COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, December 18, 2013 from 9:30 AM to 3:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

REASONS FOR MEETING

1. To provide an update from the County of Los Angeles Department of Mental Health.
2. To explain the OAC components of SB 82: Investment in Mental Health Wellness Act of 2013.
3. To give a brief update about the SAAC presentations and SAAC Enhancement Project.
4. To inform the SLT about the Department's approach to implementing the Affordable Care Act (ACA).
5. To provide guidance on the overlap between FSP focal populations and FSP ethnic targets.
6. To review the planning calendar for January through March 2014 to complete the Three Year Program and Expenditure Plan.

MEETING NOTES

Department of Mental Health - Update	***Marvin J. Southard, Director*, County of Los Angeles, Department of Mental Health** A. Dr. Southard provided an update on the law enforcement partnerships that DMH is developing. He discussed providing services for those in the LA County jail. He discussed the development of a plan for additional services, providing input for the facility of the future, 3 levels of diversion, and the upcoming spring summit with law enforcement. He also talked about the potential expansion of Laura's law programs, the development of new Urgent Care Centers. **FEEDBACK** 1. **Question:** I am thrilled that the LA County Jail is trying to use existing space to expand programs. They are getting minimal treatment so this is really good news. I wondered what your thoughts were about diverting people through the court besides just the current court of Alisa Dunn? a. **Response:** There are 3 ways of diversion: our existing approach, pre-booking diversion--there is a third diversion and treatment diversion. Sometimes we come to the opinion that the public and the individual are better served if that person were served in a treatment setting and not in the jail setting. That would be a post placement diversion program. b. **Response:** With regard to Judge Tynan's co-occurring court and other specialty courts, the limiting factor is that cutbacks the courts experienced in the last several years has led to the opinion of "no new boutique courts." We hope that a summit we are planning could change that opinion. 2. **Question:** If there is a pre-arrest diversion and the person attended to had committed a crime punishable by imprisonment/jail time; after the person is diverted and then they stabilize do they go to jail or do they go on probation? a. **Response:** No, with pre-booking diversion, if it works no charges are filed. They are not arrested. There is no record. 3. **Question:** Is there any way to expedite or help parents whose adult child is going to end up in law enforcement if they do

	not receive treatment? a. **Response:** ACA should help that. One of the ways that ACA should help that is that all plans now have to have a decent mental health benefit. That mental health benefit has to be applied with parity in mind. b. **Response:** Under ACA, if the adult child is 27 and no longer qualifies for their parent's insurance, they are very likely poor so would qualify for Medicaid expansion and therefore the treatment that they would be eligible for is 100% federally reimbursed and under parity they would have access to the full range of mental health services including rehabilitation services. Under the current law, unless they are a danger to self or others, we cannot make them use the benefits that they may have as eligibility. The next step in that direction is seeing if Laura's Law, under the right conditions, can incentivize people to participate in treatment that they might otherwise decline. 4. **Question:** Has Los Angeles County looked into programs like Certified Peer Support Specialist training where they do the wellness recovery action plan training in the jails? a. **Response:** We discussed some possibilities. The current limiting factor is space for those activities to take place within the institution as it currently exists. It requires space and sheriff's security to transport and manage those interactions. It is less an ideological problem and more a practical problem on how it would happen in the real world in a real place. 5. **Question:** Is there any consideration being given to reaching out to the health care insurance companies about the types of things that we found to be very effective and useful for adults, children and TAY aged youth and their families to try and get a comprehensive approach that is effective and beneficial to them--not just straight clinical treatment. a. **Response:** Our position is parity requires that you provide whatever is medically necessary for reaching recovery to be provided to individuals. Insofar as a team based recovery model service is medically necessary than it ought to be provided and, more importantly from our perspective, paid for. Those discussions and negotiations are current and ongoing.
SB 82: Investment in Mental Health Wellness Act of 2013	FEEDBACK 1. **Question:** Are you still planning to use people with lived experience who are working in the county as community workers or peer mental health advocates in this crisis team and are you planning to use people who are volunteers with stipends like wellness outreach workers and service extenders as part of the crisis Triage teams? a. **Response:** Yes, all of the above. 2. **Question:** Is it $9 million a year or $9 million over 3 years? **Response:** $9.1 million each year. That is the net dollars. 3. **Question:** Is inter-agency leveraging part of the plan? **Response:** It has to be. These individuals will have access to resources other than just ours. Housing, substance use, and all of those other resources are going to be important. 4. **Question:** Are we mapping this information into our existing strength of outcome generation information? **Response:** There will be ties to it, definitely. This also has its own reporting outcome requirements.

5. **Question:** Are the teams going to be RFPs that go out then to contract providers?
    a. **Response:** Yes, because both of those components will be contracted out.

    b. **Response:** The crisis transition specialists, the forensic outreach, and then the next one Dr. Byrd is going to talk about; those three will go out to bid.

6. **Question:** Will you be looking at getting the wellness recovery action plan, the certified peer support specialist trainings, and the intentional peer support-will that be brought into the jails-or programs similar to that?
    Response: The teams consist of persons with lived experience. As we know peer support is really critical for that population.

7. **Question:** Regarding the funds delivered to CHFFA, so the $40 million for Los Angeles county--that includes the facilities expenses-equipment and all that?
    Response: Yes.

8. **Question:** How many crisis transition specialists?
    Response: Under the CHFFA component, developing an additional 5 urgent care centers so there are centers located in all of our service areas. For the crisis transition specialists, we envision 8 teams with 2 people on a team. Each urgent care center would have a team assigned.

9. **Question:** Is the forensic outreach team solely for adults in county jails or will they also see youth that leaving camps?
    Response: It is for adults.

10. **Question:** What about juvenile justice? What about those children that are younger TAY and what about the children that are still with their families that call for crisis units and no one shows up? How come the distinction was made only to DCFS?
    Response: It is not solely DCFS. It will include probation, the crossover population, 241.1; we are really looking at high risk youth who can benefit from some short term triage services. We are aware that there are probation youth who are not involved with DCFS at all.

11. **Question:** The only piece I did not hear is children that are living at home that are high risk. Because they are not with protective services or juvenile justice they cannot access this?
    Response: Correct. The reason is that there is not a mechanism or an authority for us to intervene. They need to be on some way "public charge" for us to have the authority to come into a house and do the mediation that is required.

