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, DECEMBER 17, 2019

9:01 A.M.

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

COMMITTEE MEMBERS:

Ms. Rob Feckner, Chairperson

Mr. Ramon Rubalcava, Vice Chairperson

Mr. Henry Jones

Mr. David Miller

Ms. Eraina Ortega

Ms. Mona Pasquil Rogers

Ms. Theresa Taylor

Ms. Betty Yee, represented by Ms. Karen Greene-Ross

BOARD MEMBERS:

Ms. Fiona Ma, represented by Mr. Frank Ruffino

Ms. Lisa Middleton

Ms. Stacie Olivares

Mr. Jason Perez

STAFF:

Ms. Marcie Frost, Chief Executive Officer

Mr. Matt Jacobs, General Counsel

Ms. Donna Lum, Deputy Executive Officer

Dr. Donald Moulds, Chief Health Director

Ms. Jennifer Jimenez, Committee Secretary

Dr. Julia Logan, Chief Medical Officer

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

ALSO PRESENT:

Dr. Robert Friedman, Anthem Blue Cross

Dr. Dennis Hsieh, UnitedHealthcare

Mr. Rob Honaker, Anthem Blue Cross

Dr. Tosha Larios, Magellan

Dr. Jeffrey Meyerhoff, UnitedHealthcare

Dr. Michael Millman, Blue Shield of California

Mr. Dan Prettyman, Blue Shield of California

I N D E X

P R O C E E D I N G S

CHAIRPERSON FECKNER: Good morning. 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: Here.

COMMITTEE SECRETARY JIMENEZ: Margaret Brown?

CHAIRPERSON FECKNER: Excused.

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. Please also show Ms. Taylor, Ms. Olivares, Mr. Ruffino, Ms. Middleton, and Mr. Perez joining the Committee today.

I'm sorry. I thought you said you weren't earlier. I missed that.

Next order of business, Item 2, is the approved -- approval of the timed agenda. What's the pleasure of the Committee?

COMMITTEE MEMBER MILLER: So moved.

CHAIRPERSON FECKNER: Moved by Miller.

Seconded?

COMMITTEE MEMBER TAYLOR: Second.

CHAIRPERSON FECKNER: Second by Taylor.

Any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Before we move on to Item 3, I'm going to take a moment to honor the service of Donna Lum. Donna is our Deputy Executive Officer over our Customer Services and our Support Teams. Donna will be retiring next week after 21 years here at CalPERS, and another 15 with the State of

California. Throughout her career, she put her passion for mission here into action as she led her teams to improve customer service. Donna joined us early in 1999, about three months after me, so she's about the only one left here that was here when I started. And she certainly was here to help us begin preparation for Y2K, if any of you remember those days.

She had a strong vision for how technology could enhance our services and was deeply involved in the creation of the myCalPERS system. In 2012, Donna joined the executive team and I've seen many customer service enhancements throughout her leadership. Here are just a few. Our Customer Contact Center receives over one million calls each year with a 94 percent satisfaction rate. Our Employer Response Team handles near 1,000 critical time-sensitive issues each year, usually within one day, consistently exceeding a 90 percent satisfaction rating. Donna created the Employer Leadership Dialogues, which are held throughout the state, to listen to employer needs and facilitate their communication.

And finally, there's be an increase in compliance with payroll reporting with 99 percent of employers submitting reports on time. Donna, we're all very grateful for your dedication to our CalPERS team, to the members of this System, and to this Board.

So on behalf of us, enjoy your retirement. You and Alan have a great time. And we certainly will always remember the work you've done here. Thank you very much.

(Applause.)

(Standing applause.)

CHAIRPERSON FECKNER: With that we'll move to Agenda Item 3, is the Executive Report, Mr. Moulds, Ms. Lum. Who's first?

DEPUTY EXECUTIVE OFFICER LUM: Good morning, Mr. Chair. Donna Lum, CalPERS team member.

First of all, I'd also like to take a moment of personal privilege and thank you Mr. Chair for the kind words that you shared. It seems like it's not been so long ago where I was the liaison to the Benefit Program and Administration Committee, also known as BPAC. And certainly have known you and Mr. Jones the longest with regards to the work that I've done on the Board.

But it's been my pleasure to have worked with this Committee specifically on the many legislative and regulatory implementations that we've gone through over the many years that I've been involved with the Committee. In addition to that, we've worked on a lot of strategic and policy issues, many that have really shaped the way that we deliver our services, our customer services to our members and our employers. And for that, I do want to

thank all of you for the support that you've given, not only to the customer service teams, but to all CalPERS team members.

It's really been an honor and a pleasure to have worked with you all and to be able to end my public service career here at CalPERS. It's been, as I've said several times in several celebrations that I've had over the last couple weeks, the most rewarding part of my career being here at CalPERS and fulfilling and serving on the mission that is extremely important for our members, our beneficiaries, and our survivors.

So thank you all.

CHAIRPERSON FECKNER: Thank you.

With that, I do have one item to report out to close this fis -- this calendar year. And that is we are preparing for the 2020 CalPERS Benefit Education Events. Our first event is going to be held at Rohnert Park on January 10th and 11th. And this is expected to be a fairly large event. The ast time we were in Rohnert Park it was 2016 and we had nearly 1,110 attendees. Yesterday, we sent out emails to nearly 45,000 members in the surrounding counties, including Contra Costa, Marin, Mendocino, Napa, and Sonoma encouraging members who are either nearing retirement or mid-career to come and join us at this CBEE.

At the CBEEs, we do surveys and we take a lot of member input on what we can do to improve the delivery of the presentations and the education that we provide. And one of the things that we received feedback on that we are implementing for the 2020 CBEEs is, what we call, a new QR code capability. And so members that are attending the CBEE will have the option to easily scan a QR code, and the materials that are available on the website will be easily available to them on their mobile devices. And so that does help to reduce the paper plan that we -- initiative that we have, but it also gives direct access to the attendees to the material.

In addition to that, we have developed, what we're calling, learning guides for the CBEEs. And these are very concise references that will again help our attendees to retain the information that they're receiving.

And then lastly, the additional input that we received from members is that we do have a CBEE checklist available on the website. And that's to help attendees plan well in advance, which of the presentations they want to attend. And that also helps us to plan for capacity needs for the locations that we are hosting at.

The Rohnert Park CBEE will then be followed by San Luis Obispo on 7 -- February 7th and 8th. And the

full calendar of the 2020 CBEEs is located on the CalPERS website.

Mr. Chair, that concludes my remarks and I'm happy to answer any questions you may have.

CHAIRPERSON FECKNER: Thank you very much.

None for your lucky day.

DEPUTY EXECUTIVE OFFICER LUM: Thank you.

CHAIRPERSON FECKNER: Mr. Moulds.

CHIEF HEALTH DIRECTOR MOULDS: Good morning, Mr. Chair, members of the Committee. Don Moulds, CalPERS team. First, I have three items for my remarks today.

First, I want to share with the Committee that our Annual Health Plan Member Survey will be kicking off January 7th. The survey assesses member's experience with their health plans during the 2019 health plan year. The results will help us measure member satisfaction with their health plan, specific outcomes and trends, as well as quality and access to health care, including in rural areas. This year, we also added six new validated mental health questions to help us improve the quality of mental health services for our members. The survey will run through March 3rd.

Second, I want to let the Committee know that last week we sent a letter to Cottage Health after learning that they were at an impasse in their contract

extension negotiations with Anthem. Cottage runs three hospitals in Santa Barbara. If Cottage and Anthem are unable to reach an agreement by the end of the year, members living in the area who have our PPO plans or Anthem traditional HMO will no longer have in-network access to the three Santa Barbara hospitals. The next closest hospital is roughly 40 miles away.

The situation not only affects our existing members, but we are bringing two new public agencies in Santa Barbara on board effective January 1st, the City of Santa Barbara and the Santa Barbara Housing Authority. So this would impact them as well.

We're closely monitoring the situation. I've personally spoken to both Anthem and Cottage multiple times over the last few days. And while this is a negotiation between two private parties, we're pressing both sides to resolve the dispute.

Anthem has sent letters to potentially impacted members. And we've communicated internally with the call center and stakeholders in the area. We'll keep everyone apprised as we know more.

And lastly, our agenda today continues our important discussion of how to improve mental health care for our members. As you'll recall, last month, we had a discussion with Kaiser. Today, Dr. Logan will facilitate

the discussion with our three other large health plans, Anthem, Blue Shield of California, and UnitedHealthcare.

Kaiser's answers to questions that arose at the last meeting are in your packet. I also want to let folks in the audience know that they're available in the back of the room over there.

That concludes my opening remarks. I'm available for any questions.

CHAIRPERSON FECKNER: Thank you.

Seeing none -- oh, we have one. Here, we go.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Sorry about that. Mr. Chair, thank you.

The Cottage Health issue, I'm just trying to -- we have members in the area, so how -- if they don't come -- if they're at an impasse and they don't come to an agreement -- we're urging them to come to an agreement.

CHIEF HEALTH DIRECTOR MOULDS: Correct. We've sent a letter to Cottage. We've been on the phone to Cottage multiple times and with Anthem multiple times, and are pressing them to come to an agreement.

COMMITTEE MEMBER TAYLOR: I don't know that we can discuss this or not, but do we know what the sticking points are?

CHIEF HEALTH DIRECTOR MOULDS: I don't want to go

into -- into a lot of detail here, because it's a -- it's a private negotiation. Considerations of cost are always -- are always front and center in these -- in these issues. We want to make sure obviously that everyone is focused on the potential harm to our members in the area as well.

COMMITTEE MEMBER TAYLOR: All right. Well, thank you. Maybe we can talk offline about this.

CHAIRPERSON FECKNER: Great. Thank you.

Seeing no other -- pardon?

Push your button.

Ms. Greene-Ross.

ACTING COMMITTEE MEMBER GREENE-ROSS: Just how -- with respect to our contract with the plan, how would that disruption affect the terms of our contract? Are they bound by our contract with them to provide service that's more accessible for the members in that area.

CHIEF HEALTH DIRECTOR MOULDS: Yeah, that's one of the ones that I'll probably not get into too much detail, just because of the private nature of it. But it -- the short answer is it differs depending on whether we're talking about members in our PPO where Anthem is a third-party administrator to benefits that we purchase versus the HMO, where they're an insured entity. So there's a little bit of a difference in the two cases.

ACTING COMMITTEE MEMBER GREENE-ROSS: Great. It would be great to just have an update once we --

CHIEF HEALTH DIRECTOR MOULDS: Yep.

ACTING COMMITTEE MEMBER GREENE-ROSS: -- we know anything more.

Thank you.

CHAIRPERSON FECKNER: Thank you. See no other requests.

That brings us Item 4, action consent, the approval of the November 19th meeting minutes.

What's the pleasure of the Committee?

VICE CHAIRPERSON RUBALCAVA: Move approval.

COMMITTEE MEMBER TAYLOR: Second.

CHAIRPERSON FECKNER: Moved by Rubalcava, seconded by Taylor.

Any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no? Motion carries.

Item 5, information consent items. There's been a request to take 5c off of consent, so we can get an update on that. So with that, we will move onto 5c, Mr. Moulds.

CHIEF HEALTH DIRECTOR MOULDS: I have Marta Green from our team.

CHAIRPERSON FECKNER: FECKNER: There you.

HEALTH POLICY RESEARCH ADMINISTRATION CHIEF GREEN: Thank you. Good morning, Mr. Chair, Committee members. Marta Green, CalPERS team member.

I'm happy to address any questions you may have about this report.

CHAIRPERSON FECKNER: Thank you.

Mr. Rubalcava.

VICE CHAIRPERSON RUBALCAVA: Yes. First, thank you. I think this is a very innovative program, where we try to provide incentive for members to select a personal doctor and participate in preventive care. I think it was a very concise report and I thank you for that.

But I was a little concerned that under the Future Moms Programs only -- only about 11 percent have actually enrolled. And I was wondering what outreach efforts -- I know Anthem is trying to reach out to the health benefit officers. But what other -- what can be done to -- I mean, this is a beautiful program and I wish more expectant mothers would take advantage. I was wondering what efforts we can do to help or what resources are available --

HEALTH POLICY RESEARCH ADMINISTRATION CHIEF

GREEN: Great.

VICE CHAIRPERSON RUBALCAVA: -- to promote this program, which is very Beneficial.

HEALTH POLICY RESEARCH ADMINISTRATION CHIEF GREEN: Great question thank you for it.

