, it will be easier to reach out to

prescribers before they prescribe non-reference drug. Shield has established networks and communication challenge -- channels. Shield has also been planning on moving to reference pricing in their own book of business, so they have started to develop their prescriber communication challenges -- channels, sorry, for this specific purpose. Shield has also done advanced work with pharmacies and other drug dispensers to help minimize member disruption.

The Trio population is also likely an easier demographic for our first steps towards full reference pricing. It will likely be a younger and less pharmacologically complex population than most other plan populations, so it makes sense to start there first.

I want to say more about timing, because it came into play as we were looking at the best path forward. We are currently in the middle of our contract with OptumRx. And to move forward with reference pricing with them, we would have had to amend our contract with them and that would have meant paying higher fees.

We face none of those complications or costs with Trio, because Trio is a new plan and Blue Shield wants to integrate reference pricing into their own drug spending strategy. We also position ourselves nicely, so that when our contract with Optum ends, which is about the same time

as we are contemplating the phase three expansion, we can negotiate reference pricing as part of the core contract with the outside pharmacy vendor. This gives us a lot more options going forward.

The path presents a few complications that I'm want to make you aware of. One is that by moving forward with an HMO partner, we will need DMHC approval for the plan. Second, we're also proposing a mid-year change starting phase one with Trio in July of 2020. We met with DMHC together with Blue Shield back in October and we're hopeful that we'll be able to move forward with phase one of our reference pricing proposal in July.

Finally, the challenges I laid out for the PPO environment will continue to exist when we scale from Blue Shield to full reference pricing. But we've started working through a longer term strategy for that day and we're confident that our experience with Blue Shield will better equip us for that transition.

Before we move to questions, I want to thank team members who have been working on this program, the various organizations involved in this effort over the last year, and our partners at Blue Shield.

We're committed to moving the program forward while minimizing member disruption. I believe that the approach I've outlined for reference pricing will best

equip to us serve our members while lowering prescription drug spend. That concludes my presentation and I'm happy to take your questions.

CHAIRPERSON FECKNER: Thank you. Appreciate the presentation.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Yes. Thank you. I appreciate the presentation.

I have a lot of questions. So you're going to phase this in over three phases. Trio being the first, which is -- so Blue Shield is in-house drugs, so they provide their own Rx, correct?

CHIEF HEALTH DIRECTOR MOULDS: Correct. Blue Shield and Kaiser are the two of our plans that do it on their own. All of the other plans, including our PPOs do it through OptumRx.

COMMITTEE MEMBER TAYLOR: So doesn't Blue Shied already require reference pricing?

CHIEF HEALTH DIRECTOR MOULDS: No, it's not doing it at the moment. They have other related formulary -- they have a tiered formulary and some others.

COMMITTEE MEMBER TAYLOR: SO they do the generic.

CHIEF HEALTH DIRECTOR MOULDS: Yes. Yeah.

COMMITTEE MEMBER TAYLOR: Okay. So that -- and so that's the difference. They don't do the reference

pricing.

CHIEF HEALTH DIRECTOR MOULDS: Yeah.

COMMITTEE MEMBER TAYLOR: So what does -- so explain to me what is different between the generic and the formulary?

CHIEF HEALTH DIRECTOR MOULDS: Sure. There are handful of differences. One is that -- one is the way that the tiered formularies typically work is there is a set payment for various tiers. It depends on how the tiers are structured. But a payment for -- a single payment with a matched copay, typically for a generic -- generics can vary in price pretty significantly. So even though they're generally cheaper than brand name drugs, they're not always cheap, and there's often a less expensive alternative therapeutic equivalent.

So this basically creates a reference drug at the lowest price with therapeutic equivalents that would be the default prescription, that -- where you would begin.

COMMITTEE MEMBER TAYLOR: Okay. So it doesn't necessarily have to be -- so, for example, I'm going to use -- I take migraine medicine. It's naratriptan. That's the generic name for it.

CHIEF HEALTH DIRECTOR MOULDS: Um-hmm.