12. **Question:** DCFS kids that fail go to probation. That is kind of a given. The 241 does not cover kids that are solely probation. In terms of the gaps, you indicated that this money is supposed to talk about gaps. One of the concerns are children under the age of 12 who may need emergency intervention, possibly even hospitalization. Is that going to be addressed?

a. **Response:** This program is specifically for those placements where the issue is not mental illness and hospitalization is not required. If there is any chance that the issue is one of hospitalization then the PMRT team goes out as normal. This is meant to address those situations where it is clearly not mental illness, where it is a dispute between the caregiver and the kid or it is a placement issue.
b. **Response:** The goal here was to resolve the situation without medicalizing the kid's situation if it did not need to be.
c. **Response**: If it does need to be it would, of course, for safety or other issues, engage the hospitalization issue. The problem with the 'under 12' and the hospitalization is the lack of inpatient beds available. This program cannot deal with that problem.

13. **Question:** Is it a resource issue why we cannot expand it to the non-DCFS kids?
    a. **Response:** If they are not involved in DCFS but "at risk of" then the youth stabilization team might be accessed. The reality is going to be triaging the highest need youth for these very limited numbers of teams that we have. So, countywide, looking at triaging cases as they come in and making sure that those at highest risk get the services to actually stabilize their lives and placement and help them to continue to develop and grow.
    b. **Response:** I will put this in the category of "we are not the department of fixing everything." There are some areas where we have responsibility and some areas where we do not. We need to do a great job with those areas where we have a responsibility for before expanding to areas where we do not have a public charge responsibility. As you might imagine, the call would go to where to get the service for what purpose--it is not a mental illness issue, it is a placement issue--somebody is calling us, we are intervening, what's our authority and what's the liability?
    c. **Response:** I am just thinking about the PMRT calls for kids in the community who may not be attached to treatment but are also not a high enough level to be hospitalized. Someone needs to triage or link them into treatment.
    d. **Response:** If PMRT has responded that is the intervention that has taken place. If they need aftercare this team is not going to do the aftercare. They are not an aftercare team. They are a placement stabilization team. As you say, if we were going to do this, we would need a whole bunch more money as well.

14. **Question:** Is this a primarily a mental health team or are they responding solely to placement issues? As far as stabilization, are they going to include case management or mental health support during the stabilization period or just fix the problem, link the, and get out?
    a. **Response:** It started with the idea that PMRT gets called to address a situation that arises where a child's placement is not stable and where the social worker or probation officer could use some additional help or to make sure that the situation turns out best. If it is not a situation where somebody is at risk for themselves or for others then it is really not the first priority for PMRT.
    b. **Response:** So the thought in conjunction with DCFS was, "What if we develop a medium option involving stabilization?" The idea is that the team would have mental health and community expertise and be able to work on de-escalating the situation and working out a plan. But this team is not meant to be an alternate treatment team. That is the complication that sometimes impedes DCFS work. This team is not meant to the ongoing treatment team.
    c. **Response:** It evolved to integrate pieces of the Core Practice Model for DCFS kids, child and family teaming. In keeping with the model of the Core Practice Model and child family teaming we have identified case

management which will be more like intensive care coordination for the youth. So the team will provide behavioral health pieces; but also the case management to link and to follow the youth after they have been linked to make sure they are accessing the services that will help them.

15. **Question:** I am questioning the need to have a child and an adult professional on each team. Wouldn't it make more sense to have a child with a peer and an adult with a peer? Why send two providers as opposed to just one?
    a. **Response:** Because this is going to be a solicitation and bid out it has to be self sustaining. So with the limited amount of money identified for the youth placement stabilization team they have to be able to generate enough revenue to sustain the team. Because of the level of crises involved with some of the cases for which PMRT has called to respond we wanted people who had a mental health background to be available in case they needed to be in the placement for 3 or 4 hours dealing with a crisis that is escalating. So we wanted people with the training necessary to both claim for mental health services within their scope and the training to actually intervene to de-escalate a crisis; to work with the foster parent or placement to teach them skills or help them work more collaboratively with the youth and help stabilize once that team goes.
    b. **Response:** Wouldn't it be better to have the person always billing as opposed to the person you cannot bill because it is the wrong age group for them?

16. **Question:** Can you explain how two peers are going to serve 8 teams?
    a. **Response:** We hope to put the two aged out foster youth, the two peers, at the command post to help deal with the overstay issue and the linkage. In speaking with DCFS there is a high rate of youth declining placements. The State is concerned about overstays at the command post.
    b. **Response:** The Board of Supervisors has, at least for PMRT, insisted that response to DCFS cases consists of two licensed professionals. PMRT can use a licensed professional plus a community worker or a licensed professional plus a mental health medical caseworker. We have developed the staffing pattern presuming that the Board of Supervisors' directive to us remains the same. That is why the hiring of peers is attached to the command center rather than to the community response in this instance.

17. **Question:** Do you already have an anticipated outcome set for these different elements that would identify positive outcomes in advance? Do you also include in this model a quarterly review just like what we have been doing with a lot of other things where we have lessons learned and how to improve the process and system to also improve the outcomes as well?
    a. **Response:** Quality improvement in that sense, yes, that is necessary. We are applying for funding in this case. They have evaluation criteria and will look at our county as well as other counties in terms of meeting the outcome requirements, the data reported, and those types of things

18. **Question:** Regarding the overall priorities, as far as the multicultural county that we live in, what languages are you going to be prioritizing besides English?
    a. **Response:** We need to look at it by service area as well. This is the difficulty here: When we talk about individuals with lived experience we know that you are talking about an individual with lived experience as a mental health consumer. But you also have now lived experience as a veteran. And as it pertains to the underrepresented ethnic populations we have people with lived experience from a given geographic community or ethnic

community or a cultural group as well.

b. **Response:** How do satisfy those things? That is our constant struggle. We need some targets and goals in terms of what those languages and cultures should be at least through our process in terms of hiring.
c. **Response:** It is just not consumers. We have outreach workers which are stipend. We also hire mental health advocates into our system who are paid employees of the county. They can promote up to a community worker. We also added senior community workers as well.

19. **Comment:** I am glad that the issue of linguistic capacity is in your minds. I wanted to say particularly for older adults, since there is an API county wide collaborative that deals with older adults, I hope that in the planning process if you receive the funding that maybe there is a partnership or subcontract that could go out. You are not going to be able to assess them or make a linkage because you will not have that language capacity.