So in addition to reaching out to the heath benefit officers, Anthem's clinical team is also reaching out to the providers that are known to be providing services to expectant women to try to get to them earlier in their pregnancy to encourage them to participate in the program.

One of the challenges Anthem faces is that it may -- there may be a lag in time before Anthem, through the claims data that they receive, know that a woman is expecting because they need to see claims specific --

VICE CHAIRPERSON RUBALCAVA: Right.

HEALTH POLICY RESEARCH ADMINISTRATION CHIEF GREEN: -- to the fact that she's expecting.

And so by getting the providers that are providing these services to the women in advance of them presenting as pregnant, they can encourage them earlier in the pregnancy and hopefully increase uptake. So between the health benefit officers, which usually know earlier in a pregnancy and they can courage the women to uptake in the program, as well as the providers, as soon as a woman

whom presents who is pregnant that she can then join the program.

So those are the two strategies that they're implementing. But we did, like you, notice that the uptake was much lower than the other health related --

VICE CHAIRPERSON RUBALCAVA: Yeah, I noticed that.

HEALTH POLICY RESEARCH ADMINISTRATION CHIEF GREEN: -- in the program.

VICE CHAIRPERSON RUBALCAVA: There's also an app. Does the app also work for this program?

HEALTH POLICY RESEARCH ADMINISTRATION CHIEF GREEN: I actually don't know the answer to that question, but I'm happy to research it and get back to you.

VICE CHAIRPERSON RUBALCAVA: Because I wonder if that could be a way to reach out to them? I know -- so anyway.

HEALTH POLICY RESEARCH ADMINISTRATION CHIEF GREEN: It's an excellent question and I will find out get back to you.

VICE CHAIRPERSON RUBALCAVA: Thank you. I think I really appreciate the report and look forward to next quarter's report.

Thank you.

HEALTH POLICY RESEARCH ADMINISTRATION CHIEF

GREEN: Thank you.

CHAIRPERSON FECKNER: Very good. Thank you very much. No other questions. Appreciate it.

Okay. That takes us to Item 6, information item. Mr. Moulds.

CHIEF HEALTH DIRECTOR MOULDS: I'm going to turn this one over to Dr. Logan.

(Thereupon an overhead presentation was presented as follows.)

CHAIRPERSON FECKNER: Very good. Good morning, Dr. Logan.

Other side.

The other side.

There you go.

CHIEF MEDICAL OFFICER LOGAN: Good morning. How does that sound?

CHAIRPERSON FECKNER: Good morning.

CHIEF MEDICAL OFFICER LOGAN: Okay. Thank you, Mr. Chair. And good morning again. My name is Julia Logan, CalPERS team member. If I may, I would like to take a moment of personal privilege to honor an important person in my life who was taken too soon.

CHAIRPERSON FECKNER: Please do.

CHIEF MEDICAL OFFICER LOGAN: A few weeks ago, I was painfully reminded how mental health personally

impacts all of us. My eight year old son's devoted and wonderful second grade teacher took her own life a few days before Thanksgiving. She was full of life, passion, and was easily the best teacher my kids will ever have. She taught her students and her community to love and respect each other and our differences. Our community and world lost a unique and amazing soul.

Her life and death will have a lifelong effect on my children and thousands of others in our community. Her family hopes that something positive will emerge as a result of her suicide, starting with more widespread understanding that mental illness is nothing to be ashamed of. At her memorial service a few days ago, her husband said that mental health is something that we should all talk about and be open about, so that we can make a difference in people's lives and prevent the unthinkable. And that's my hope too.

And so I thank you for listening and thank you all for continuing to discuss mental health so openly. I really appreciate it.

CHAIRPERSON FECKNER: Thank you for sharing with us.

CHIEF MEDICAL OFFICER LOGAN: Thank you.

So on with our program.

Over the last several months, this Committee has

taken a closer look at how mental health is delivered to CalPERS' members and how CalPERS is working strategically and innovatively with our health plans and other stakeholders to achieve mental and physical wellness for our members.

As a quick recap, in August of this year, CalPERS team members presented an overview of mental health disorders, their social, financial, and physical impacts, and discussed barriers to achieve mental health wellness, including stigma and a shortage of mental health care providers.

At last month's PHBC the Department of Managed Health Care presented on their responsibility to protect CalPERS' members health care rights and ensure a stable health care delivery system through their enforcement of the Knox-Keene Act and the Mental Health Parity and Addiction Equity Act of 2008.

Additionally, Kaiser Permanente provided a report on their own challenges and innovations regarding mental health access and treatment, using a standard set of guidelines that CalPERS' team members put together based on PHBC feedback.

The Committee requested that all the large health plans present using the same set of guidelines. Today, we will be hearing from the three remaining health plans with

large CalPERS membership, Anthem Blue Cross, Blue Shield of California, and UnitedHealthcare.

They will each provide an overview of efforts to improve mental health access and services for CalPERS members and will also demonstrate how they're integrating mental health and primary care, addressing the social drivers of health, and are complying with mental health parity laws.

As you will hear throughout their presentations, each of these three health plans has different ways in which they deliver or contract to deliver their behavioral health service, including using an affiliated company or a separately contracted behavioral health plan.

From Anthem Blue Cross, we will have Dr. Robert Friedman, Managing Medical Director at Anthem Blue Cross; from Blue Shield, Dr. Michael Millman, Behavioral Health Clinical Director, Dan Prettyman, Vice President and General Manager CalPERS and Federal Employees Program. And for the Q&A portion, Dr. Millman and Mr. Prettyman will be joined by Blue Shield's Mental Health Service Administrator Magellan Health represented by Dr. Tosha Larios, Chief Operating Officer of California Markets.

And finally from UnitedHealthcare, Dr. Jeffrey Meyerhoff, Senior National Medical Director, Optum Behavioral Health, and Dr. Dennis Hsieh, Senior Medical

Director UnitedHealthcare will be presenting.

To be able to get through all three of these presentations, we ask that you hold questions until all three presentations are complete.

And with that, I will now invite Dr. Robert Friedman from Anthem Blue Cross to present.

DR. FRIEDMAN: Thank you very much. Thanks for that introduction. And I'm sorry for the loss.

Thank you, everybody, for inviting us here today. My name is Rob Friedman. I'm a child, adolescent, and adult psychiatrist. I am still in practice and a provider of behavioral health services in San Diego, and also the Managing Medical Director for Anthem Blue Cross Behavioral Health and focused mostly on the west region and California.

Anthem has made tremendous strides in the past several years in enhancing behavioral health services and bolstering up what Anthem can do as a -- and a health plan can do to help address some of the challenging issues that we face in the state and frankly the nation, regarding access, coordination of care services. And happy to go through some of -- a quick summary of what Anthem does.

Is somebody advancing the slides, or am I doing that, or there are no slides.

All right. Thanks.

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DR. FRIEDMAN: So I think CalPERS had posed some questions to us about the top diagnoses and by diagnosis and cost.

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DR. FRIEDMAN: And it shouldn't be surprise that -- it's pretty much we are faced with a high percentage of depressive diagnoses. When we look at really what kind of diagnoses are most prevalent, it's some variation of depression, depression and anxiety. I think we know that one out of four people suffer mental illness at some point in our country, and one out of five people suffer depression.

I think we've all become much more aware over the past few years that identifying issues like depression, substance abuse, and improving access for members who suffer from those disorders to get treatment, not only improves their depression and substance use disorders, but also improves their physical health, outcomes, and compliance with treatment.

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DR. FRIEDMAN: So Anthem has taken a whole person approach to health care and recognizing that, of course, you can't separate the physical from the mental. And Anthem being one integrated health plan has all of the

management of physical health and mental health services under one umbrella. There's one record system. There's coordination of care between the physical health medical directors and clinicians, as well as the behavioral health medical directors and clinicians, because it's an integrated health plan.

On the mental health side, we approach care for our members and your members by having two parallel systems, a utilization management system, and a case management system. And these are all licensed professionals who work hand-in-hand to make sure on the utilization side that people are getting the appropriate treatment, the medically necessary treatment, and trying to steer people towards evidence-based treatments.

And on the case management side, also licensed professionals that are more member facing, clinician facing, and help members access treatment, and coordinate care between their medical providers, their behavioral health providers, discharges from hospitals, and getting the resources that they need in the community.

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DR. FRIEDMAN: So again, of course, you've heard the expression the right care at the right place, better coordination of care. We've -- we -- the care man -- the case managers follow patients from the time they may be

admitted to the hospital through discharge, and the importance of finding follow-up care in the community.

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DR. FRIEDMAN: Because everything is under one umbrella, we're able to coordinate medical and behavioral care, as I said. So we have medical case managers who are routinely reviewing medical cases, complex care cases, and behavioral health case managers are participating in those treatment team discussions.

So there's a flow of information back and forth between the medical side, the behavioral side, at the utilization level and at the case management level.

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DR. FRIEDMAN: We've -- we all know that access is one of the biggest problems facing our communities. Several years ago, Anthem introduced a live health online for Anthem members. They can access telehealth service directly from their phone, their tablet, their computer by just click a button the screen. And it will pull up therapists and psychiatrists that have availability. Where it used to take sometimes four weeks to get in to see a therapist, now somebody can find a therapist who's available within four days typically.

Psychiatrists, you know, it takes months to get if. And now with LiveHealth Online, the average time to

get in has been reduced to less than ten days. The satisfaction measures are taken on LiveHealth Online. And these are Anthem providers already. They're in-network providers that are having this as an add-on service. And the satisfaction is extremely high for patients/members that are using that service.

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DR. FRIEDMAN: So the collaboration and coordination of care between behavioral health and medical providers is also a focus. And finding ways to help primary care doctors and behavior health providers work together has also been a focus. There's a whole team that's been put into place to incentivize the coordination of care and the collaborative care model through value-based reimbursement and supporting the medical behavior integration through those efforts.

Through outcome measures, if behavioral health providers are coordinating care with primary care clinicians, they have the opportunity to get an increase in their pay for the upcoming year.

And that program was just launched like two years ago and it's increasing, and being used throughout California. The same with substance abuse facilities, we know that one way to try to decrease the relapse rate is to make sure people get appointments upon discharge,

rather than just having a revolving door and turned back out onto the street.

So the substance abuse facilities are also incented to make sure their patients get appointments immediately post-discharge. And if they do, then they have the opportunity to get a high reimbursement rate coming -- going forward.

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DR. FRIEDMAN: You know, one of the questions was, you know, what does Anthem do or what do health plans do to ensure the quality of care? And there's an elaborate quality improvement program. There's one that focuses on behavioral health. We look at the needs and to -- for where improvements can be made. A big focus of the behavioral health quality improvement program this past few years is focused on the opioid epidemic. Trying to increase the providers that are able to prescribe medication-assisted treatment to make sure that those getting medication-assisted treatment are also getting quality medication-assisted treatment, which means behavioral health therapeutic interventions, not just the medication. And we monitor and measure the various programs that impact behavioral health and members with behavioral health conditions.

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DR. FRIEDMAN: There was a question about the social determinants of health care. Well, you know, there are two ways that Anthem has gone about this. And this is, you know, a relatively new concept that's getting a lot more attention at the health plan level. The case managers that I mentioned work with members to help make sure they have transportation, that they have access to care. And that's a big role for case management.

We know that people need safe housing. They need transportation to get to appointments and they need healthy food. Through the Anthem Foundation, there are programs for grants to make sure that communities with those kind of needs receive funding and grants for food banks, cooking classes, and support at the local level.

I think we'll see more of that on the commercial side. I think, you know, Anthem being a provider of the government business Medicaid, Medi-Cal, and also on the commercial side, I think there's an opportunity to leverage a lot of this -- the programs that have fiscally been able to be implemented on the government business kind of side and leverage that for the commercial side. And we're seeing more of that.

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DR. FRIEDMAN: Okay. I think that is the end of my slides. And I hope I didn't take too much time and

thanks for your attention.

CHAIRPERSON FECKNER: Thank you very much. No, you did not take too much time. That was great information.

CHIEF MEDICAL OFFICER LOGAN: Thank you. I will now turn it over to Mr. Prettyman on behalf of Blue Shield.

(Thereupon an overhead presentation was presented as follows.)

MR. PRETTYMAN: Thank you, Dr. Logan.

All right. Thank you, Dr. Logan.

Blue Shield is sorry to hear of your family's loss.