COMMITTEE MEMBER TAYLOR: So you're saying that my doctor -- you'll communicate with my doctor and may say

the formulary equivalent of this is something else, some other triptan, but it's cheaper?

CHIEF HEALTH DIRECTOR MOULDS: Correct. That's the -- and that -- and that really just touched on the key, which is the communication with your doctor at the front end, so you don't end up at the pharmacy wondering why you have a higher copay all of a sudden.

COMMITTEE MEMBER TAYLOR: Okay. Phase 2 will bring in Access+.

CHIEF HEALTH DIRECTOR MOULDS: Correct.

COMMITTEE MEMBER TAYLOR: So more patients -- a little more patients, not a whole lot more. And then phase three is all of OptumRx or just the PPO OptumRx?

CHIEF HEALTH DIRECTOR MOULDS: So it would be -- it would be basic members within OptumRx.

COMMITTEE MEMBER TAYLOR: So that's -- that's all of the rest of the HMOs too?

CHIEF HEALTH DIRECTOR MOULDS: Correct.

COMMITTEE MEMBER TAYLOR: So that's a lot of members.

CHIEF HEALTH DIRECTOR MOULDS: It's a lot of members, yes.

COMMITTEE MEMBER TAYLOR: How are we proposing to communicate with the physicians for that?

CHIEF HEALTH DIRECTOR MOULDS: So that's the --

that's the piece that we've started talking through. I've had informal discussions with some of the physician community about using organized medicine as an outlet to these -- they try to, just like any membership organization, to communicate changes and updates that affect their doctors. So one possibility is working with them. Another is communication strategies directly to large medical groups, another way.

You know, the physician organizations, depending on the organization of course, tend to do a better job of reach -- of outreach to smaller solo practice and small practices. They also have communication channels to the larger -- the larger medical groups, but we can do that directly as well.

COMMITTEE MEMBER TAYLOR: And as you go forward with each of the phases, do you plan on increasing the -- increasing the amount of drugs using -- that you're testing?

CHIEF HEALTH DIRECTOR MOULDS: Yeah. So we're starting with the four. We are -- we have -- in our work with Blue Shield right now, we have a clinical team that is -- that consists of Dr. Logan, our two on-staff pharmacists, and we're working with the pharmacy and have included the -- a physician at Shield to talk through the classes.

As we -- we're not moving forward with classes that we don't feel comfortable with, that -- where there's known therapeutic equivalents. At some point as we get into more classes, we're going to have to engage somebody in all likelihood outside of CalPERS, and Shield certainly when we go beyond Shield, but to -- this is emerging work. There are national organizations that look at this question of equivalents that we would need to engage.

But, you know, among other things, for example, as new drugs come onto the market, there are open questions about whether they are, what are sometimes referred to as, me-too drugs, so high-priced drugs that have a cheaper equivalent or whether there are genuine improvements on the class. Those are the kinds of questions that we will need to be working with people outside of the group -- the group now to settle. But for now, we are working in four very known groups and we'll be adding as we identify possibilities.

COMMITTEE MEMBER TAYLOR: Who's your data provider?

CHIEF HEALTH DIRECTOR MOULDS: Data for -- so we use our own data.

COMMITTEE MEMBER TAYLOR: You're using your own data, so you're not using a data provider.

CHIEF HEALTH DIRECTOR MOULDS: And Shield. So

our data provider -- the -- our data warehouse is -- is managed by Milliman, but we have data -- internal data resources.

COMMITTEE MEMBER TAYLOR: Right, but there were other -- so originally we went -- we've gone this long trying to do this reference pricing, because there was a couple of different companies that wanted to have that contract.

CHIEF HEALTH DIRECTOR MOULDS: Yep.

COMMITTEE MEMBER TAYLOR: Those companies have data already, because they have big contracts on reference pricing on how that works for them. So have you reached -- have you reached out to those companies?

CHIEF HEALTH DIRECTOR MOULDS: We've had -- we've had conversations with various groups that have -- I mean, we've had -- we've had conversations before I got here certainly with some of those groups. As we progress outside of those -- the four classes of drugs that we're proposing to move forward with in Trio, we would presumably having additional conversations. And at that point, we'll need to talk about whether we have the capacity -- the extent of our capacity there.