20. **Comment:** In about 10 years half of our LA seniors will be immigrants. I will be one of them. It is not just the language capacity. We also have issues of hoarding and suicide. We have had good experience that when we did these types of services a lot of the cases where cases of hoarding so also have a hoarding task force that have access to, comprised not just not mental health but also of fire department and so forth. With the old old (85+). Half that commit suicide visit their primary care physician the month they commit suicide. Half of them–a quarter of them that commit suicide, commit suicide the day they visit their primary care physician.
    a. **Response:** And that is going to be the difficulty in implementing this. You do not want to implement any of these in isolation. They have to be connected with the existing resources.

21. **Question:** How do we tell if a community worker referred or applying to a crisis team is someone with lived experienced as is required in the law?

22. **Question:** Since the jobs created for peers are new jobs how does DMH plan to interview people from the mental health advocate list as potential crisis team members?
    a. **Response:** Much of this is contracted out so the questions do not apply at all because the hiring process in the community agencies is what it is. It is not the DMH process. Within the DMH hiring process the issue, as I understand it, is the concern that the promotions to community worker will be for anybody who could be a community worker rather than people with lived experience.
    b. **Response**: So we cannot have an LA County process in which we say, "Only people with this characteristic, racial, ethnic, or medical qualify" because that is discriminatory. What we can do is say that we will, in the interview process, give extra consideration to individuals with lived experience. In this case that is a crucial consideration. But it cannot be a part of the hiring bulletin if that is what you are doing because we cannot do that.
    c. **Response**: The answer to the question is it will be a part of the interview process. The reason that we will adhere to that in the interview process is because it is what we need for the program. If we do not get people with lived experiences in mental illness the program will not work right. That is why we will hire according to the way its set up.

23. **Question:** People who are wellness outreach workers (WOW) or service extenders (older adults) who may be qualified for

crisis teams are often on SSI or SSDI. What guarantees do these volunteers have if they report their stipends to social security as they are required to do that they will be invited back to volunteer as a member of the crisis team from month to month?

Response: We do not see the addition of these WOW workers to these teams as an as needed basis. We have budgeted for 6 positions per 8 teams so it is not as needed. Generally it is an annual basis that we are working with our WOW workers and then their badges have to be renewed after that. So it isn't a month to month basis.

24. **Question:** Regardless of the increase of the stipends, how does DMH legally and ethically justify using peers as crisis workers who are not employees, have no protections under the law that employees in public mental health have and receive stipends that do not allow them to live above the poverty level?
    Response: We do not see WOW as an ending step for our consumers. That is never why the program was developed. The program was developed for our consumers to believe in themselves and reinforce that they can move forward. Many of our volunteers are very passionate about giving back and want to do this. We do not encourage people to remain WOW workers forever nor do we try to lock them into something. We are always trying to assist them in moving forward toward employment in whatever they want to.

25. **Question:** That is not enough time to build one from scratch.
    Response: No, it is not. What the State has told us is that we need to present a timeline that includes not just the process of implementing a program like this one but also the fact that there are licensing, permits--those kinds of things needed in our timeline. This grant does not provide funding for services.

26. **Question:** In regard to the areas that are covered in service by Tri-Cities, are you going to get close to those areas or are we not going to step into those areas?
    Response: Tri-city is actively involved in our planning process. What we are hoping to do is locate one urgent care center in that area as well as the crisis residential.

27. **Question:** What about peer run?
    Response: Peers will be an active part of each of the programs.

28. **Question:** Will they run the programs?
    Response: No.

29. **Comment:** The model that they are proposing--it is a team of 2, which is correct. But it is a clinician and a community worker, which could be a peer. The two identified peer advocates that they are talking about are not going to be assigned to each one of the teams. Those 2 individuals are going to be assigned to the command center.

30. **Comment:** We call it the command post. It is our 24/7 center from which children services responds to immediate child safety crisis including parents who call and say, "come take my kid, I cannot handle him anymore." They call the child abuse hotline. The child abuse hotline is housed directly with the command post.

31. **Comment:** The model for the other teams would be a clinician and community worker. Those are the teams that will be

responding to situations that may occur in a placement. What got confused when Dr. Southard was talking about the board requirement of two licensed persons, that was for the regular PMRT involved in DCFS cases. This is different. It will be in our proposal to the state.

32. **Comment:** The peers at command post were intended to continue to help stabilize the youth once they are brought into the command post and they are awaiting placement elsewhere or waiting to return to the same placement from which they had left.

33. **Comment:** In children services when we have crises, they are often family crises. Sometimes it is the child that is in crisis and sometimes it is the parent or foster parent that is in crisis. It is very useful to have expertise in both adults and children on team calls because you do not know who the person in crisis is.

34. **Comment:** As a community member there are a lot of youth that definitely need services. Being in service area 6 and being at the schools there is a lot of youth that end up either in our prison system or just unserved or unmet. Although I agree that we cannot help everyone, at the same time when in the trenches and you see this on a day to day basis, it is a dilemma.

35. **Comment:** Carmen had also echoed a same issue in terms of, "what about the folks who are not in a placement--before they even get there."

36. **Comment:** I think to help the TAY and youth, I think there should be more TAY aged peers. So when the [inaudible] or the PMRT or [inaudible] the youth, there be a youth peer to say, "I had their experience." They could address the problem the youth [inaudible] adult or older adult on their team--to have a youth peer on their team to help that youth and say, "you are not alone. I have been through this."

37. **Comment:** I think that is the plan for folks that might be assigned to the command post. That whole issue--at some point we need to address it. Technically, it is not within our population and our funding and that kind of stuff, but those are truly areas where you can actually do some prevention and early intervention but not early intervention as we define it because it may not be a clinical intervention type of thing. At some point, we as part of this whole system need to address it.

38. **Comment**: I know it has kind of been decided but in cases there is any wiggle room, on the service area mobile teams that are being planned, perhaps the children could be a fourth target population after homeless, veterans, and older adults. Maybe we need community children, not DCFS children, but community children.

39. **Comment:** We have a unique opportunity since we have been developing this system for the past 3 years and the 4 years that I know about to look at collaboration strategies, referral capabilities, and teaming strategies that make this possible to work. As you are out there experiencing it you are going to see things that come popping out and say, "hey, this is a problem and we need to do that." I think this would be a good thing to say at some point, "here's the strategy we are going to address those issues in these communities that we say." For me it is the immigrant population that concerns me whether you are from Africa, the Eastern European population, the Hispanic populations from south of our borders, it

does not matter. You can be an immigrant and still not understand the culture that you just immersed yourself into--the big divide that goes on between the culture they came from and the culture they are now migrating to. That creates a lot of problems too. I am hoping that, as these pop up, we come up with strategies on how to better collaborate and integrate these services.