Hello. Good morning, Mr. Chair and Committee members. My name is Dan Prettyman. And I'm the Vice President of the CalPERS and Federal Employee Program at Blue Shield of California.

Thank you for inviting us to participate in today's discussion. And we appreciate CalPERS attention and commitment to ensuring appropriate mental health care for our members. At Blue Shield, we recognize the importance of mental health and partner with Magellan Health to provide services to our members, our employees, and the communities we serve.

Joining me today is Dr. Michael Millman from Blue

Shield.

DR. MILLMAN: Good morning. My name is Dr. Mike Millman. I'm a clinical psychologist, Clinical Director for Behavioral Health at Blue Shield of California.

MR. PRETTYMAN: Also joining us today to answer any questions you may have is our -- Tosh -- Dr. Tosha Larios from Magellan Health.

DR. LARIOS: Hi. Good morning. My name is Tosha Larios. I'm dual board certified in primary care and rare foot surgery. I spent 13 years in the military. So I continue my active -- active reserve as a primary care provider. I'm really happy to be here. Mental health means a lot to me with the service members that I've seen go through various issues. And integration is really key to helping to serve our members. So thank you for having me.

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MR. PRETTYMAN: Per your request today, we will speak to a number of ways that Blue Shield ensures CalPERS members receive the proper mental health care they deserve. And our focus will be based on the questions that CalPERS team previously provided.

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MR. PRETTYMAN: Here, of course, are those questions that we have been asked to discuss, which are

addressing throughout today's presentation. And the corresponding slides to those questions are identified here.

I will now hand it off to Dr. Michael Millman to provide further insights on our approach.

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DR. MILLMAN: Thank you. To highlight our top five mental health diagnoses by prevalence and cost for our CalPERS population, you will see that both lists have diagnoses surrounding autism, anxiety and depression, with a slight difference between the rankings within the two lists.

Keep in mind, this information will look different depending on how you pull the data. For instance, if we put all the depressive disorders into a single category, rather than listing them separately, you would likely see depression move to the top of the list.

Throughout our discussion, we will highlight some of the programs, services, and initiatives Blue Shield is undertaking.

Next slide.

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DR. MILLMAN: During the last Board meeting, Dr. Logan referenced a number of alarming statistics associated with mental health in the CalPERS population.

Recognizing these challenges, Blue Shield is committed to helping improve access and quality of care. Blue Shield partners with Magellan Health to access a broad provider network of almost 12,000 behavioral health clinicians, which has grown by 23 percent over the last five years.

Magellan Health has de -- has a dedicated team that recruits both facility and individual providers, as we work to establish and maintain strong relationships. Blue Shield monitors and partners with Magellan Health in this statewide effort.

In addition to traditional network growth, we see a huge opportunity to leverage telebehavioral health. We continue to expand the telebehavioral health network providing easy and secure access for our members through a mobile device at a time and place that is convenient for them.

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DR. MILLMAN: You also asked us to speak to screening and treatment for mental health and chronic health comorbidity. In addition to the importance of continuing to improve access to providers, we also see an opportunity to further improve the integration between behavioral health and medical care. Behavioral health conditions add significantly to the overall cost of care

are frequent -- and are frequently treated inadequately.

To help improve integration, we screen for mental health and chronic medical conditions in a variety of ways. We leverage information from medical and pharmacy claims to proactively identify members with unmet mental health needs. We have a chronic condition program that identifies mental health condition and refers members to appropriate resources. We also leverage patient health questionnaires to screen for members' needs, connect them to treatment, and enroll them in Blue Shield's Shield Support Program.

Shield Support includes access to a team of co-located mental health and medical professionals offering personalized care and support, including care coordination, case management, and home visits.

Through these integrated behavioral health and medical care programs, we are better able to support our members, we're able to improve health outcomes, and lower costs.

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MR. PRETTYMAN: Mental health stigma has long been prevalent throughout our society. Recently, Blue Shield has taken action to address the mental health stigma in two important segments of our populations, our students and our first responders.

The following two slides will speak to Blue Shield's approach to improve mental health awareness and mitigate the stigma in both these populations. With one in five students having a serious mental health need and too few of those not understanding how to seek help, breaking down the stigma of asking for help is crucial.

Earlier this month, Blue Shield announced an initiative that will do just that called the BlueSky Initiative. BlueSky is a statewide multi-year effort to support mental health care for California's students. It will enhance awareness, increase advocacy, and improve access to mental health services for students across the state.

The program provides additional mental health clinicians in the schools, trains teachers to recognize the typical signs and symptoms of mental health illness, and empowers students to overcome mental health stigma and get the help they need.

Blue Shield is proud to partner with the California Department of Education and other nonprofit organizations to support mental health for California students through this BlueSky Initiative.

Dr. Millman will now discuss Blue Shield's work with our first responders.

DR. MILLMAN: We have a tremendous amount of

respect and appreciation for our first responders. They make a tremendous sacrifice on a daily basis to help keep us and our families safe and healthy, which unfortunately often impacts the health of the first responder themselves.

We recognize first responders also face a challenge with the stigma surrounding the use of mental heath services. Some of the examples of our commitments to help include our focused efforts on employer-based programs that reduce stigma and promote mental wellness. We also are partnering with organizations such as the Center for Firefighter Behavioral Health to give them access to technology-based resources. And to reduce the negative impacts of stress and trauma amongst first responders, we are working to offer mental health first aid training program for first responders.

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DR. MILLMAN: Moving on to embedding mental health in primary care, we recognize the need for all care to be coordinated and with the primary care physicians at the center of the care hub. We believe that behavioral health must be embedded to ensure whole person care. To help, we have implemented a number of strategies. One example is that we have provided our primary care

physicians with a behavioral health toolkit that supports the interactions with CalPERS' members.

This toolkit gives providers access to guidelines, referral information, and screening tools. Blue Shield has also partnered with our medical groups and primary care physicians to provide space for members to access telebehavioral health services in primary care practices.

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DR. MILLMAN: To address your questions on mental health parity compliance, Blue Shield and Magellan partner to provide ongoing monitoring and compliance with all parity laws. Plan benefit changes and business operations are evaluated prior to the implementation for parity compliance. Both Blue Shield and Magellan Health are audited by the Department of Managed Heath Care for continued compliance with mental health parity regulations.

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DR. MILLMAN: Research shows that the majority of a person's health is related to social drivers of health, such as socioeconomic factors, health behaviors, and a person's physical environment. In looking at the impact

of social drivers on health, an example of what Blue Shield is doing to address these drivers, takes place right here in Sacramento.

In Sacramento, we've identified health outcomes are generally impacted by transportation barriers. We have partnered with Lyft, the rideshare company, to offer our members no-cost medical transportation to and from appointments with one of our Sacramento-based providers.

This program can potentially benefit over 500 Blue Shield CalPERS members. Additionally, we have a suite of clinically tested wellness programs for our members that address several key health behaviors, such as smoking cessation, diabetes prevention and fitness club discounts.

Dan will now share a few comments to conclude our presentation.

MR. PRETTYMAN: I'd like to close our presentation today by thanking the Board for giving Blue Shield this opportunity to speak on this critical topic that impacts each of us in one form or another.

Thank you again.

CHIEF MEDICAL OFFICER LOGAN: Okay. I will now turn it over to Drs. Meyerhoff and Hsieh from UnitedHealthcare.

(Thereupon an overhead presentation was

presented as follows.)

DR. MEYERHOFF: Thank you so much.

Okay. Can you hear me okay?

Thank you.

And if you could pass down the slide changer, I can then have somebody else do that.

So I'd like to thank the Chairman and the Committee for having us today. It's really an opportunity to be able to talk about some of the solutions that UnitedHealthcare has for our members with mental health and substance use disorders. And, Dr. Logan, thank you as well. And I really am sorry to hear about what's happened. And it really speaks to the need for access to mental health services.

But even beyond access, it really goes to engagement as well, because we can get people to a provider, but they don't always stay, or it's not the right fit, or it's not how they want to get their care. So we really have worked over the last few years to expand the way in which our members get care, not only access, but also in the way that they want to have it, including supporting PCPs, if that is where they choose to get their mental health care.

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DR. MEYERHOFF: So if we go to the agenda page,

which is the next slide, I just want to tell you we're going to cover all the questions that you gave us about access, which is our biggest focus. Integrated care. I am Senior National Medical Director at Optum Behavioral, which is owned by United -- UnitedHealth. And my primary job is medical behavioral integrative solutions.

And then we'll talk about the social determinants of health, parity, and some of your stats with your membership.

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DR. MEYERHOFF: If you go to the next page, we can't have access without addressing the shame and stigma that comes along with having a mental health or substance use disorder diagnosis. That is a huge barrier to people seeking treatment and getting the care that they need. And we recognize that. And as part of our solution to getting access is we really are aggressively trying to change this conversation. We've been working with national organizations that are well respected in this area.

This year, we partnered with Coping After Suicide; Give an Hour, which is an organization that asks therapists to donate one hour a week to military and veterans; Psych Hub, which is a tremendous online source for psychiatric information; ShatterProof, which focuses

on substance use conditions; and Stamp Out Stigma Campaign.

And this next year, we're going to expand that, because we know that's not enough to the American Foundation of Suicide Prevention, Mental Health American. We're going to expand our first -- our Mental Health First Aid offerings through the National Council for Behavioral Health. We're going to work with a group called Mental Health Innovations that tries to kind of approach this stigma issue and alternative ways. The Trevor Project, which focuses on the LGBTQ plus community, which has a huge prevalence of some of these issues.

And we're also partnering with University of Maryland to do some more research. And what else do we need to do to change this conversation?

CHIEF MEDICAL OFFICER LOGAN: Dr. Meyerhoff, I hate to interrupt, but would you mind advancing the slides?

DR. MEYERHOFF: Oh, I'm sorry.

CHIEF MEDICAL OFFICER LOGAN: Thank you.

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DR. MEYERHOFF: I said I would do it and then I never did. I'm really excited. Sorry.

Okay. So the next one is really what are we doing at the workplace level.

Ooh, I hope this didn't go on.

Yeah. So we also have campaigns at the workplace level to try to reduce stigma. And we're doing that for CalPERS currently working with leadership to kind of talk about how do we communicate the importance of behavioral health wellness, how do we create a culture within the workplace environment that is more supportive of people who have these conditions, how do we connect them with similarity to physical conditions, and how do we kind of engage your members in more kind of preventative wellness programs.

We also have efforts that are at the member level to try to reduce stigma. You know, we have -- we have care advocates that help kind of help people understand the importance of seeking care. We make sure people are -- know, and understand, and use their benefits when necessary. We work to provide early intervention screening, which we'll talk about in a minute, because the quicker we get in front of us the less severe hopefully the condition is going to become. And again, even focusing with members regarding this is really equivalent to having a medical condition.

So we're going to talk a little bit about our PCP connection and then we'll continue -- I'll continue.

DR. HSIEH: I'm Dennis Hsieh. I'm a Senior

Medical Director UnitedHealthcare. My background is Internal Medicine and geriatric medicine. And I wanted to talk a little bit about our collaboration with our PCPs on behavioral health.

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DR. HSIEH: So we share with them various clinical resources, including information about cultural competency, screening for depression, alcohol, and substance misuse, management of ADHD, and patient education materials.

We also provide real-time data on clinical care opportunities for our PCPs. As an example, for our Medicare members, we share with our PCPs reports that include ER visits, inpatient hospitalizations, emissions, and discharges, which includes behavioral health hospitalizations in those reports. And we don't differentiate between medical and behavioral health hospitalizations. And we ask our PCPs to outreach to every member -- every one of their patients after a hospital discharge to follow up on that -- on their patient.

The majority of our members in our disease and care management programs are screened for depression. And if a member has an elevated score, with the member's permission, we share their results of that assessment with

the PCP. And then we also have an Optum -- UnitedHealthcare Optum behavioral health clinical advocate reach out to the member to assist them in getting additional care.

And finally, an example of how we're working on addressing and supporting our members and PCPs around the social determinants of health, our Medicare members have as -- available to them a free annual in-home assessment. And part -- that assess -- the results of that assessment is sent to the PCP. And the member is also given a checklist of things to follow up and discuss with their PCP. And in that assessment, it includes evaluation of things such as safety in the home, access to food, utilities, transportation, medical care, income level, work situation, VA status, and evidence of social isolation.

And between January and September of 2019, 1,075 CalPERS Medicare members were identified and were referred to a UnitedHealthcare social worker for additional support around the social issue that we identified.