COMMITTEE MEMBER TAYLOR: So as -- and as I understand it, one of the data gathering groups also was working hand-in-hand with OptumRx and already had a

relationship with them. They may not have had relationships with the providers. So what -- what is our strategy moving away from doing that and doing this ourself and bringing down the amount of drugs we were going to do?

CHIEF HEALTH DIRECTOR MOULDS: The strategy -- the strategy -- my strategy was to start small, learn, and then -- and not jump in the deep-end first. So we are -- the PPO population is exponentially harder to do this work in. It is -- the communication with independent physicians is very different than in-network physicians. Shield, as I mentioned, had been moving forward in this space. I wanted to start slow, watch, and do this slowly and thoughtfully. So that was -- that was the thought about not doing this in the OptumRx space.

COMMITTEE MEMBER TAYLOR: Right, even though they've done it before.

CHIEF HEALTH DIRECTOR MOULDS: OptumR --

COMMITTEE MEMBER TAYLOR: With a different provider or a different -- a data provider is what it is. It's -- that's who we were understanding that they had worked -- already worked with, I believe, with United Food and Commercial Workers.

CHIEF HEALTH DIRECTOR MOULDS: Yeah, there have been some other -- there have been some other examples of

reference pricing. As I said, certainly none on this scale. You know, I spent a chunk of time on the phone with the Reta Trust folks talking through that. And their experience was largely very positive with reference pricing, but they also cautioned that, you know, it was a different kind of benefit, different members, and we're suggest -- had suggested that moving slowly was a wise approach.

COMMITTEE MEMBER TAYLOR: Okay. And then when we were originally considering working with some of these other providers, contractors, and OptumRx, we were told that our contract with OptumRx actually included this, that it wasn't outside the contract.

CHIEF HEALTH DIRECTOR MOULDS: Yeah, that's -- that certainly wasn't the way that Optum had -- as we started conversations with Optum, that wasn't how they looked at it. And when we looked at our contract, we thought pretty clearly that there was going to be a need for a contract amendment. So this would have -- they are not -- they are not structured with their contract with us specifically to do reference pricing. They do something closer to the tiered approach and so they would have had to re -- make adjustments to their formulary. It would have meant reaching out to existing members. And that would have -- that would have required a number of

changes, which they -- they conveyed to us would -- would cost money.

COMMITTEE MEMBER TAYLOR: Be outside the contract?

CHIEF HEALTH DIRECTOR MOULDS: Yeah.

COMMITTEE MEMBER TAYLOR: Okay. All right. Thank you very much.

CHIEF HEALTH DIRECTOR MOULDS: Sure.

CHAIRPERSON FECKNER: Thank you.

Mr. Rubalcava.

VICE CHAIRPERSON RUBALCAVA: Thank you, Mr. Chair. Thank you very much for the presentation. And I think I appreciate you being part -- leading team, because you were able to recognize the complexities of implementation. And so I applaud your initiative for -- I mean, we had entered on a path. You said there was two RFPs. And I also share Ms. Taylor's concerns. But from some of the discussions we had, I understand you have entered into a discussion to make sure that all the RFP respondents understand the reason for this new approach, which I think is -- is a better path to success, because we're starting, you say small, but I think it makes sense to start with a population, the young invincible, so to speak, that are probably more suitable to this. And you have identified the whole thing about the

patient-physician disruption that we have to be very sensitive to.

So I thank you for moving us in a direction that will hopefully lead to more success and the cost savings that our members deserves. So I thank you for that.

CHIEF HEALTH DIRECTOR MOULDS: Thanks.

CHAIRPERSON FECKNER: Thank you.

Ms. Brown.

COMMITTEE MEMBER BROWN: Yes. Thank you, Mr. Chair. Mr. Moulds, I want to thank you for your presentation. Based on what I heard from you today, I can honestly self-identify as PC, which is pharmacology complex, as opposed to politically correct. I'm never PC, but I appreciate that now I am today.