40. **Comment:** Regarding the jails in terms of trying to reconfigure Tower 1 to possibly give more services to the inmates that are there just getting sicker everyday--believe me I know that. He said this another of times in the past: "We cannot really work with the Sheriff's Department because they are them and we are us." Yet, I have been working with Brandt Chode who is the director of the educational based incarceration program. He has come to try to talk to the department of mental health people in the weekly meetings. There just does not seem to be any willingness to try to brainstorm and come up with, "how can we have groups and how can we get the sheriff on board to do more supervision and how can we get people from Antioch that want to come in and give services to these inmates?"

    Response: He needs to have other people working with him. He needs assistance. What we need is that new 82 money possibly to pay for an assistant for Brandt Chode who is the educational based incarceration program to work only with jail mental health.

41. **Comment:** I wanted to congratulate the team for including culturally sensitive and cultural competency in this information. The fact that you guys are developing and implementing culturally responsive field based Triage teams, I think it is really wonderful, especially with the types of populations that we are dealing with. That is so needed. The fact that you guys have, as a target population, the underrepresented ethnic populations and underserved, included in all of the programs that you guys are talking about here--I just want to say, "Thank you."

42. **Comment:** Between now and January 1, I would ask that what I have heard today, LA County does not have to compete for the money. Yet, at the same time, LA County is the role model for everybody else. If in our proposal we are looking at the fact that it is either compete or collaborate and if we deal with the issues of collaboration within our own county so that we become the pattern for others it can be really important. I ask that you keep that in your focus as we go forward.

43. **Comment:** That is one of the core requirements of the funding--the collaboration. It will be within the county, law enforcement, health services, other community groups, provides, those types of things, DCFS--so yes that has to be a key thing. Plus, also we have to coordinate these things. There are so many things going on out there. It is amazing what we do not know about, even within our own system, what folks are doing. We do not have the resources to meet the need. That is why we need to kind of coordinate these efforts.

44. **Comment:** Talking about the forgotten service area, service area 1, Antelope Valley--I went out to Antelope Valley last year. I am going out there tomorrow for the commissioner meeting. There are hardly any services out there. They have one psych unit with 14 or 15 beds. If [inaudible] they take you to LA, [inaudible] San Fernando Valley, [inaudible] Long Beach, [inaudible] outside the county. There is no transportation out there--no bus services. The sheriff is the only law enforcement out there. [inaudible] What we should do is have a command post in the Antelope Valley so they could work with agencies in the Antelope Valley to improve services in the Antelope Valley. That is the forgotten service area county.

45. **Comment:** They are not forgotten in these particular efforts because they are also going to get resources on both sites,

	the CHAFA as well as the mobile Triage personnel.
DMH's Approach to Implementing ACA	***Dennis Murata, MSW, Deputy Director, Program Support Bureau*, County of Los Angeles, Department of Mental Health** A. This morning what I want to discuss what things will change January 1st and what does not. I am going to talk a little bit about what does change for beneficiaries after January 1st: the managed care implementation for the Medicaid expansion population, the new mental health benefits available through the managed care plans, and the impact on specialty mental health. I will update you on we have done so far, and where we think we are going. B. Covered California is basically private health insurance for individuals and families above 138% of the federal poverty level. People whose incomes are above 138% of the federal poverty level and up can now enroll in what are basically tantamount to private health plans. There are different levels of coverage: the platinum level, the gold level, the silver level, they all carry with them different entitlements, different co-pays, different deductibles, but people above 138% of the federal poverty level have a choice among those plans. This is basically federally subsidized insurance for health care based on income and family size. In Los Angeles County, the private health plans that will deliver services through Covered California include LA Care, Health Net, Kaiser, Anthem Blue Cross, and Molina Health Care. C. The Medicaid expansion is for individuals and families who are up to 138% of the federal poverty level. We have been delivering services to that income group through Healthy Way LA. If people chose to enroll in Health Way LA, up to a 138% of the federal poverty level they were eligible. Since November 2010, DMH and subsequently all of our providers were delivering Healthy Way LA mental health services to individuals who met the eligibility criteria for that benefit. D. As of midnight on December 31st, Healthy Way LA goes off into the sunset. The beneficiaries who have been enrolled in Healthy Way LA will automatically be transferred over into the Medicaid expansion as of January 1st. They are getting information about whether they choose to stay with their existing health care provider or whether they want to choose another health care provider. For people who do not make a choice they will stay with their existing providers. E. The other change, and this is huge, is that the Medicaid expansion beneficiaries will be enrolled in and will enroll if they haven't already in one of two health plans for their primary care services. They will enroll or are already enrolled in either LA Care or Health Net. After January 1st and this is the big change, LA Care and Health Net will provide non specialty mental health services to their beneficiaries. DMH and our contractors will continue to deliver specialty mental health services. F. What does not change after January 1st is that DMH and our providers continue to deliver those specialty mental health services to eligible individuals who meet the Medi-Cal medical necessity criteria for specialty mental health. What changes, is that the managed care plans become responsible for the delivery of non specialty mental health services to the enrolled beneficiaries. G. Medi-Cal medical necessity criteria for people to receive specialty mental health services, the mental health services that we deliver, include having a covered DSM diagnoses, significant functional impairment, a condition for which effective

intervention exists, and an intervention that is required for improvement in a person's mental health condition or to prevent deterioration. So there has to be an intervention that we can offer and that intervention needs to be important to that person because otherwise if they did not receive it they might deteriorate or fail to maintain their current status. Finally, for specialty mental health services the condition is not responsive for physical health care based treatment. There has to be a reason why people are coming to us rather than just being treated by their primary care provider. That has always been the case.

H. What are non-specialty mental health services? Non-specialty mental health services still need to meet medical necessity criteria for the health plans. Those criteria were defined by the state as follows: non specialty health services are those that are medically necessary, that protect life, prevent significant illness or disability, or alleviate pain to the diagnosis and treatment to the disease, illness, or injury. The criteria that they are using for non-specialty mental health services include the following: an included diagnosis, which is the same as it is for us, mild to moderate functional impairment; that is the big key. For people to get specialty mental health services they have to meet the definition of significant functional impairment and for non-specialty mental health services they just have to mild to moderate functional impairment.

I. How do we differentiate moderate from significant? Nothing has been put out from the state, the health plans, or any of the county mental health departments that will explicitly help people know the difference. The 3rd criteria for non specialty is that the person is best served in a primary care or non specialty environment. Managed care plans will provide the following services: a mental health assessment--in fact they are obligated to do that; at least a screening and assessment for beneficiaries with potential mental health conditions--they will deliver and offer individual and group evaluation and treatment, psychological testing as necessary for evaluation, psychiatric consultation to primary care providers, and outpatient labs, drugs and supplies.