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DR. MEYERHOFF: Thank you.

And that in-home assessment also includes mental health screening and referrals to behavior, if necessary.

And United behavioral health, Optum behavioral

has the largest network of providers in the country. We have an extensive network. But we know just having a large network doesn't necessarily mean that you have access. And so we have actually focused on developing, what we call, our Express Access Network, where we actually contract with providers to get a member into care within five days. The industry standard, as you heard, is closer to two weeks. So this is a face-to-face appointment within five days for our members when they need more immediate access.

We also have the largest network of virtual providers in the country for tele-mental health.

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DR. MEYERHOFF: And we actually own -- thank you. We actually own the largest -- the largest provider of tele-mental health services, Genoa Healthcare. So they are actually one of our affiliates and they're the largest provider of tele-mental health, including about 3,000 psychiatrists and nurse practitioners.

We also have a huge network of specialty networks, ABA, medication-assisted treatment, and autism spectrum providers.

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DR. MEYERHOFF: So for California, because

obviously that's where you're interested, over the last couple of years, we have increased your behavioral health network by 22 percent. We've increased the number of substance use disorder facilities by almost 50 percent. We've increased the number of medication-assisted treatment providers to prevent worsening of the opioid epidemic by 30 percent. We've increased the express access appointments that I talked about by almost 50 percent. Our virtual visits went up 174 percent in California. And our ABA practices, we increased that by 33 percent. So really working aggressively to make sure your members have good access to care throughout the state.

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DR. MEYERHOFF: The other thing that we do to improve access is actually partner with providers at higher levels of care. All that we've talked about so far is our outpatient services. But at higher levels of care, it's really important that we have access as well. So one of the things we've done is instead of the industry standard, which is to review a case every couple days to make sure it meets medical necessity, we actually use our data, and we have a lot of data, and compare it to severity, age, diagnosis. And we actually know what the average length of stay is going to be for that member at

that level of care.

And we go ahead and we authorize that average length of stay, plus one extra day to be able to get out of the provider's way and let them really take good care of your members.

The reason we get involved after that is if someone stays longer, we know something is different about that case. It's not your average bipolar case, let's say. And so they might need more services when they get out of the hospital. They might need something else. They might need some increased case care engagement. And so we partner with providers. And this really had a really positive effect on the care that our members receive, because not only do we get out of their way, but we also help them provide solutions when a case really isn't your standard case.

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DR. MEYERHOFF: We also have really revamped our care engagement program. It used to be our case management program and it really is about engaging members. And we've gone beyond just looking at behavioral claims and behavior -- and behavioral clinical data. We actually bring in medical claims, medical data, pharmacy data. And that gives us a much more holistic view of your members.

And therefore, we can really figure out who's falling through the cracks, who needs more high touch, and who could we -- who could we kind of put those high-level resources towards, whereas who could benefit from more educational resources and lower level touch services.

So it's really been a great thing. And we, of course, in addition to all that, transition everybody out of the hospital and make sure they get a timely appointment once they're leaving, a substance use facility, or an inpatient facility.

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DR. MEYERHOFF: We also -- and I'm almost done. But we also did a study, because one of the problems with medical behavioral integration is there was a study about ten years ago that said if you just chase everybody with a comorbid disorder, you're going to save tons of money. And nobody in the industry has really managed to achieve those savings.

So we looked at the study, found some serious problems with it and redid our own study looking at 60,000 matched conditions. And what we found is it's not everybody. That, in fact, in this slide, it's really a heterogeneous population, meaning that 14 percent of the population has a comorbid medical and behavioral condition. But only 25 percent of that 14 percent is

driving 80 percent of health care costs in that group.

So historically, we've been chasing the other 75 percent with really expensive resources, and that has not paid off. We've been able to figure out and actually create an algorithm that helps us identify who are these 25 percent, really throw those high-level resources at them, case managers, medical doctors, behavioral, you know, psychiatrists within the organization, partnering with their providers in the community. And we've been able to have a tremendous outcome with wellness -- improved wellness in this chronically medically ill population, as well as serious reduction in total cost of care for this group.

Some of our initiatives on the next slide --

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DR. MEYERHOFF: -- for medical behavioral integrative activities are screening, as we talked about. We now have every disease management program that sees your members, screening for depression, anxiety, substance use. We have programs that if somebody has a chronic medical condition and depression and anxiety, they can get an eight-week session of coaching once a week and cognitive behavioral therapy once a week. And after eight weeks, their total cost of care dramatically declines, as and well -- and their wellness, their adherence to

treatment goes way up.

And we also, of course, offer all the other services I talked about, and we report on this. So we report to you, how we're doing with our medical, behavioral integrative activities, and the reporting helps us continually improve the program.

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DR. MEYERHOFF: We address social determinants of health. We actually have an algorithm that identifies people who might be falling through the cracks, because of their barriers to care. Our care advocates always inquire when anybody -- whenever they're talking to members, what are the barriers that they're receiving. We have a connector tool that helps reach the community resources necessary to help improve transportation, housing, how to get to the pharmacy. Whatever it is that they need, our care advocates really resp -- really work to close those gaps in care, because we know without closing those gaps in care, these people are going to fall through the crack and not get the proper mental health and substance use care that they need.

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DR. MEYERHOFF: We comply with parity. We partner extensively with the health plan in this regard. And we have an annual assessment of our -- of our tool,

and we also comply with your California specific guidelines, which are different and the Department of Managed Health Care surveys.

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DR. MEYERHOFF: And then finally, you did ask about you diagnoses. Your prevalence is really comparable to our national book of business, which I think is really interesting. There are very little differences between the way your membership prevalence comes out and our national book of business, and the same with cost. There's a little more in your -- in your basic plan, a little more anxiety than maybe in the national book of business, but really it is quite equivalent.

And you can certainly look through that list and see where the costs and the preponderance or prevalence is.

I'm really appreciative that you let me talk today and come in front of you.

Thank you.

CHIEF MEDICAL OFFICER LOGAN: I'd like to thank all of our presenters and now we're all open for any questions you may have.

CHAIRPERSON FECKNER: Excellent. Thank you. I thank all of your for being here and for offering such good comments.

It's very enlightening to me to see the use of virtual medicine, telemedicine, et cetera, especially in this arena, because we know a lot of folks, one of their biggest hurdles is actually leaving their home. So I think that's good that we're reaching out and trying to find other ways to access these folks.

I do have a question, however, for all of you. It seems it's an industry-wide issue that it's harder and harder to find professionals in this field. Is that your knowledge as well? I mean, we keep seeing, well, there's longer and longer wait times. And some of that is because there just aren't enough professionals out there. Do you find that in your book of business, any of you?

DR. LARIOS: Hi.

DR. MEYERHOFF: Yes. I mean, that's absolutely a huge barrier to getting access. And I think it's one of the reasons that we all have talked about alternative solutions, because we can only create so many providers, and we have tried to support initiatives, even at the kind of medical school level to try to encourage more graduates to go into mental health and psychiatry.

But, you know, that's the long game. And it takes a long time. So we had to really come up with solutions for the short term. And, yes, I mean, that's -- that's the reality all over the county, especially in

rural areas. We know how difficult it is to find a provider. And that's why I think we're all talking here today about really going to telemental health, because that does level the playing field at least, especially for people in a rural area.

CHAIRPERSON FECKNER: Thank you.

DR. FRIEDMAN: Yeah, I would concur. I think, you know, if -- I'm child psychiatrist. There's, I think, only 4,000 or so child psychiatrists in the country. Many psychiatrists and child psychiatrists are, I think, half or like above the age of 50, and, you know, approaching retirement. So it's really more of a national effort to try to encourage more medical students to go into psychiatry. I think we're all -- all of us are understanding the importance of other licensures, like nurse practitioners and getting them trained in mental health. There are programs increasing to train mental health nurse practitioners. And I think we all need to understand that we need to embrace that.

And then finally, really the whole collaborative care model, as has been talked about by, I think, all of us. You know, we need to support primary care physicians in recognizing, diagnosing, and treating mental health and substance abuse conditions by specialists being available, either on-site, or for referrals, or through telehealth

mechanisms to help bolster their treatment. But it's a shortage.

I will say, on a personal level, I've -- I'm doing what I can. My daughter is graduating as a resident in psychiatry this year, so. I told her she had to do it, so...

(Laughter.)

CHAIRPERSON FECKNER: Add one more. Very good.

DR. LARIOS: So I would like to echo everything that they said.

CHAIRPERSON FECKNER: Please.

DR. LARIOS: I would like to include the telehealth we have seen great success within the cardiology and dermatology paring with primary care. So a few years back, close to ten years ago, there were issues with finding access to dermatology and cardiology. And that was solved through telehealth initiatives within the PCP clinics.

And so Dr. Millman had mentioned that we are paring our telehealth services with our larger primary care groups at Blue Shield. And that is to introduce the telehealth for mental health diagnoses to members, so that there is that comfort level of getting on a video and perhaps they want one or two sessions within their primary care office. And after that, they want to take them from

home and they have that convenience.

Thank you.

CHAIRPERSON FECKNER: Excellent. Thank you all for your comments.

Microphone

DR. MEYERHOFF: We developed telehealth originally, because we thought younger people were going to want to get their care that way. And, in fact, our biggest uptake is in the older population.

CHAIRPERSON FECKNER: Sure. Thank you.

All right. We have a number of requests from Board members.

Mr. Ruffino.

ACTING BOARD MEMBER RUFFINO: Thank you, Mr. Chair. First of all, I'd like to begin by thanking, on behalf of my principal the Great Treasurer -- State Treasurer Fiona Ma, to each and every one of you here in the panel and to your respective organizations for all that you do for our members and for the public at large.

I think we all agree that it's a very, very important critical work. And also thank you for this update that you give us today. It's very helpful to understand.

I do have a few questions for all of you. But I'd like to reflect for a moment before I begin the

question. If you happened to see yesterday's article in the Los Angeles Times. I'm not sure if you happened to see it or not. But it was describing -- describing the experiences of our enrollees in that particular story that we're referring to, Kaiser's, attempting to access care from Beacon and Magellan therapists.

And if you did not see it, I strongly recommend that you look at it, because they reported -- these folks reported making dozens of calls to therapists who were unable to give them appointments. One person, in particular, attempted suicide after spending weeks phoning through 60 therapists and awaiting their return calls in at attempt to find a therapist able to care for him.

So I guess the general question is what is Anthem, Blue Shield, UnitedHealthcare, and so on and so forth, what are you doing to make certain that these provider networks actually deliver appointments and care to patients with mental health conditions? I'd like to begin with that question.

DR. LARIOS: So hi. Thank you for that question. It is very important to ensure that members have access to care in a timely manner. And it is something that we've been discussing as far as provider availability throughout the state. Again, we've discussed how we are increasing our access by recruiting network providers, by offering

additional options in how members seek care through telehealth. And we still are seeing articles that you were pointing out.

And so what we have done on Blue Shield's side is we do offer, what we call, appointment assistance. So we are able to call and identify providers within the ten, 14 day, and six-hour time frames that regulatory-wise we adhere to. And that is something that we have done to offer assistance to our members.

DR. FRIEDMAN: Yeah, again, it's just a real problem. You know, one of the -- it's a supply and demand issue. And it's -- what happens is let's say a new provider joins any of our networks. They're going to be booked. Within three months, their practices are now full. And it's a challenge to get them to see more patients. Of course, it -- there's some geographic variability. But because there's such a shortage of providers and people wanting to access care, which is a good thing, it is an ongoing problem, but -- and I think we were all trying to come up with the same solutions, increase the network, bring more providers into the network, make it desirable for them to want to do that by making the rates attractable, so they will do that.

Telehealth is a way to increase access. Anthem is actually starting a pilot project next month in January

for California for -- it's going to be hard for me to say this, but I'm going to say it -- chat therapy. Again, we want to reach people where they're at. And there's a huge population that uses texting. And if we can engage people through texting services, then we can pull them into telehealth and even bridge a gap to get them into an online appointment -- an online or in-person appointment.

You know, Anthem is trying to increase the network of providers through the pending merger with Beacon that you've probably heard about. And that's going to increase our network of providers as well. So there's -- I think all of us know that access is a problem and there are a number of things that we're all trying to do to address it.