I do appreciate your phased-in approach. I think this is a good idea. I have a concern, because Trio is brand new for a lot of our members. Starting in January they're going to be brand new. There is going to be some learning, some transitions for those patients -- or for our members. How many have signed up for Trio? Do we know what the number are?

CHIEF HEALTH DIRECTOR MOULDS: So we -- we are still counting in open enrollment. It's slated to be a small plan. I can't give you exact figures right now, because we don't have them.

COMMITTEE MEMBER BROWN: Yeah, but thousands. It's thousands, correct?

CHIEF HEALTH DIRECTOR MOULDS: Correct.

COMMITTEE MEMBER BROWN: Okay. Hundreds of thousands?

CHIEF HEALTH DIRECTOR MOULDS: Yeah, and they're in three counties.

No. No.

COMMITTEE MEMBER BROWN: Okay.

CHIEF HEALTH DIRECTOR MOULDS: Their projections are significantly smaller.

COMMITTEE MEMBER BROWN: And have we already done the analysis of about how many prescriptions per year are written to those -- that Trio population?

CHIEF HEALTH DIRECTOR MOULDS: We can't do that analysis in total --

COMMITTEE MEMBER BROWN: Until you --

CHIEF HEALTH DIRECTOR MOULDS: -- until we actually have a hard number, but we have an -- we have an idea. It will likely be in the hundreds or small thousands in each of the classes, so not a huge number of people.

COMMITTEE MEMBER BROWN: And how does that compare to our reference pricing we've done up till now?

CHIEF HEALTH DIRECTOR MOULDS: So we haven't --

we haven't done reference pricing yet. The -- we've done things that are similar. So the tiered -- tiered formulary, member pays the difference, similar --

COMMITTEE MEMBER BROWN: Okay.

CHIEF HEALTH DIRECTOR MOULDS: -- but this would be novel for CalPERS. We have done it -- I should mention I think you all know this, but we've done reference pricing on the medical and surgical side --

COMMITTEE MEMBER BROWN: Right.

CHIEF HEALTH DIRECTOR MOULDS: -- at CalPERS, starting with hips and knees. And that is one of the huge successes for CalPERS. It's known nationally and internationally as a very innovative intervention that both, you know, improved quality and lowered cost.

COMMITTEE MEMBER BROWN: I taught I remembered your predecessor talking about corticosteroids and reference pricing.

CHIEF HEALTH DIRECTOR MOULDS: Yeah.

COMMITTEE MEMBER BROWN: So I'm not sure if we had or had not done it, but it sounded like we had.

CHIEF HEALTH DIRECTOR MOULDS: Yeah.

COMMITTEE MEMBER BROWN: I'm interested. I like the idea of a carrot and stick for patients. And so what you said is the carrot is they get to pay just their standard copay and the stick would be they get to pay you

said a higher copay, so basically the retail price of that drug?

CHIEF HEALTH DIRECTOR MOULDS: So Shield is proposing -- Shield is proposing a carrot that would be -- would be essentially a refund or a rebate of the difference between the cost -- the full cost of the name brand drug, or the expensive drug, and the cost of the reference drug that would come in the form of a gift card or some similar compensation.

So it would be a reward essentially for making the initial transition. The second one obviously is the -- is that you would be in the lowest copay cohort going forward.

COMMITTEE MEMBER BROWN: Oh, so it would get --

CHIEF HEALTH DIRECTOR MOULDS: There was a second part to your question, I'm sorry.

COMMITTEE MEMBER BROWN: Okay. No, so that's good to understand. And so what if I'm a patient that just says no I don't want the therapeutic equivalent.

CHIEF HEALTH DIRECTOR MOULDS: That was the -- that was the second part of your question.

COMMITTEE MEMBER BROWN: I'm going to appeal.

CHIEF HEALTH DIRECTOR MOULDS: Yeah.

COMMITTEE MEMBER BROWN: So how long -- I'm standing -- assuming my doctor didn't tell me or he did

tell me, but I didn't listen when I got my prescription, I'm standing at the counter trying to get my prescription filled and they're saying it's going to be $87 or something.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. So we're trying to get to a place where that doesn't happen. And the key to that again is having the communication with the prescriber at the front end. If your physician or other prescriber has a medical reason for prescribing something that is not the reference drug, there is an avenue for doing that.