J. What changes after January 1st? Not much. We continue to deliver services to individuals who meet the criteria for specialty mental health services and to serve as the local mental health plan to oversee the delivery of those services, the quality assurance related to those services, the contracting for those services--nothing changes in terms of the DMH role. Things that we do expect to change as of January 1st: there are many administrative requirements that are part of the MOUs between the health plans and the department and DPH and that are also a requirement by CMS and the state. Some of these are pre-existing but will be emphasized even more after January 1st. They include: access requirements. There is some debate about how quickly we need to see people who have a specialty mental health included condition.

K. EQRO (External Quality Review Organization); when they have been here they set a standard of 30 days. I have seen 14 days. The actual determination of what benchmarks will be required to meet will be negotiated in the MOU. Nevertheless, we will be working now and will be talking with providers tomorrow at the all providers meeting, about our efforts to work with the health plans to differentiate people who have an urgent need to be seen versus individuals who can be seen and given a regular appointment to access care; how we will differentiate those two levels, what requirements we will put in place, and how we will ensure that those timeliness requirements are met in terms of access.

L. Number 2: we have a tracking requirement. Many have you have been doing tracking under Healthy Way LA of the referrals that you received through the health providers who have Healthy Way LA beneficiaries. But that pool of medical

providers that delivered Healthy Way LA services is going to expand when we go into health reform.

M. The Healthy Way LA medical providers included DHS and the community projects. After January 1st, we will be coordinating our services with LA Care and Health Net and all of their contractors, which will include DHS as a contractor of the two plans, but it will also include many FQHCs in Los Angeles County. Many managed care entities that are subcontractors of LA Care and Health Net including Molina Healthcare, Care More, Care First, and Kaiser; they have many subsidiary contract providers. All of those providers, should they identify a child, a TAY, an adult, or an older adult with a specialty mental health need, they will be referring to us as they always could in the past. But we will increasingly be held to a standard that ensures that we provide timely access for those individuals that are referred and that that we coordinate care with the primary care providers and communicate to ensure that we are working together on a plan for that beneficiary.

N. So the two big things for DMH are access to care and tracking. On January 1st it is not a change but a renewed emphasis on those two requirements. The other thing that changes in the other direction is that up until now if an individual did not meet our medical necessity criteria for specialty mental health there was no non specialty service to which they were entitled. They either met our criteria and if they did not all of us scrambled to try and find a self help group, a peer support, a counseling center in the community that would see somebody that did not meet our criteria.

O. Now we will have the option if someone comes to our programs who does not meet the Medi-Cal medical necessity criteria for specialty mental health those folks will have an entitlement on the health care side. We will be able to refer them back to LA Care, Health Net, or the primary health care providers and we will be able to say, "You know this person just does not meet specialty mental health medical necessity criteria but they need something." And the "something" happens in your world now.

P. I should also add that LA Care and Health Net are huge organizations. Mental health has not been their basic book of business; so each of them has contracted with a behavioral health entity to manage their non specialty services. So, for LA Care it is Beacon. And for Health Net it is Mental Health Network (MHN). Those are the intermediary entities that we will have the most contact with.

Q. So there are things that are on the horizon but it will not happen on January 1st most likely. Some of this will happen maybe February 1st or March, maybe June or July, or maybe 2014-15. We will have a renewed emphasis on coordinating clinical care for enrolled beneficiaries who are seen in our system and the health care system. The mechanisms for ensuring that is in place, other than saying that this is what we should do, will be spelled out shortly after January 1st. On January 1st access and tracking have to be in place. Coordination of care and discussion around the needs of beneficiaries should be in place January 1st but we need to continue to work on the mechanisms for exchanging information.

R. DMH has been involved in a very lengthy conversation with county counsel about constraints on sharing information or the circumstances and kind of information that we can share without special permission. We are working on that now because there is a lot of misunderstanding of what HIPPA says we can and cannot do. So we will be doing presentations and educating people about that as time goes on.

S. We will be working with the health plans on the expansion of the concept of health neighborhoods. Because care is so difficult to coordinate in a county as big as Los Angeles--it is not too hard if you are in Glenn County or Alpine where you've got one FQHC and one mental health agency and maybe you know each other pretty well and go out to lunch all the time--but in Los Angeles we have had a virtually unlimited number of different provider to provider arrangements. That makes it very difficult to coordinate here.

T. When we went into Healthy Way LA we began to--of course clients always have freedom of choice--but where a client did not have a particular provider or agency that they wanted to be seen in what we started to do is look at agencies that might share clients geographically. We paired FQHCs with contract agencies delivering specialty mental health services, DHS with DMH clinics, so that in the even they shared clients in common they could do a better and more meaningful job of coordinating care. Because Healthy Way LA was focused on adults those mini health neighborhoods were focused on relationships between providers who were serving adults. We are now about to start folding children's providers into those same neighborhoods. The next step for us is working with Wayne and SAPC on folding in the substance abuse providers.

U. Again clients will always have freedom of choice. We are not eliminating any access to any providers. But where we have providers who are in close geographic proximity it may just be more convenient to be selectively seen in those arrangements. There is unlimited potential in terms of the "Health Neighborhood" concept in terms of what we do about things like prevention and population health and specific underrepresented ethnic modifications and accommodations and understanding of what health and mental health look like among different populations.

FEEDBACK

1. **Question:** Will in-home services be provided in terms of those who are non-significantly or moderately impaired?
   Response: I do not know.

2. **Question:** You mentioned that the department was in significant discussions with county counsel regarding the sharing of information. CFR 42 is the more stringent of the regulations and that is in there too?
   Response: Understood. I have to say that the information sharing work group that we have had within DMH has been limited to the sharing of mental health information; not that we have ignored the issue of substance abuse information and the more stringent concerns there. Our county council Stephanie Reagan happens to be the HIPPA council for the county. She's quite aware of both the mental health issues and the substance abuse issues and she's going to be working with council for public health.