DR. MEYERHOFF: So at UnitedHealthcare, we make ourselves available to our members 24 hours a day, seven days a week. We have a care advocate on the -- on the phone to help assess people and assess what their need is at that time. And then if indeed they need an appointment in the community, that we ask them how they want to receive that. So it could be telehealth. It could be an in-person appointment. It could be they want to call a few people and kind of interview them. So if they want to call and interview a few people, we let -- we do that. We give them a few names.

But if they call back, then we actually pass that on to a team that does nothing but find people appointments. So that we take the member out of those 60 calls and we really do that for them and make sure they have an appointment in hand.

Also, our telehealth system, you know, a lot of these shops are one, two, mom and pop kind of shops. And so for telehealth, we actually will provide any of our network providers who don't have access to a HIPAA-compliant system our own system. And what that includes is it's HIPAA compliant. People can get their care right in their home from their computer. But also it has online scheduling for that provider, so the member can go into their computer, look at the provider's appointment schedule, and schedule that appointment right there and know that they have an appointment.

ACTING BOARD MEMBER RUFFINO: With respect to shortage, and I -- first of all, by the way, thank you for your comments and thank you for everything that we are trying to do. You know, whether it's Anthem with the LiveHealth Online, I think it's awesome, and some of the other programs.

But we are keeping hearing about shortages. And, of course, it's real. There's no questions about it. Everybody acknowledges.

But I wanted to ask generally, could it be too that is the low reimbursement rate paid to therapists and psychiatrists who participate in the Beacon and Magellan network, could that potentially be also an issue?

As I understand it, for example, I've heard that reports -- I've seen reports that reimbursement rates have not -- have not been increased for eight years or more. And that, in some counties -- in some counties, the rates paid by these networks are lower than the Medi-Cal program's reimbursement rates.

So do you know what your rates are and how these rates compare to Medi-Cal rates? How have the rates changed over the past ten years? Can you provide some general -- I know, possibly you may not disclose them, or maybe you can to our staff. But have you -- are you aware of that issue? Because I believe that issue is also contributing, you know, to this difficulty maybe. I'm not sure. What's your thoughts.

DR. LARIOS: Hi. Thank you again. So absolutely, I think anytime you discuss insurance, reimbursements, and access to care, the rates have to be discussed. And so we do actively look at our network of where we have our providers. We look at the benchmarks of TRICARE and Medicare for reimbursements. And we actively pursue providers within those areas where we are currently

needing additional expertise and we are negotiating to terms.

So there may have been issues in the past. I guess you had mentioned ten years. I apologize. I haven't been at Magellan for ten years. But looking over it, I could see that there was probably some issues with reimbursements in the past. But that is something that we actively look at.

ACTING BOARD MEMBER RUFFINO: Okay. Thank yo. One last question for -- oh, sorry.

DR. FRIEDMAN: I'm happy to pipe in. I mean, I think, you know, this is -- as a physician that's not my responsibility to negotiate rates, but I do work with the provider network teams that negotiate with providers in the community. And I think it's a fair state -- I can't speak for Beacon or Magellan. I can speak for Anthem. And I think they're constantly evaluating the rates in the communities. And they will negotiate rates that are competitive to bring people into the networks, where there's, you know, a supply and demand need. There is some areas where people's rates are higher than other areas, because of that need.

But I think, you know, your -- I think you're right, the cost of living goes up and the rates to reimburse providers needs to parallel that at least, so

that we can get more people into the network.

It's a little more complicated. I'll just make another point, because other experience. If you're a provider in the community and you have a very busy practice, you then will have your cash rates. And as soon as health plans raise their rates to -- for reimbursement, providers then raise their cash rates. And then they cut that -- their -- you're constantly chasing a higher rate in the community.

So a provider will say, well, I have -- you know, if somebody calls up and says, well, I have no room to take you, but, oh, I do have room, if you pay cash. Which that shouldn't be happening, but there's, you know, an element of that on the provider side also.

DR. MEYERHOFF: Add I'll just add in that, yes, I mean, UnitedHealthcare also has been guilty of the same problem, where we were contributing to the access problem by not increasing our rates for such a long time. And we recognized that we're not going to solve the access problem, unless we change that.

So this year, we actually did a substantial rate increase for our provider network. And we have another one scheduled for this next year, because indeed, we need to compete with cash practices and we need to reimburse providers what they -- what they need to be able to take

your members.

DR. FRIEDMAN: And that -- we need to encourage providers to want to join our networks, because we pay them enough and we make it easy for them to treat our patients, our members.

ACTING BOARD MEMBER RUFFINO: Very good. Thank you.

One quick question for Anthem. I know that we saw the announcement that in June you reached a deal to acquire Beacon Health, which obviously is one of the state's largest network of mental health providers. I understand that the deal is supposed to close during the fourth quarter of this year. Can you give us an update on the status and whether or not -- how will it impact, hopefully positive. I'm sure it will be positive to provide, again, timely and appropriate outpatient mental health care to our CalPERS members.

DR. FRIEDMAN: Sure. I'm -- you know, there's -- I'm not privy to a lot of the private information, because all that is very tightly controlled. But I -- the latest I heard was that it may be pushed to the first quarter. All the different -- every state that's involved has to sign off. And there is a few states that still haven't signed off. So I think to get everything in order, it looks like it's been pushed to the first quarter of 2020.

But it still looks like it's on track to happen from what I'm hearing.

And I think you're right, it -- if Anthem and Beacon do it correctly, it's taking the best practices of both of those organizations. It will expand the network for Anthem/Beacon, because now they're -- you know, there are overlapping provider networks, on those two organizations. But there is some that aren't overlapping. So it will automatically increase the network.

You know, Beacon has lot of strengths. They're -- a lot of their focus has been on the government side, Medi-Cal, Medicaid. And they've developed some robust case management programs and complex care programs. And I think by picking best practices from both organizations, you're right, it does afford the opportunity to really enhance the delivery of care for members.

ACTING BOARD MEMBER RUFFINO: We wish you well in that.

DR. FRIEDMAN: Thanks. Thank you.

ACTING BOARD MEMBER RUFFINO: Thank you all again -- thank you all again for being here and to give us this presentation.

Thank you, Mr. Chair.

CHAIRPERSON FECKNER: Thank you.

Mr. Rubalcava.

VICE CHAIRPERSON RUBALCAVA: Thank you. Very good presentations. Thank you very much. And I thank you for taking this issue very serious, because it is serious to our members.

I have a question for each of the plans. Dr. Friedman, in your -- in the discussion and on the slide about coordinated care, it seems to be like a coordination between inpatient and outpatient. So how is -- what is the utilization say inpatient versus outpatient, In your system?

DR. FRIEDMAN: What do you mean by what is the utilization? What -- I --

VICE CHAIRPERSON RUBALCAVA: I mean, what percentage of medical service -- or health services -- mental health services provided outpatient versus inpatient? And the reason I'm asking is because on your slide six, it starts with -- the title is coordination, but it starts basically with an inpatient setting, it seems to me.

DR. FRIEDMAN: Okay. Well, no -- well, I think, there's actually more people receiving care on an outpatient basis, and Anthem doesn't do any utilization management of our outpatient services. We want people to access outpatient services very freely. With the

exception of autism services, we do require authorizations and with a technique called TMS, transcranial magnetic stimulation. We do require a prior authorization to make sure that that's appropriate. So people don't get that if it's not safe or effective for them.

But otherwise, if somebody wants to go to a therapist, a psychiatrist, they don't need an authorization. They don't have any kind of limits on how often or how frequent they can see those providers. So we want to make sure people have open access to outpatient care. So actually, I think there's more treatment going on in the outpatient basis.

When people do access higher levels of care, like inpatient, residential treatment, those are the triggers that trigger care -- case management, I think for all the health plans, to try to make sure those folks, when they get out of the hospital, they can access an appointment on an outpatient basis more quickly. I'm not sure if that answered your question directly, but --

VICE CHAIRPERSON RUBALCAVA: No, that's fine. Because I was -- when I first saw the questions formatted, I thought we were going to be -- well, from my point of view. When I said the question about coordination was how to -- you know, the screening identification, how do you take them -- you do you identify them, screen them, and

take them to the appropriate level of care, I guess? And I was interested, because right away it seemed to focus on how -- once they're in inpatient, how does the coordination follow after that?

DR. FRIEDMAN: Right. Well --

VICE CHAIRPERSON RUBALCAVA: I thought it was interesting.

DR. FRIEDMAN: Sure. Well, people usually access care -- you know, higher levels of care by showing up at an emergency room or directly at a mental health or substance abuse facility. And then a request for coverage of those services comes into the health plan. And then assuming it meets criteria, the -- there's an authorization provided. And as was said a numbers of days are approved. And then there's follow-up reviews to see if patients continue to meet that level of care. And as they improve, they're expected to step down to lower levels of care. It could be going from inpatient to residential. It could be going to partial hospital. It could going to an intensive outpatient program.

And those decisions are really made by the clinicians who were treating the patient. And if they provide the information to support those services that are being requested, then Anthem and the other health plans will support that and approve that.

And then there's the case managers who facilitate people coming from higher levels of care going to outpatient, as Dr. Meyerhoff said and others said, you know, there's people who are actually making phone calls, finding providers, and making sure that they can get an appointment.

The responsibility really is at the treating provider level, like the facility has a responsibility to find appointments, but often they need help, because they're not as familiar with the networks or they're just not as incented. So we work together with them to try to help them -- help find appointments for people, coordinate that care.

VICE CHAIRPERSON RUBALCAVA: Thank you, Doctor.

I had a question for Blue Shield. Dr. Millman, there was a -- as you can tell, my interest is identification screening of an engagement with a patient. There -- in Blue Shield, there's something called a co-location of mental health and medical care managers. So I was hoping -- and there's a tool that where you create a list, I guess, that goes to the PCP. So how is that list created, what are the triggers, and what are the entry points into that list? And how is that toolkit used by the PCP?

DR. MILLMAN: Thank you for the question. The

toolkit is something that the primary care provider can use. And some of this may be better answered by Dr. Larios, but I'll give it a go here for the first part of this. The co-located part is Magellan has licensed clinical staff that actually work out of one of our Blue Shield offices and are integrated with, what we call, medical care solutions where -- it's the department where I work. And so they interact with our physicians there directly and our nurses for -- who do medical management. They also interact with the concierge team that provides extra supportive services to members, including CalPERS.

Some of the other screenings are done through the Magellan staff. And I'm going to let Dr. Larios talk a little bit about that.

DR. LARIOS: Thank you.

So we do have our co-located care managers that are capable of screening members utilizing national screening tools for depression, anxiety, substance use disorders. And from there, those screenings are utilized to help gauge where the member needs to get care, so if they need an outpatient provider versus a higher level of care provider.

We also have our care managers who are out in the field. And they are linking between outpatient providers through the PCP toolkit. So the PCP toolkit is actually a

website that links the primary care providers to clinically based practice guidelines. So the primary care provider can go and look at ADHD, and the current medications, and the best way of treating it, should they send them to a therapist, in addition to giving them medications.

They also have a direct link to our clinicians that are field based and our psychiatrists, our Board Certified psychiatrists. So if they have any questions about medication or where they should be taking the treatment of the member, they can outreach in those regards.

VICE CHAIRPERSON RUBALCAVA: Thank you.

DR. LARIOS: Thank you.

VICE CHAIRPERSON RUBALCAVA: I had one final question here, Mr. Chair, for UnitedHealthcare.

Dr. Meyerhoff -- sorry about that. So again, my interest is the continuation of care and the integration. So and maybe I should have asked Dr. Millman too, but I'll ask it. How -- what is the -- how does the integration work between Optum and UnitedHealthcare? At what point is there a hand-off, or is it integrated, or is there -- how does the reimbursement work, and -- because for most people, I would think, and you correct me if I'm wrong, their first interaction would be with their primary care

physician. So how does that go from their primary care physician to say an Optum service provider? How would that work?

DR. MEYERHOFF: Yeah. Well, that's a great questions. I might let Dr. Hsieh also jump in. But, you know, at the PCP level -- first of all, Optum and UnitedHealthcare are really just one company and we are really seamless in the way we do business. Optum being a little more of the service side of the company, so that, you know, the networks, and providers, and United being a little more of the insurance side of the company. But generally, all of the services, whether they be medical or, you know, behavioral, are really seamless in the integration.