They can -- so I'll give you a good example. There are people, a small percentage of the population, who are intolerant, have adverse reaction to particular kinds of statins. Some of those can be expensive name drugs -- name-brand drugs, some of those can be inexpensive or less expensive generics, but that -- that happens. There is a process in place as part of this. And this is one of the things that we're -- that we've got to -- that's in place generally, but we're revisiting as part of the reference pricing strategy for a physician to document that intolerance and to prescribe for the drug where there's a tolerance. And in that instance, the member would pay the lower copay, rather than the cost of the drug.

Now, in the instance where someone wants to be on a -- on a name-brand expensive drug where there's no -- there's no medical reason for doing that, they're subjected to the difference in cost between the two drugs, right now, in an HMO with a cap of $250, which is a DMHC regulation.

COMMITTEE MEMBER BROWN: Great. So I didn't get an answer on sort of the timeline for the appeal. Let's assume I'm at the counter trying to buy my drug and they're trying to give me an alternative. I don't want it. About how long do we think that appeal is going to take?

CHIEF HEALTH DIRECTOR MOULDS: So there's standards I can -- Julie, do you have -- 72 hours is the standard.

COMMITTEE MEMBER BROWN: Okay. Great.

CHIEF HEALTH DIRECTOR MOULDS: We -- again, we're trying to get into a -- we're trying to create a scenario where it doesn't come to that. We can -- we have certainly talked about whether we can improve upon that number in our early discussions about the appeal process, which is the topic that we have been talking about with our partners at Shield over the last couple of weeks.

COMMITTEE MEMBER BROWN: I think 72 hours for the first time I get something rejected is fine. And if we

can stick with that or make it better, I think that's fine too.

So we talk about carrot and stick for patients. Is there going to be a carrot and stick for doctors?

CHIEF HEALTH DIRECTOR MOULDS: So --

COMMITTEE MEMBER BROWN: Or just a stick. How about just stick.

CHIEF HEALTH DIRECTOR MOULDS: I'll take that as a point --

(Laughter.)

CHIEF HEALTH DIRECTOR MOULDS: -- and well received. I don't know. I would have to -- I'm thinking out loud about whether -- I think, you know, you run into lots of difficulties when you try to -- I'm not going to use the word force, but force doctors to prescribe certain things. Certainly, there have been lots of issues, both -- you know, for all sorts of different reasons that place. Pretty heavy restrictions.

COMMITTEE MEMBER BROWN: Okay.

CHIEF HEALTH DIRECTOR MOULDS: So I think that would be a hard thing to do.

COMMITTEE MEMBER BROWN: All right. Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Jones.

COMMITTEE MEMBER JONES: Thank you, Mr. Chair.

Yeah. Thank you Mr. Moulds. I appreciate your vision of implementing a new program by stating to start small and slow and phase in, because it's -- I think its's important that we -- any new program, we need to have some kind of evaluation mechanism built in. And I often say this, every time a new program is presented, I -- where is the evaluation component?

CHIEF HEALTH DIRECTOR MOULDS: Yeah.

COMMITTEE MEMBER JONES: So I would assume that you're going to have reporting capabilities to evaluate the effectiveness of this program at some point in the future?

CHIEF HEALTH DIRECTOR MOULDS: So as someone who used to run a federal evaluation office, I really appreciate that question.

(Laughter.)

CHIEF HEALTH DIRECTOR MOULDS: We brought David Cowling who heads our evalu -- or Innovation and Evaluation Office in on this very early on, because I had exactly the same concern. I wanted to make sure that we were -- that we were measuring and learning as we go forward.

We also -- we also went, during the Educational Forum in Oakland, we had a little side-bar with Jamie Robinson, who's a health economist at UC Berkeley to talk

through evaluation of this, too.