3. **Question:** How far along are we in terms of actually having a standardized system of tracking between managed care and DMH? For instance, assessments, is it going to be standardized and how far along are we in that process?
   a. **Response:** I am not sure I know what you mean by a "standardized tracking between"—
   b. **Response:** Not so much tracking but tools that we would be using.

	c. **Response:** That is what Wayne, Dr. Shaner, and Carlotta and I have been living for the last 2 months. We are still working on it. We are hoping that there will be one standardized screening tool. There is for Beacon and LA Care and DMH. Whether MHN will use that same tool is doubtful as of today because Health Net and MHN are in 16 counties. They prefer to use a tool that they are using in their other 15 counties besides Los Angeles. d. **Response:** What we are trying to do right now is to match the content of their assessments and ours so that we do not put a client through a 2 hour interview and then a day later send them another provider and have them give exactly the same information. We are matching the content so that clients do not have to repeat the same information, particularly the information that can be validated and is historic. So family history, history of hospitalization, history of outpatient treatment--that does not change. e. **Response:** You may, if you see a client for the first time, want to ask, "Well what's bringing you here today?" You may want to get an update on what the presenting issues are. But some of the information that is already established and part of somebody's history--they do not need to tell you every single time they come. That is the work we are doing now. All three entities, DMH, Beacon, and MHN are all agreeing that we will work on that together. 4. **Question:** We have an awful lot of people, professionals in crafts in entertainment, writing, and a variety of professions where they are really sole individuals and obtain their health coverage of professional associations of which they become members. Questions have been raised nationally that under the law as currently written these are to be eliminated. How do you deal with this? a. **Response:** I think the issues are dual. One of them is it depends on what benefit that professional organization offered. If they offered a benefit that did not meet the threshold for, say, mental health coverage then they would not qualify because of that kind of issue. b. **Response:** The main issue might be an issue of what's better for the individual. What those groups really do is they negotiated a group rate for the individuals. So the individuals did not have to do that alone. Now in the context of Covered California, for example, the individual may do better on their own than they would have been as done as part of a group. So it may not be an issue that that kind of coverage is not viable from a business perspective. 5. **Question:** Is SCAN considered managed care? **Response:** Many health plans have both a private and public managed care component to them. SCAN is or was--for seniors was one of the managed care plans that was going to be included under LA Care for people who have both Medicare and Medi-Cal, which is going to be implemented in April. There has been some change in which managed care providers we are going to contract with LA Care for the dual eligible program. We are going to have to get back to you on whether SCAN is in or out.
FSP Slot Allocations	*Debbie Innes-Gomberg, PhD., MHSA Implementation and Outcomes Division*, County of Los Angeles, Department of Mental Health FEEDBACK 1. **Comment:** Service Area 5 is the first area you presented in. So far, the data is incredible and came out of the

whole. Now we need to find a way to apply it to our service area. What is apparent is that the voice coming out of the SAAC is being valued. For all of the constraints that are going on, we need to step up to the responsibility of the value of that voice. While we are giving you the best feedback we can in the timeframe it is important to continue with what Jackie has now called a living document. Where are these resources?" I am hearing this very loudly in this meeting. How will we form more collaborations? The resources and needs are out there. They just may not be brought together. How do we educate, inspire, and motivate ourselves to accept the facts?

2. **Question:** Has that been the experience of other people that have started to talk about the 3 year plan in your service area?

3. **Comment:** Our SAAC had you present on Friday-3 days ago. It is definitely a lot to digest and try to put together in 1 month. I think unfortunately, because we are under such time constraints, that the feedback that you are going to get is hopefully helpful but not as thorough as we would have liked to present. But we only have 1 or 2 opportunities to meet before the deadline.
   Response: While you are right for the 3 year plan, what this could prompt is a multi month and multi year process. Changes that we may make may not be reflected in the next fiscal year, '14-15, but may be reflected in '15-16, or '16-17. One of the things that a SAAC could do is say, "Here are some of the issues that are emerging in the SAAC. We need more time to give you recommendations but we wanted to put these on the table and let you know that we are thinking about this." Then you could take more time, and as a result add it into our annual update.

4. **Comment:** What I am seeing is that there is not enough time to do what we need to do. Can we make major changes at our annual update if we were to start looking more closely at what's going on? Would we be able to make changes? Aren't contracts for 3 years? How is that going to work?
   Response: I do not think the intention of the MHSA, when it called for a 3 year program and expenditure plan, was meant to be a time limited--"If you miss it, you have to wait 3 more years"--so I could envision that there are certain circumstances where it might take several months in a SAAC, SLT, or executive management team to come up with ideas that would then be implemented in future years. We do that in the department now. A good example is the crossover youth 241.1. That came up mid- year and that was a mid year adjustment to last year's annual update. Laura's Law is another example.

5. **Comment:** I am looking at the allocation of FSP slots and where they are going and how. Can we change change those? Would we be able to change the UREP and who is getting what? I am very interested in figuring out why it is that the penetration rate for African Americans is 250%. That means 150% more people are being served than we would expect in the general population which makes it look to me like it is being used as a control mechanism or a mechanism to disempowering people rather than to treat mental illness. That is pretty awful when you look at the number. We already know that African Americans are more likely to be in locked

facilities and are more likely to be over medicated and are more likely to be all these other things. We really need to start addressing that issue. I do not know how we do that before February.

6. **Comment:** That is one of the issues in terms of how we present the data and what the state does. That whole thing about "200% over," you have to consider it is not a good method in some cases. They are using a certain prevalence rate for African Americans that obviously are inappropriate. How do you over utilize to that degree? "What services are people accessing?" Historically, African Americans have been incarcerated, put in locked settings. "That is the nice thing about the data. It is not perfect. You shouldn't take it as if it is written in stone. Question it. We all have to question that data. "What is the prevalence rate?" Whatever rate they use for prevalence does not accurately reflect the community.

7. **Comment:** I think penetration is just one indicator of need and not necessarily the definer of that need. This is not the first time that this issue has been brought up. But in the African American community we are just as concerned about that because we have raised that at different meetings before. You have to really go deeper to find out what those dynamics are and what the drivers are for that need. I just do not want that data to be misperceived or misconstrued by the community.
   Response: The next discussion we get into we can talk a little bit more about this issue. We can look at really where the ethnic disparities are and what we need to do about that.

8. **Comment:** The whole point of planning is not just to establish goals that are never question but rather to establish at this point in time we have made a judgment. What is critical is the ongoing monitoring of what is going on. That is part of the planning process: change, revise, get better statistics and data, and do not be afraid. You will never have all of the data you want. You are going to have to make decisions in any of them.

9. **Comment:** There still is a question in the minds of the children's commission about how to get more diverse age group voices at the SAAC meetings. I would love some suggestions from the membership here how that particular concern can be addressed. I do not know also whether there are sufficient numbers of older American voices in those meetings.