But at the PCP level, we have a number of initiatives that we engage to try to bring best practices to PCPs. We really want to help support. And especially when you saw our case care engagement grid, that middle group that doesn't drive all the costs but still needs good treatment, if they're getting their care with the PCP, we actually -- so we identify and stratify the entire population. And we assess what do they need? Do they -- are they in that top group, where they have medical and behavioral risks and they need more serious -- more intensive care engagement or are they more in the middle

group, where we can support their provider that they have.

If they have a provider that's a PCP, we will outreach to that provider, let them know what we have found, and also help them with best tools, so best green tools, and best treatment algorithms.

And in fact, what we have found is that our PCPs have been really amenable to those conversations and willing to kind of continue to treat that member up until the point when they don't feel that they, you know, are comfortable.

The key to this is when they don't feel comfortable getting them a really quick and easy referral, so that they can hand that person off to a provider. And so we are working, especially one -- now that we own the largest provider of telehealth -- telemental health services with a huge number of psychiatrists, we are working to see if we can actually support that PCP right there in their office through an appointment immediately with one of our telemental health providers. So that's the PCP level.

We also have the disease management level, which is anybody with a serious chronic medical condition, heart failure, diabetes, all get enrolled in a UnitedHealthcare Optum disease management program. And we work hand in hand with those nurses that manage those members. And we

help the nurses really identify any kind of medi -- any kind behavioral health condition that might be occurring. They screen everybody now. That was not always the case.

And if there's a serious condition, they will refer it over to us, or, like I said, one of our providers like the AbleTo Program, where they actually address those chronic medically ill members that have behave -- that have depression and anxiety.

So we have a number of -- we also have a program called Life Solutions for those nurses, where we actually just kind of jump in and coach somebody who might have a behavioral health or substance use condition, but is not really interested in seeking treatment. We just provide them a coach to help them kind of meet their needs, their goals, and see at what point they might be amenable to moving into some behavioral health treatment.

So that's the kind of integration that we try to provide to your members. Does that --

VICE CHAIRPERSON RUBALCAVA: Thank you. It sounds like a very robust program. Thank you.

DR. MEYERHOFF: Thank you.

VICE CHAIRPERSON RUBALCAVA: Thank you, Mr. Chair. I'm very happy to hear that although they have different models and approaches, they are working to interface with our members and appreciate that.

CHAIRPERSON FECKNER: Very good. Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. Thank you all for this -- the time you're spending with us and your openness to answer our questions and have the discussion. A couple things that kind of come to mind. I happen to -- the other day to be over at the Crocker. I don't know if anybody has been over there for -- they've got a -- the Journey to Hope Exhibition. And it's art inspired by writing by people about their mental health and its impact on their life. And so it's a wonderful exhibition. And if you go when they have the artists and the writers there, you can -- you speak with them. And some of these really common themes came up, both in terms of why they were there and some of the challenges they faced. And the issue of dealing with the stigma, and dealing with the judgment, and everything, to get over those initial barriers to get help.

So I'm really encouraged at all of you are really making the effort and the investment, because that's -- when you get the kind of root cause why, why, why, why, you get to that, certainly on our member's side of recognizing, and being aware, and accessing help.

But the other thing that struck me is -- in so many other stories was not just access, but continuity of

care. And particularly, as you had mentioned, sir, when there's these comorbidities with the -- especially things like chronic pain that they run into kind of a one-size-fits-all type of approach. And for that 25 percent, or whatever it is, to go through all the hurdles of being required to go through all these approaches that aren't really effective for them, like spending a lot of time with cognitive behavioral therapies that are just frustrating the heck out of them. So again, I'm really encouraged to see that there's some recognitions that we need to get a little more focused on getting the correct care plans, the correct -- for the -- for them.

And finally, what it really seems to come down to with a lot of this is capability and capacity issues, whether it be turnover and mobility of professionals, so that patients who finally get to where they've established and are making progress, and suddenly they no longer have access to that person, because they move to another location, or another city, or change careers, or whatever, and it seems that some of it is, at this point, at a level that's kind of beyond what the approaches are addressing.

And there's almost this artificial shortage of capability and capacity just in terms of having access to the professionals, whether it be physicians, or health care paraprofessionals, or -- because the pipeline is

constricted right from the get-go in the medical educational systems and is very constrained, in terms of new graduates, in terms of who can be accepted and get through, in terms of the cost to all those barriers. And I'm curious if your organizations or your industry has been looking at how do we change the fundamental model, if necessary, to be able to have the number of nurses, physicians, physician's assistants, psychiatrists, post-graduate medical programs, where we don't have this really artificially created shortage.

Because there are plenty of people capable of doing these careers, but the vast majority of them are excluded from the get-go, because there's such a limited -- limited opportunities for them.

DR. MEYERHOFF: So I can jump in first. First of all, I want to comment on the art show, which is -- you know, that's really where we need to find the solutions is bringing the shame and stigma out into the open and having open conversations about mental health and substance use. And shows like that I think really help facilitate that conversation. So I'm glad to hear that that's happening.

Number two --

COMMITTEE MEMBER MILLER: Through January 5th.

DR. MEYERHOFF: What?

COMMITTEE MEMBER MILLER: Through January 5th

right across the street.

DR. MEYERHOFF: Okay. That sounds great. Number two, you're exactly right that, you know, we used to be in the business of telling our members what they needed, when they needed it, and how they needed it. And, of course, that wasn't what was important to them, right? That wasn't what they were seeking when they were trying to get help for their substance use disorder or their mental health condition.

So we have retrained everyone of our front-line care advocates in the art of motivational interviewing. And the focus of that is really to find out from our members what do they want to get out of treatment and make that the goal of what we focus on, so that they're really -- you know, it may just be they want to get to their daughter's graduation in the summer, or a wedding, or they want to be able to walk further, or they want to be able to sleep better.

But we need to find out what they want to get out of treatment, not tell them what they should get out of treatment. And so we have completely revamped the way we train our front-line staff to get at that information.

And then thirdly, like I said, you know, we're doing our best to support training programs. But I think that changing the reimbursement will make those fields

more attractive, to go into mental health, and hopefully change some of the kind of trajectory that you're talking about.

DR. MILLMAN: If I could add a little bit to what was said here. We have some similar programs, so I won't go over those. And you had mentioned about chronic pain. And that's certainly -- it was a concern of mine when I was a provider. And one of the things that we were able to do at Blue Shield recently was to contract with a telebehavioral health provider that focuses on two exclusive areas, one is eating disorders, the other is opioids.

And in part of that, they -- for a local medical group here in the greater Sacramento, Bay Area, focus also on issues related to pain management around that. And they came to our attention, probably because of the medical group who had had such great success with them. So both Blue Shield and Magellan have separate, but very much overlapping, networks. And Magellan was able to contract with them this past summer, as well as Blue Shield to address that.

The pipeline portion that you speak of, it's not a major focus as yet. Although, I'm hoping it will become more of one. But last summer, I personally was able to have talks with one of the local medical schools about how

we might work together to develop some sort of relationship to support more behavioral health specialists, both medical and on the therapist side.

So -- and then I think Dr. Larios, you wanted to add?

DR. LARIOS: Thank you.

So I do want to add that we also actively pursue ensuring that our providers that are in-network have resources to refer members to. So it can be very frustrating to sit in a silo as a solo practitioner or small group practitioner, where you don't have resources to refer somebody out for food security, or for housing, or for legal.

And so to be able to link members to that through the health plan has been something that Blue Shield and Magellan have been very committed to. We have resources to link members, and the providers as well, to those resources. And I think expanding further in that realm is really where we've concentrated through 2019 and into 2020 is making sure that there are those links between our network providers. So that if there is something that they don't feel comfortable in handling in their outpatient clinic, they either have a higher level of care that they know that they can refer the member to or they have another provider within our network that they can

coordinate with.

DR. FRIEDMAN: I don't have whole lot to add other than I think your comments about the pipeline maybe, you know, sort of ahead of the curve and maybe where we all need to get to is -- maybe that challenge provided opportunities for health plans to start looking at ways to support training programs, like nurse practitioners, our -- you know, I think there's new a program for primary care nurse practitioners to get a certificate in mental health with a one-year program. And maybe health plans can find ways to support and -- those types of programs to get more providers into the community.

COMMITTEE MEMBER MILLER: Well, thank you all for your answers and coming out to speak with us today.

CHAIRPERSON FECKNER: Thank you.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Mr. Chair. Thank you for the presentation.

And our goal is to further improve the treatment to our members. And listening to your presentations and also comments from our Board members, Committee members, there's some takeaways that there seems to be a lot of work left to be done, and -- you know, whether it's dealing with the rates, or the reimbursement rates, or whether it's dealing with more resources, or staff time

dedicated to this area.

So what I would like to suggest, Mr. Chair, is that we get an update after -- giving the providers time to go back and address some of these issues that's been raised today and then report back to us on progress.

Having said that, looking at the UnitedHealth chart of improving access to behavioral health care, and I was trying to put some numbers to those percentages, because the previous chart there it talks about national data in terms of numbers, but the percentages talks about California. So what improvements in terms of what are those numbers for California where our members reside?

DR. MEYERHOFF: That's a great question

Sorry. It's a great question. I don't have those numbers on me today. We can get those immediately.

COMMITTEE MEMBER JONES: Okay.

DR. MEYERHOFF: But I don't have them on me. So I'm happy to report back to the Committee --

COMMITTEE MEMBER JONES: Okay. I appreciate that.

DR. MEYERHOFF: -- and get you those ac -- what those numbers actually are --

COMMITTEE MEMBER JONES: Right.

DR. MEYERHOFF: -- in terms of, you know, the entire spectrum of the services that we've increased over

the last couple years.

COMMITTEE MEMBER JONES: Okay. Appreciate that.

DR. MEYERHOFF: Yeah.

COMMITTEE MEMBER JONES: Okay.

CHAIRPERSON FECKNER: Thank you.

Ms. Middleton.

BOARD MEMBER MIDDLETON: Okay. Thank you, Mr. Chair. Just coming at the end, most things have already been said. But a couple of them will bear repeating.

First, I want to thank Dr. Meyerhoff and Dr. Hsieh, in particular, for partnering with the Trevor Project. The incidence of the need for access among LGBT youth is greater than it is in the larger population, not because of underlying issues of greater propensity for mental health issues, but because of the discrimination that is faced in the community.

So my thanks and congratulations. I am certain that those kinds of approaches need to be followed in all programs. I would like to ask what more do you believe can be done in working to integrate non-medical doctors into the treatment of the population? Clearly, we are not going to be able to produce the number of M.D.s that we need within the next few years to provide treatment.

Many of the treatments that are needed do not require medical doctors. I'd like to hear more on that

area.

Anyone of you can jump in.

DR. MEYERHOFF: Okay. I'll jump in. Well, thank you for your comments, because it really is important to reiterate that as often as we can, that, you know, there are all kinds of vulnerable populations. And the LGBTQ kids are particularly vulnerable and really need a lot more support.

I -- you know, we -- we all up at this table use as many ancillary personnel as we can who are prescribers, so nurse practitioners, physician assistants. But even those specialties now are in hot demand. The unemployment rate for nurse practitioners is zero. We actually -- UnitedHealthcare with our House Calls Program, employ the second largest number of nurse practitioners in the country, only second to the VA.

And these people either work -- see members in nursing homes, almost on a daily basis, to try to make sure we get ahead of any kind of, you know, medical or behavioral issues. But they also do these house calls and really visit people at home, and really address those social determinants of health, do mental health screenings, as well as medical screenings and really get people connected to the resources that they need.

But -- and, you know, PAs, the same thing, we

need to be able to access that network in a larger way who can prescribe. But I think, you know, there does need to be a conversation about how do we increase prescribing capability, because obviously, you know, we also need to increase probably the therapy capabilities.

But it sounded like your question was a little more about psychiatrist and medications. And so we do need to figure that out. And it's one of the reasons that we're looking at this program to help support PCPs do a little more advanced care and give them the out that they need if they get into trouble, because that is where a lot of people do get their primary mental health care today.

BOARD MEMBER MIDDLETON: I was very pleased to hear comments regarding those that are suffering from opioid abuse and for opioid addiction. My own experience within the workers' compensation system is frequently very, very frequently, issues of depression and anxiety were underlying and comorbidity with issues of pain.

And where we have individuals with opioid addictions, frequently there is a depressive issue as well. And following up the program to respond directly to first responders is something that is extremely important. I know from conversations in my city with our police officers and our firefighters, they have frequently found themselves in situations where they are exposed to human

nature at its worst, and human nature, in some of its most vulnerable and difficult situations. And so thank you for that program.