There -- you know, in the early stages, most of the learning is going to be less like a classic evaluation and more about troubleshooting and making sure that we have the mechanisms in place, so that people are getting the notices, that we're able to get our communication with the physician and other providers community down. But we're doing -- there will be an evaluation component with this for sure. And as I said, we're bringing in the team -- that team in all of these steps, so they can be there right along.

One of the things that I've found is that, you know, a lot of the time you bring in an evaluator after the fact. And it's really hard, because it wasn't designed for an evaluation. It wasn't designed as a learning initiative. And the goal here is to design it exactly like that as a learning initiative.

COMMITTEE MEMBER JONES: Thank you. I appreciate that. And what about the member satisfaction component?

CHIEF HEALTH DIRECTOR MOULDS: So great question and I think implicit suggestion. And we certainly plan to reach out to members and to gauge their satisfaction levels. And that's going to be one really powerful tool as part of the evaluation is going directly to members and asking about their experience.

COMMITTEE MEMBER JONES: And lastly, you made reference to our successful hip and knee replacement.

CHIEF HEALTH DIRECTOR MOULDS: And not just hips and knees, but hips and knees plus.

COMMITTEE MEMBER JONES: So what lessons did we learn from that successful program that we'd be able to carry forward to this program?

CHIEF HEALTH DIRECTOR MOULDS: I wasn't here, so I didn't learn those lessons. I've read about those lessons and I've talked to people after the fact about those lessons. One of them is, you know, in the case of hips and knees, I think there are a lot of folks who have looked at that, particularly after the fact and said that, you know, CalPERS was really, because of its size, able to move the market in some pretty significant ways. So if you were one of those high-cost hip and knee replacement providers, who didn't have very good quality marks, you knew, because of this initiative and because of the buying power of CalPERS that you needed to change your tune. And a lot of that happened. So it's -- you know, it's really powerful.

COMMITTEE MEMBER JONES: Okay. Thank you.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests, anything else on this item, Mr. Moulds?

CHIEF HEALTH DIRECTOR MOULDS: No.

CHAIRPERSON FECKNER: All right. Very good.

Brings us to Item 6c, Summary of Committee Direction.

Do you have anything in front of you?

CHIEF HEALTH DIRECTOR MOULDS: Also, my first time, I'll -- you can tell me what I missed, but I just have one which is report back on the number of CalPERS members that were affected by the DMHC settlement and any dollars involved. That was from Mr. Ruffino.

CHAIRPERSON FECKNER: All right. And I do have one other. A Board member asked a question earlier off record. Could we get Kaiser to respond to the comments what were made today by the folks in public comment.

CHIEF HEALTH DIRECTOR MOULDS: Yeah.

CHAIRPERSON FECKNER: I didn't want to call on them and put anybody on the spot, but do the research.

CHIEF HEALTH DIRECTOR MOULDS: Absolutely. Yeah.

CHAIRPERSON FECKNER: Thank you.

All right. That brings us to --

CHIEF HEALTH DIRECTOR MOULDS: I think Ms. Greene-Ross had one other that I might have missed.

ACTING COMMITTEE MEMBER GREENE-ROSS: Actually that was my question.

CHIEF HEALTH DIRECTOR MOULDS: Oh, great.

Excellent.

CHAIRPERSON FECKNER: Very good. Public comment. I, Item 6d. I have one request from the public to speak. Let's see where did that list go. Ernest Goldsmith.

I don't have Tim on here. Oh, there he is. You're right. You're here, sir.

(Laughter.)

CHAIRPERSON FECKNER: You have up to three minutes for your comments, please. And please identify yourself for the record.

CHAIRPERSON FECKNER: Right here, Mr. Goldsmith

MR. BEHRENS: Thank you, Chairman Feckner.

Am I on?

CHAIRPERSON FECKNER: Start his clock over, please.

Mr. Goldsmith, that's your seat there.

Go ahead, Mr. Behrens.

MR. BEHRENS: Thank you, Chairman Feckner, members of the Committee. Tim Behrens, President of the California State Retirees. I really appreciate the Kaiser presentation on mental health. I would like to offer our monthly publication as a way of moving that process on to our 40,000 members, complete with phone numbers, and website, and email addresses, et cetera.