10. **Comment:** In service area 3 there is a lot of Asian and Pacific Islanders and Latinos; West Covina, Baldwin Park, El Monte. Those 2 groups of people--and we talk about African Americans over utilizing service--African Americans are diagnosed with schizophrenia for example. About the APIs and Latinos, both of those groups, like African Americans, to talk about mental health issues is shameful. It is taboo. In service area 3 the director of services in service area 3 can advocate to educate those 2 groups of people about the importance of getting quality mental health services.

11. **Comment:** There are diverse communities in every service area and there are underrepresented communities

too. There is a lot of talk about cultural considerations and making sure that we meet these groups but there is also a blanket assumption about them. We have a large API population in our service area but our needs are so diverse. It is not just initial language. We have youngsters who have cultural conflicts with their parents because they grew up in a different life. We have Japanese Americans struggling with their parents being in the camps. It is the same with the Hispanics. The Hispanics are the largest served population in our service area and, yes, the immigrant Hispanic community does have that stigma. When we talk about cultural considerations we really have to break it down into the needs of those broad cultures. They are not monolithic.

12. **Question:** I thought it was part of the older adults focal population but it is not there--where you say "imminent risk for placement" or nursing home or released from an IMD as well because there are older adults in an IMD as well. Older adults also are in IMDs. They are also discharged by IMDs. Back to my box of the immigrant, half of older adults in 10 years will be immigrants.
    a. **Response:** You can see a Rubik's cube that we are trying to build. At the very top, in terms of equity, we want to make sure we are effective and equitable by age group. For each of those we have a focal population. We also have to make sure we have effectiveness and equity by service area. We know that the demographics by age are very unique by service area and so are the systems. But we cannot stop there. We have some core principles: client driven, cultural competence, community collaboration, etc. Whatever systems we create by age and that service area have to embody all 5 principles, not just one. All of this has to be focused on unserved, under served and inappropriately served.
    b. **Response:** We added under represented ethnic populations as an explicit under served, inappropriately served population. Within that, immigrants are part of almost every under represented ethnic population. We also developed targets in terms of the FSPs by ethnic, under served population.
    c. **Response:** I think it is our holistic task for us--when someone says, "I am proposing a new program for older adults"--that is fine, but again, it has to be client driven, family driven, etc. It has to embody those principles. We may have a program under TAY that is good as service integration. Some of your recommendations, for example, may have to do with quality of the service rather than the service being there.

13. **Question:** Where you see the "presence of one of the following co-occurring disorders", when we had that discussion, hoarding was not a disorder. With the ICD 10 coming out in October the DSM V will become in effect. Hoarding will become a disorder--that was part of the discussion, that hoarding will be added as another co-occurring disorder.

    Response: What we are trying to do here is show you what we have. Then in January, we are going to have a session where we are going to go through this. We cannot take anything out. But if we are going to add anything else in terms of the criteria we have to be clear about the justification so we are clear about why it is being added.

14. **Question:** The allocations for the age groups were based on the 2000 census. Older adults had a percentage of the allocation for FSPs based on the 2000 census. By the time the MHSA and FSPs came into effect older adults were already about 15% of the population. We only got 8%. By now it is probably close to 20%. Now we have the 2010 census. The final thing is one thing that we have to wait in terms of how we are going to allocate FSP funding--extensions for FSP--with the ACA coming out in January, those under the ACA, the feds are going to cover 100%. If the feds are covering 100% for 3 years and then 90% after that, those first 3 years, the feds cover 100% so we do not need to put MHSA money to draw the fed match, which means that we will have MHSA savings that we could invest to serve the under-served and then the unserved. So, the savings that we are going to have in MHSA, of the money that we are not going to have to put in to draw the match, part of that money to go to the un-served and underserved.
    a. **Response:** What you just walked us through is the kind of dialogue we are going to have January, February, and March. We are going to go through a conversation around how much for the CSS plan do we need to allocate by age group, "do we keep the same percentages or do they get modified?"
    b. **Response:** For the PEI plan we also did the same thing in terms of age groups and had a different percentage allocation by age group for PEI, by ethnic targets, service areas, and anything else. What's the information we are going to need? On the one hand, demographic information, demographic projections by age with county-wide service area; for example, we will need to know about the ACA. What will it fund and what will it not fund?

15. **Comment:** EPSTD is changing. It is a complicated scenario that I do not fully understand yet. If the change results in less money being available for children then that would affect how much money we have to allocate to other unmet needs because then that potentially becomes an unmet need.

16. **Question:** Considering unmet needs, the core principles and focal populations with older adults and the FCCS programs in particular, my understanding is that they were providing field based services. But what I am seeing happening in the field-based services is only with mental health support and case management and not medication support. One of the criteria is "imminent risk of placement in a SNF." What if an individual needs home care for medication management to stay out of the nursing care?

17. **Comment:** I want to make a distinction that these focal populations are only for FSPs. I think you are referring to is FCCS—
    Response: No.

18. **Comment:** I see. For FSP there should be the ability to provide any psychiatric medication. Are you saying linkage to an institution--is that—
    Response: [inaudible] because of mobility issues. But even an older adult FSP program requires for them to get to the clinic for their medication management.

19. **Question:** When the ACA kicks in and January rolls around how will FSP look like?
    a. **Response:** FSPs will not change. One of the things that may happen is that you may have an unfunded client, somebody that is indigent, that then gets covered because of coverage expansion. That MHSA money would be freed up to serve additional people and perhaps even people that are undocumented. You are right. We are going to have to in the next couple 2, 3, 4, 5, 6, months take a look at how that impacts our programs. I do not know how we know that quite yet.
    b. **Response:** Part of our discussion is about resource allocation. But the other part of our discussion is that when you look at the FSPs that were allotted by age, service area, focal population and ethnic targets, there is a dynamic relationship between and amongst them. We wanted to point out one of those that had to do with the focal population and the ethnic targets because while, in many ways, the focal populations have been achieved, or at least the targets for the focal populations, that wasn't the case with the ethnic targets. Who we said we would serve in terms of ethnic, underrepresented populations is not necessarily the percentages that we arrived at.
    c. **Response:** It is not just about resource allocation. It is about examining the system by which, at the concrete level, when you get someone referred to you and either refer them to FSP or not, how do you do that, what criteria do you use--we wanted to share some of that now and come back to it in more depth in January.

20. **Comment:** For the underrepresented ethnic populations, it is also looking at strategies. Even though you were allotted a slot, because of the uniqueness of the community, the area, the populations that you were trying to reach out, maybe our strategies were on, maybe they were not on, but there was some reason why we were not able to fulfill that slot.