And while I'm issuing thanks to Dr. Logan and to all of my colleagues for taking the kind of time and attention that has been taken over the last couple of meetings to issues of mental health I think speaks for highly of CalPERS and its commitment to the greater health of our community.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Olivares.

BOARD MEMBER OLIVARES: Thank you for your presentations. As we were talking about reimbursement rates, I would like to follow up on Mr. Ruffino's questions. I think there was some language around the improvements in the reimbursement rates. I'd like to know if those could be quantified as a percentage of the median provider cash rate.

DR. LARIOS: So thank you for your question. I can give it more in a percentage of Medicare, because the cash rates as -- I'm sorry. I think it was Dr. Friedman had mentioned the cash rates can be so variable.

BOARD MEMBER OLIVARES: They vary by area.

DR. LARIOS: So the percentage of Medicare, we

are getting a hundred percent to over a hundred percent of Medicare reimbursements during our rate adjustments at Blue Shield Magellan.

BOARD MEMBER OLIVARES: How can we get that data by provider cash rate not Medicare rate?

DR. LARIOS: So I look to my colleagues on my right to see if you guys have any suggestions on getting the cash rates?

DR. FRIEDMAN: When you say cash rate, you're taking about a provider in the community -- if I'm a provider in the community, what do I -- if I say I don't insurance. This is what I charge. Here's my cash rate.

BOARD MEMBER OLIVARES: Exactly. Insurers have that data by metropolitan statistical area. And so I'm wondering if we can get that response, perhaps not now, but later.

DR. FRIEDMAN: Good takeaway. Yeah, I wouldn't have that data have, but, you know, most providers probably post it on their website or they're tell you what their case rate it.

BOARD MEMBER OLIVARES: Yes. Insurers have that data.

DR. MILLMAN: Yeah. That's something we'd have to probably talk to our actuarials about, track that kind of thing.

BOARD MEMBER OLIVARES: Yeah, it's in market data too.

DR. MEYERHOFF: We'll get you that data.

BOARD MEMBER OLIVARES: Thank you.

MR. PRETTYMAN: Yeah, the same with Blue Shield. We'll take that away and we what we could find.

BOARD MEMBER OLIVARES: Thank you.

CHAIRPERSON FECKNER: Anything else, Ms. Olivares?

BOARD MEMBER OLIVARES: No, thank you.

CHAIRPERSON FECKNER: Very good.

Mr. Perez.

BOARD MEMBER PEREZ: Good morning. Can you -- I understand the different programs will have different copays, but can you provide an example of what a copay would be for in-service -- or, I'm sorry, in-office visit? And then also one of the telecoms or web geniuses?

DR. FRIEDMAN: So I think copays vary. You know, they -- it -- they very by contract, I guess, you know, different -- every employer group or person negotiates different a arrangement. So, I mean, I've seen people have like $5 copays, or $20 copays, or it could be a percentage of the visit. But what I can tell --

BOARD MEMBER PEREZ: Let's say the State of California, because it's so big?

DR. FRIEDMAN: Sorry?

BOARD MEMBER PEREZ: Let's say the state of California.

DR. FRIEDMAN: No, I just -- it's just so different for each person's health plan. But the other part of your question was for telehealth. And the telehealth copay rate is the same as a regular in-office visit, right?

So if somebody is going to pay a $5 copay for an office visit, they're pay a $5 copay for their telehealth visit though Anthem's --

BOARD MEMBER PEREZ: Okay. What about State -- the State workers? I'm not -- I'm not a State worker, so I don't know what their copays are.

MR. HONAKER: Yeah. Our reimbursement for behavioral health is con --

CHAIRPERSON FECKNER: Identify yourself for the record, please.

MR. HONAKER: I don't --

CHAIRPERSON FECKNER: No, you're on, Rob. You need to identify yourself.

MR. HONAKER: Oh. Okay. Because of the mental --

BOARD MEMBER PEREZ: What's your name, sir, and who do you represent?

MR. HONAKER: Pardon me?

CHAIRPERSON FECKNER: Give us your name, Rob.

MR. HONAKER: Oh, that's tough one.

CHAIRPERSON FECKNER: The court reporter needs it.

MR. HONAKER: Okay. I got that. Rob Honaker, Anthem Blue Cross.

CHAIRPERSON FECKNER: There you go.

MR. HONAKER: Because of the Mental Health Parity Act, the reimbursements for the behavioral health services will be consistent with your medical benefits. So, for example, you have variable benefits within CalPERS. But primarily, your office visit is $15. That will be your office visit for the mental health. We extend that to the LiveHealth online.

Inpatient on a hospital is a hundred percent. Your Care program is 90 percent and your Choice is 80 percent. So again, it's consistent with your other benefits.

DR. MEYERHOFF: And with us, with your Medicare population, an in-person appointment is a $10 copay, your basic plan is a $15 copay in-person, and telehealth is a zero copay.

BOARD MEMBER PEREZ: Thank you. And then --

DR. LARIOS: Yeah, so it is the same copay for

in-office versus telehealth, so it's 10, 10, and 15 for the therapy visits.

BOARD MEMBER PEREZ: Thank you.

The -- and you all addressed the difficulty of people being able to get appointments and you -- when people try to call in several times, they can't get an appointment. Do you rise it -- elevate that call somehow? Is there a code word that the employee needs to use to get elevated, or is there a special phone number, or how do you guys track that?

DR. LARIOS: So for Blue Shield Magellan, if an employee calls in and says that I have looked on your website, I've called -- I've called providers, I can't get a hold of one. It actually gets escalated into our appointment search team.

If they call in and say I'm looking for providers, we will give them the option would you like a list for your to call or would you like for us to link you to our team to help you?

And we get about 30 percent of people who want us to look for the appointment and 70 percent want to start looking at their own. And I understand that. That's a really different type of relationship that they're going to have, so they want to do the interviewing of those psychiatrists or therapists.

DR. FRIEDMAN: So at Anthem, if a member is trying to find an appointment, and there's -- having trouble finding it themselves, they can call the member services number, and they will try to -- they help facilitate giving the patient the names of providers who are within the geographic area. If they're still having trouble, then Anthem will take over that role and start calling the providers within that geographic area and seeing if they have availability to see the member with this condition and then they'll facilitate that.

You know, if a member says, look, I'm calling five people, ten people, and I can get an appointment, but I found this one clinician, and they're not in your network. Well, if we don't have an in-network provider available, then we will pay the out-of-network provider at the in-network rates.

DR. MEYERHOFF: Yeah. And so very similar to our system. There really is no code word per se. But when people call in, we present them with the various ways in which they can get treatment, which sometimes they don't even know, they could do it right in their home, if that's what they choose to do. So I think that's an important piece to bring up early in that conversation.

We also do an assessment to make sure the person is not at risk or doesn't need something higher level at

that moment. And then we give them that choice, right? Do they want to interview a few people, do they want some names, or do they want us to look for an appointment?

But if they call a second time, we absolutely escalate that to our appointment search team. We have a dedicated team that just does that, and we will call the member back with that appointment.

BOARD MEMBER PEREZ: So I don't -- I didn't -- maybe you guys said it, I didn't copy it -- or I didn't hear you. The -- it's not tracked by like a medical record number. So if I just call in Joe Schmoe, and then two days later I call in Joe Schmoe, but I don't give you the whole backstory.

DR. MEYERHOFF: No, we'll see that you called immediately. We'll see that you called us a few days ago looking for an appointment. And we'll ask you how did that go? And presumably it didn't go well.

DR. FRIEDMAN: Yeah, and -- yeah, you would -- you would always be asked identifying information and a record with that -- of that would be kept in the record log, and there would be -- so if somebody else took the call, they would be able to continue that follow up.

BOARD MEMBER PEREZ: To the same extent that they would?

DR. FRIEDMAN: I think it's kind of standard

practice. And, you know, we're all regulated by the Department of Managed Care and these are pretty standard practices to document everything. And, yes, there's --

BOARD MEMBER PEREZ: Not the documentation, the escalation of the service.

DR. FRIEDMAN: Yeah. Yes. It will even get escalated to a licensed provider to understand the particular issues of the patient and try to match the best provider with that person.

DR. LARIOS: And so, yes, we document everybody who calls in. And we even put in the providers that we've provided, if we did send them a list, so that we can go through and understand. If those providers were not responsive, we follow up with them on our network team as well.

BOARD MEMBER PEREZ: Slick. Thank you all very much.

DR. LARIOS: Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Greene-Ross.

ACTING COMMITTEE MEMBER GREENE-ROSS: So first, I just wanted to thank the staff for responding to Controller Yee's request in August to hold these hearings, so that we could dig in and understand the complexities and ensure that our fund's beneficiaries are getting

timely access to quality health care. And we have definitely heard how -- from all you, and it sounds like you're all committed and passionate in trying to, you know, aggressively ensure parity for mental health access.

I -- we look at some of the national trends on legislation federally and across many states trying to ensure that pay parity is also out there. I know California's had some legislation last year. But given the complexities of the need to tap into these new innovative strategies to ensure access, especially in the rural areas into telemedicine and the other networks anticipating there will probably be some more efforts for legislation to ensure the quality of that care. And to that end, I hope our -- we're -- CalPERS can be helpful in hearing any of those legislative matters that might help improve access to care, that would be great going forward.

And lastly, I just wanted to ask our new Health Benefits Director, Mr. Moulds, who shared with me some of the work that they're putting into, as far as the customer survey enhancements, and how they're working with -- collaborating with other State providers. And how that will be integrated in our contracts going forward.

And specifically, Don, just because it sounded really important work, I thought you -- you should share it with everybody what you told me.

And lastly, you know, it is unfortunate, but again wanted to thank you all, because I definitely heard your cute awareness of the compassion and concerns, particularly about young adults, and focusing on children and veterans, and the LGBT community

So on behalf of Controller Yee, we very much appreciate your time and effort and continue with the good work on this. Thanks, Don.

CHAIRPERSON FECKNER: Thank you.

CHIEF HEALTH DIRECTOR MOULDS: Sure. Yeah. Happy to -- happy to share. And I mentioned this very briefly in the -- in our last meeting, but maybe add a little bit of detail.

And we've -- and this is -- this is prompted in part by the focus that Board has taken on mental health issues. But it's also just the right thing to do as well.

We've been talking to Covered California, as I've mentioned, about a number of common priorities and identified mental health -- improving the mental health care for all of our collective members as high priority for both of us. And as part of that, we're using it as sort of a test case to try to move forward with -- with both entities at the same time to increase our influence with health plans across California.

And as part of that, we've begun what I would

describe as a listening tour with national experts, Dr. Logan, and a number of the folks behind me have been on calls with staff from Covered California and national experts talking about a handful of key issues. What the best practices for measuring a plan's delivery of mental health services, quality of health care of mental health care, access to mental health care.

And a lot of the issues that surface today, integration with primary care, some of the challenges that can arise when you have what I describe as a carve-out situation where you have two separate legal entities providing mental health care on the one side with physical health care on the other.

So we've had some very good conversations to date. We're planning on wrapping up those discussions. One other thing, sorry, which is how you use the contract -- our contracts with health plans to drive some of those outcomes.

So you identify the north star and then you look at how you use our contracts to get to the north star in this space. So we're -- we're going to be -- we have some other calls lined up over the next, I think, six weeks or so. Be wrapping up that part in February I think is our goal. And then -- and then in the spring, we're going to be working together to try to come up with a common set of

measures and next steps.

The other part of this, of course, is decreasing the number of different messages that the plans are receiving from large purchasers in California, so that they're hearing -- they're looking at the same things, we're asking the same questions, and then we're able to compare notes with one another on performance.

So those are some of the things that we're doing internally that I think are going to be critical to making sure that we're doing the best we can in this space.

ACTING COMMITTEE MEMBER GREENE-ROSS: Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Ruffino.

ACTING BOARD MEMBER RUFFINO: Thank you, Mr. Chair. Sorry for taking up -- but two quick comments or questions. One about data and one about the process.

So with respect to process, do you think it's appropriate for patients with mental health conditions to be forced to make multiple phone calls, sometimes through unresponsive provider panels, to try to find care? And should patients struggling with depression bipolar disorder, anxiety disorders be forced to go through this burden? Wouldn't it be easier to provide each patient with a scheduled appointment with a provider, rather than forcing them to dial for care? Not sure. Just -- just

asking.