Many of our members were in safety and went out

at an early age, 50, 55. I talked to the two compliance folks that were here and they would be willing to also put their numbers in there and talk about what they do. So I'd like to make that offer to the CalPERS Board and Health team.

I also want to talk about a member, an 84-year old member of mine who got his dependent eligibility papers in the mail and didn't know what they were and threw them away. He didn't have any computer skills. I don't even know if he had a cell phone. He must not have read our paper, because we put things in paper many times about the importance.

Long story short, Larry Woodson, the chairperson of our health committee contacted Vanessa Albritton, the Acting Division Chief for CalPERS, and within 24 hours that problem was solved. So I think that's the kind of service that needs to be talked about publicly. We always slam CalPERS for not doing something right. Well, I'm going to give them kudos for doing something right in a really timely basis and I appreciate your help.

Finally, to my left here, Donna tells me that she's going to retire next month. So I just wanted to thank her for her working together with the California State Retirees and staff in the past, solving a lot of our health benefits problems. And I'll be bringing her an

application to join the California State Retirees next month.

(Laughter.)

MR. BEHRENS: Thank you, Donna.

(Applause.)

CHAIRPERSON FECKNER: She will be here at our next meeting, but I suggest you bring that and have her sign it while she's sitting here.

(Laughter.)

CHAIRPERSON FECKNER: Mr. Goldsmith.

MR. GOLDSMITH: I'm here regarding the long-term care insurance plan. My name is Ernest Goldsmith. I'm a member of CalPERS by virtue of my State service, 20 years as a judge of the Superior Court of California, and long before that a research assistant at UC Berkeley and an employee of Caltrans, total 25 years.

My wife and I are among the many hundreds of long-term care insurers who joined long-term care when the inflation protection lifetime plan was aggressively marketed to State employees. This group left the inflation protection plan when the premiums were increased by 85 percent. As you know, this increase resulted in a class action breach of contract case.

We could not afford that 85 percent increase and opted for a less expensive long-term care plan, which

brings me here. We were recently presented with a Benefit Increase Option, a BIO, which would increase our coverage 16 percent for a premium increase of 92 percent and 95 percent for my wife and self. That spells out to over ten percent of me retirement income, my State retirement income, and is unaffordable by us and many others who are so affected.

First, long-term care's answer to this to me is it is justified by actuarial tables based on our ages. We're 83 and 84. We could not get coverage any place else. In connection -- well, I should say that we have paid into this plan since 1997. And without the premiums from us, and those like us, long-term care would not be in business today I speculate.

Long-Term Care gave me an explanation for this increase from the Health Director. Quote, "Several factors affected long-term care insurance programs, which included low underwriting standards, increased claims experience, the rise in the cost of long-term care services, low policy lapse rates, and investment losses incurred during the economic turndown of 2008", end quote.

I submit to you that if CalPERS made inaccurate pricing decisions plus losing investments, such as derivatives, involved in the 2008 financial crash, we should not have to make up for those miscalculations.

Insurance is to spread risk among lower and higher risk people. I suggest to you that if long-term care was regulated by the California Department of Insurance, the 16 percent increase in benefits for a 95 percent premium increase would not have been allowed.

I respectfully ask that you not simply accept the product of an actuarial table designed to make up for past pricing problems, but ask you to make a tough decision, in this case, to rollback these impossible draconian rate increases for this -- for this group who were forced off the inflation protection plan some years ago and do not penalize us by the two-time cutoff for future BIOs.

Please consider also that prospective long-term care insureds who will know that they may pay -- may pay in for many years and then eventually be faced with unaffordable rates when they are old. I don't know how those people would be interested in buying into long-term care.

So may I answer any questions you may have?

CHAIRPERSON FECKNER: I don't believe we have any at this time, but thank you for your comments.

MR. GOLDSMITH: All right.

CHAIRPERSON FECKNER: Thank you.

Okay. Seeing no other requests and nothing else before us, then this Committee is adjourned.

(Thereupon California Public Employees' Retirement System, Pension and Health Benefits Committee meeting adjourned at 12:11 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 24th day of November, 2019.

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