21. **Comment:** I want to add, 'systemic.' There was no way, 5 years ago, we were looking at the state sending everyone back to the local communities and then it happened to be the point of demarcation at jail which is downtown and close to the African and Latino communities that surround it. Systemically, the state government created a situation for our communities and for us as a system that we have to adjust to. That was not even in the plan then.

22. **Question:** What kind of timeframe are we looking at to find out if we are going the right direction, particularly with all of these changes with the ACA? How can we realign?
    a. **Response:** This may be something that we have to study for awhile. You may have some initial recommendations that will come out of your SAAC. This may be something that we study, get data over time, and then make recommendations.
    b. **Response:** That is something that we have to monitor pretty closely because when Robin talked about the Healthy Way LA population, that is a population that is going to be newly enrolled under the ACA. If

we take a look at the service utilization of that population that we have seen since 2011 about 70% of the services that population received were MHSA funded. A very small part of that was PEI. So how is that going to impact us? Those folks will not be using MHSA funding. They will be drawing on 100% Medi-Cal. However, they will be using MHSA resources. So we are looking at folks that were enrolled, to a small part, in a FSP, a lot of wellness and a lot of FCCS; PEI, less than 20%.

23. **Question:** Does this create funding for our MHSA system that they are going to be able to draw down Medi-Cal?
    Response: Two things happen that is going to continue to happen that started with the Healthy Way LA. Because of MHSA we saw more uninsured than we did before because we did not have available county or realignment dollars to see them. MHSA allowed us to do that. But also, you figure that programs and agencies--also to develop their program they also develop it including the revenue dollars so that they can serve more individuals. But they can only bill MediCal for the traditional population as much as they have matched dollars for. Now you are going to have a whole new group of folks come in where there is no local match. Whether it is county matched dollars or MHSA, it is going to be funded 100% by the feds for at least the 1st three years.

24. **Question:** Are we going to empower our providers to be able to draw those dollars down to serve the greater community?
    Response: Not only are our providers doing that now but we are going to discuss tomorrow is that for children providers who do not traditionally see adults or the parents some of those folks may now be covered 100%. So we are allowing the children agencies to now begin to see the adults for those that need those services.

25. **Question:** Seeing that Healthy Way LA will be going away Jan 1st, how will that affect caseloads for those that are moved over?
    Response: We anticipate only 8,000 more clients a year--at least in the initial year. That is our projection. We are not going to get overrun the newly eligible beginning January. Keep in mind, the newly eligible for the Medi-Cal population is 19-64 years old.

26. **Question:** With that increase will there be more people employed to—
    Response: Yes, there should be.

27. **Question:** Did I just hear you say that with the transition we are going to be having people getting 100% drawn down? But that is not going to free up any resources. So our resources are going to be occupied even though our dollars aren't. Is that what I heard you say?
    Response: Agencies are still going to incur the costs. So the federal dollars are going to pay for those.

28. **Comment:** Those dollars that are freed up to see other people, you still have to have other resources other than dollars.
    Response: Yes, definitely.

29. **Question:** After we complete the three year program and expenditure process what becomes the next step in terms of operationalizing?
    Response: Part of the 3 year plan that we will present to you in March will include an implementation plan. It will describe our programs, all of the community input that happened around this and then the recommended changes. For those changes that we will make in that 3 year period we will then do our best to stage those changes. In other words, we anticipate this change happening this fiscal year, this change happening this fiscal year, along with a budget that our department will put together.

30. **Question:** That change is based on the different age groups or focal populations? What change is that?
    Response: We would look at the MHSA component. Let's say you wanted to prioritize a certain focal population in child FSPs. We would indicate that change and we would say when we would expect to implement that change. Then we would probably also have to say the number of clients that would impact. Any change that we make as to be tied to the budget and has to be tied to the number of clients we anticipate will be impacted by that change.

31. **Question:** Will this be relevant toward the healthy neighborhoods concept of coordinating this care?
    Response: In a way a health neighborhood is an approach to care that is not specific to a particular component of the MHSA. The document that we are going to put together will be specific to each component of the MHSA.

32. **Question:** If my income is between 0 and 100% I am on Medi-Cal? In terms of what the county is paying the county is going to pay 50% of my coverage whereas from 100 to 138% the county does not pay anything for my coverage. The feds pay all?
    Response: It depends on what type of Medi-Cal aid you are eligible for. There are folks who are under 100% Medi-Cal. In terms of federal poverty level you would think they would apply for the current Medi-Cal program but they do not. You have, for example, adults with no children. There was very little Medi-Cal aid that they could apply for unless they had a disability. Then they could apply for SSI. This population is going to be the newly eligible. Those who will most likely benefit from those are those in need of substance abuse treatment.

33. **Question:** Rather than getting people enrolled in traditional Medi-Cal we will get people enrolled in the expanded Medicaid. So we should be getting everybody--getting people into Healthy Way LA at the moment and then on January 1 extend it rather than applying for regular Medi-Cal.

	Response: The traditional Medi-Cal programs do not go away. They are still there. 34. **Question:** In terms of how we strategically work the system with people who do not have benefits we want to change how we do it so that they go to the expanded Medicaid first- **Response:** It will be easier now not previously eligible for the traditional Medi-Cal program now to get Medi-Cal. When we take a look at the Health Way LA population and who enrolled that is supposed to be the so called non disabled population. We estimated that about 10% of them actually move on to SSI. You will have folks who--for whatever reason their situation will change--they are going to move off of the new Medi-Cal program and then go into a traditional Medi-Cal program. But when that happens they are no longer 100%. They are going to go back to the traditional program and require a match. 35. **Question:** Do we have a commitment from the county to maintain the children's levels of funding now that the county has all of the money and the state does not pay anything for the EPSDT? Do we have a commitment from the county to maintain the children's level of funding? **Response:** I do not think we have a choice. That is an entitlement. So whatever programs and funds that are needed we have to match. It is not the ACA, the Medi-Cal expansion, that is affecting children's programs, it is the recent realignment dollars that took away the state general fund match. So rather than us coming up with only a 6% match for EPSDT we now have to come up with 50%.
Planning Process Calendar	N/A
Public Comments	1. **Comment**: Message from director of the Disability Rights California Group: She is reaching out to see if the SLT will take a position on a proposed federal bill by Murphy. Information will be distributed. 2. **Question**: The Alternatives conference just passed. Will there be time to present information from those workshops at the SLT? [No]