And the question about data real quick. I'm not sure if you have a data system that allows it to track whether its enrollees, when they're referred to Beacon and Magellan, or whatever, for care when they're, that they'll actually receive an appointment? Do you track that? Does the system, or whatever system you have in place, measure the elapsed wait time between the date when a patient is referred for mental health treatment and the date on which the patient actually receives treatment?

Do you guys have a system to calculate the drop-off rate that indicates the number of patient who are referred to external provider networks, but never get an appointment, or perhaps an appointment 60 days down the road?

So what is the drop-off rate and what are the elapsed time -- the wait time in each of your respective plans. I recognize that you may not have that right on your fingertips. But to President Jones' comment, you know, perhaps when -- if you come back to give us a additional information, perhaps you can provide some of that data to better understand and get a better picture. Because ultimately -- ultimately, and I hate to quote it, but the LA Times yesterday, the public perception out there is an I quote, I read you directly is that, "The

industry experts paint a more troubling picture of superficial gains that look good on paper, but do not translate into more effective and excessive care".

And that's what we need to fight. That's what we need to prove. We need to disprove this perception out there, that collectively you, as the provider, us, CalPERS, and everybody, that's what we are up against. And that's what we need to prove that they're wrong that we're doing it.

And I think we are. We're trying, but we have to be more aggressive in showing that we are.

Thank you, Mr. Chair.

CHAIRPERSON FECKNER: Than you. That's the end of our list. I do want to say before I ask you all to step back, thank you again for being here. Great presentation. Great dialogue and discussion back and forth. We all know that this is an issue for all of us to deal with. It's not just the providers. It's not just our system, but it's society in general.

I served on our local grand jury, and part of what we looked at was part of this issue. And we realized that our county had done away with their mental health program, and that falls to everyone. And then further study showed that 30 percent of those in our local jail are there because of mental health issues. That's not

where they need to be.

So we need to, as a society, address these issues. And hopefully having this dialogue and having people on the web watching and listening, that we'll be able to get more people that are interested in this field. And they can help alleviate some of the problems that we have with not having enough providers.

So again, I want to thank you all very much for being here. A great presentation.

We do have some requests to speak from the audience, but I'll wait until after you'll taken a seat back and we're going to take a ten-minute break for our court reporter. So we'll be back here at 11:10.

DR. FRIEDMAN: Thank you so much.

Thank you.

CHAIRPERSON FECKNER: Thank you.

(Off record: 11:02 a.m.)

(Thereupon a recess was taken.)

(On record: 11:12 a.m.)

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

Thank you. So we do have three requests to speak from the audience. I do want to, first of all, again, thank Dr. Logan for helping put this together. It was a great presentation. Thank you.

We have Phyllis Johnson, Fred Seavey, and Jerry Fountain. Please come forward. The microphones are one. Please identify yourselves for the record. You'll have up to three minutes for your comments.

MS. JOHNSON: Phyllis Johnson representing California State Retirees, but a general question is in order. I've heard a lot about coverage after the fact. My question is what's being done for prevention and early care in the early years to prevent mental illness from getting too far too quick?

Thank you.

CHAIRPERSON FECKNER: Thank you.

MR. FOUNTAIN: Okay. Jerry Fountain, Chief Financial Officer of the California State Retirees. I believe I heard a statement. And if I'm wrong, please correct me, that if a person seeks help through a practitioner and cannot get one in-network and they have to go to an out-network, the out-network provider is paid at the in-network price.

I was wondering if there's anything that the organizations do to mitigate that extra expense that the individual would receive, that may contribute to their mental condition, or would it force them to not seek help, because they can't afford the difference between in-care and out -- in-provide and out-provider.

Thank you.

CHAIRPERSON FECKNER: Thank you.

We'll make sure that we get those answers for you and we'll have them for our next meeting.

MR. FOUNTAIN: I appreciate that.

CHAIRPERSON FECKNER: Thank you.

MR. SEAVEY: Hi. Fred Seavey with the National Union of Healthcare Workers. We're a union of 15,000 caregivers in California, including 4,000 mental health therapists, who practice in the private sector. We're the largest union of private sector mental health therapists in the state.

You know, first of all, we want to thank the Committee for its focus on mental health. We think it's extremely important. As others have referenced, you know, public health data indicate the growing incidence of mental illness and substance use disorders across the U.S.

And just as example, the CDC recently released reports and suicide is now one of the top ten leading causes of death in the U.S. And among adolescents between age 14 and 17, suicide is the leading cause of death.

So these are not only illnesses that are on the rise in our society, but they're life-threatening illnesses oftentimes.

So again, want to thank the Committee. Just

three quick comments. You know, first, as far as the adequacy of the provider networks, you know, we have experience, because Kaiser uses both Beacon and Magellan. And we've interacted with more than a thousand consumers and a lot of therapists.

But we have lots of experience about sort of these phantom provider networks, in other words, lists of providers that are on paper. But when patients seek to actually access them, they have huge difficulties. And they'll call through dozens and dozens of therapists trying to get care.

I had one patient she phones through 100 therapists. This is following a suicide attempt and couldn't access care. Another, who was diagnosed with depression and referred out to Beacon or Magellan. Made 92 calls over five months, again without any care. And the plan did not track the weights and had no indication that this patient never received any care whatsoever.

And I think also it's -- many of these patients -- I mean, imagine they're functionally compromised with the conditions that they have. But imagine having depression where you have difficulty getting out of bed every morning and then being asked to phone through, not only just five, but it could be 20 or 40 therapists to try to get care, and await their return

calls and emails.

It's just not appropriate care. And what we find is each time you erect an obstacle in front a patient that they have to leap over or crawl through to access care, you'll find a certain percentage of the patient population drops out. And they throw up their arms and walk away without care. They may cycle downwards into crises or try to pay out of pocket for their own care.

Secondly, in terms of the workforce shortage, there was lots of discussion here today. I wanted to point the Committee to a report that was issued by the California Legislative Analyst's Office in May of 2019, where they described mixed evidence of a workforce shortage.

They said, yes, there are shortages among therapists in rural areas, and the Inland empire, but the rest of the state has adequate therapists. I think the -- in our experience, the fundamental problem here, someone mentioned it early, it's a supply and demand question. But it has to do with the reimbursements rates. And many of these external therapists report to us that their rates have not risen in many, many years, and are inadequate, and that they can receive much more from cash paying patients.

So when they get the call from a patient referred

by Beacon, Magellan, et cetera, they'll often -- they'll say their panel is fall. And they won't take those patients, because simply the reimbursement rate is too low.

Thank you very much.

CHAIRPERSON FECKNER: Thank you.

All right. That bring us to Agenda Item 6b, summary of Committee Direction.

Mr. Moulds.

CHIEF HEALTH DIRECTOR MOULDS: Sure. Let me -- so I've got -- I've got five items to report back on. The first is was the item that Mr. Rubalcava mentioned, and the question was whether the PERS Select app can identify women eligible for the Feature Moms Program and the current -- and the coinsurance reduction, or whether there's any possibility of using that in a -- to do an earlier identification. We will look at that and get back to you.

Second was from Mr. Jones and that was just a request for a general update at a future Board meeting on the progress on some of the key area -- in some of the key areas, where there was widespread acknowledgement by the folks presenting today that we're in need of progress.

I would add to that, the average wait times that Mr. Perez mentioned I can just sort of roll that into --

to that general report. So we will report back to you at a future meeting on those items.

Third, of the new mental health providers nationally, what percent are located in California?

Fourth, what is the cash rate? This was Ms. Olivares' question, what is the cash rate for a mental health provider reimbursement by MSA?

And then the last one was the -- in cases where a member identifies a provider who is out-of-network as the available provider, is that provider reimbursed only in-network rates. There is a -- it's actually more complicated than that. But we will -- rather than get into it now, we can -- we can report back along with these other items to the Board.

CHAIRPERSON FECKNER: I think more to the question was is the member paying a higher fee than otherwise if it's out of network.

CHIEF HEALTH DIRECTOR: Yeah.

CHAIRPERSON FECKNER: So Great. Thank you.

Next is item 6c. I have two requests from the public to speak, Larry Woodson and Tim Behrens, please come forward. You'll have up to three minutes for your comments and the microphones are on.

MR. BEHRENS: Go ahead.

MR. WOODSON: I was going to defer to seniority.

(Laughter.)

CHAIRPERSON FECKNER: He wants to be last.

MR. WOODSON: Larry Woodson, California State Retirees. Thank you for the opportunity to comment, Chairman Feckner and Board members.

I want to comment on some news that was just breaking today, or maybe late yesterday, the House of Representatives leadership has reached a bipartisan agreement, which is rare commodity these days, on a budget bill with some accompanying provisions that would be very beneficial to us at CalPERS with health plans, and specifically cancellation -- permanent cancellation of the Cadillac Tax, the HIT tax, and tax on medical devices.

And also, The White House apparently has been in the loop on this and is supportive. So if it comes to pass, I would urge CalPERS to bring UnitedHealthcare back to the table, renegotiate the contract with them, because they used the HIT tax to justify the large premium increases for 2020. Other carriers may have also used the same justification. So this is kind of an early heads-up, but CSR, if it does pass, will be back asking the same thing more formally.

Secondly, I'd like to comment on the Santa Barbara contract, Anthem contract impasses that I just heard about for the first time. And I talked to some of

my colleagues here, and they hadn't heard either. And it seems very late in the game to be telling us about this.

But I think Dr. Molds mentioned that it -- I'm assuming it would apply in 2020. And he clarified that it's just for PPO -- Anthem PPO not HMO plans. But I don't think he specified if it's -- that the supplemental Medicare plans are not included. Is that -- is it just the basic plans? And that was the case before with other breakdowns.

And then late -- you know, I've been doing this for four years. And this last year, it's become way too common or Anthem to have hospital contract negotiations break down at the last minute and not be able to reach them.

And so I appreciate the need to control hospital costs. CalPERS itself has a big say in this. It's not just Anthem on these self-funded plans. You set the guidance that they follow.

And so the last thing is I'd like to request a copy of the letter that was sent to members. I'd appreciate that.

Thank you for your time.

CHAIRPERSON FECKNER: Thank you.

CHIEF HEALTH DIRECTOR MOULDS: Can I -- just one clarification, Anthem traditional HMO, correct, or is it

Select HMO -- one of the Anthem HMOs would be implicated here.

MR. WOODSON: Right, but it's the PPO supplements that I'm asking about.

MR. HONAKER: And I -- thank you. Rob Honaker, Anthem Blue Cross.

CHAIRPERSON FECKNER: There you go.

MR. HONAKER: Yeah, thank you.

(Laughter.)

MR. HONAKER: I just through I'd address the Medicare supplement. It will have no implication on that. We will supplement the benefits based on the Medicare reimbursements, so your members won't be impacted on Medicare supplement.

MR. WOODSON: Okay. That's what I thought, but I wanted to make sure.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Behrens.

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

A great second shot at mental health this morning. I appreciate it. I think there may be an untapped resource in California that the different

providers can look at, and that's something called a Licensed Psychiatric Technician. That's a State employee classification now. And 13 years when I left State service at an institution, psych techs were going into the community, and into public, and corrections, and other jail systems, and evaluating mental health issues and mental health possibilities for inclusion into the State system.

I think this may be something that they could look at that would help them with their intake patients, and maybe cut down on the phone calls that have to be made repeatedly, and at least become part of the system that could redirect them. I know when CalPERS changed their system in the health care here, when we call in, we give our membership two instructions. If you're on Medicare, tell them right away, so they can direct you to the correct staff. If you're not, tell them right away and they can direct you to the same staff.

I'm hoping in the mental health system, that could be just as easy as that. You know, if you know what the issues is, you can direct them to somebody and they wont have to wait. Or as Mr. Ruffino pointed out, bad things happen.

The other thing I wanted to do is acknowledge Donna Lum for her 21 years of service. She has provided

outstanding service to the stakeholders of the California State Retirees. She's been instrumental in enhancing the communication system between CalPERS and the stakeholders.

And Donna, as promised, I brought you an application to join the California State Retirees.

(Laughter.)

(Applause.)

CHAIRPERSON FECKNER: Very good. Thank you. Seeing no other requests to speak, everyone have a great Holiday Season.

This meeting is adjourned.

(Thereupon California Public Employees' Retirement System, Pension and Health Benefits Committee meeting adjourned at 11:26 a.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 19th day of December, 2019.

JAMES F. PETERS, CSR
Certified Shorthand Reporter
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