July 8, 2013

Via electronic mail

LIHP Transition Team
Department of Health Care Services
LIHPTransitionProject@dhcs.ca.gov

RE: Comments to Draft Continuity of Care Framework for the LIHP Transition

Dear LIHP Transition Team Members:

Thank you for the opportunity to comment on the Draft Continuity of Care Framework for the Low Income Health Program Transition that was discussed at the June 28 stakeholder meeting. National Health Law Program and Western Center on Law and Poverty – on behalf of AIDS Project Los Angeles; Alliance of Californians for Community Empowerment; American Cancer Society Cancer Action Network; Asian Americans Advancing Justice – Los Angeles; California Pan-Ethnic Health Network; California Partnership; California Primary Care Association; Coalition of California Welfare Rights Organizations; Health Access California; The Health Consumer Alliance[1]; Health Consumer Center of the Legal Aid Society of San Mateo County; Legal Aid Society of San Diego; Legal Services of Northern California; Neighborhood Legal Services of Los Angeles County; Public Law Center; Project Inform; San Francisco AIDS Foundation; and Southeast Asian Resource Action Center – submit the comments below for your consideration.

As an initial matter, we appreciate that DHCS has repeatedly committed to applying "lessons learned" from the SPD and Healthy Families Transitions to the LIHP Transition. From the transition of SPDs into managed care in 2011, in particular, we learned that continuity of care is arguably the most critical factor in successfully transitioning thousands of beneficiaries into a new health care setting. The poor performance of continuity of care protections led to

[1] The Health Consumer Alliance is a statewide collaborative of consumer assistance programs operated by community-based legal services organizations, which includes: Bay Area Legal Aid, California Rural Legal Assistance, Central California Legal Services, Greater Bakersfield Legal Assistance, Legal Aid Society of Orange County, Legal Aid Society of San Diego, Legal Aid Society of San Mateo, Legal Services of Northern California, Neighborhood Legal Services of Los Angeles County, the Western Center of Law and Poverty, and the National Health Law Program. The HCA's goals are to help individuals with their health care problems, develop remedies to systemic problems affecting health consumers, and educate communities as to their health care rights.

significant, and at times catastrophic, disruptions in care; beneficiary and provider dissatisfaction; increased costs for providers; and increased administrative costs for the plans and State. Prior to the SPD transition, advocates argued that the continuity of care protections in place were inadequate. Following the transition, we discovered that not only were the continuity of care protections grossly insufficient, but they were of no avail. More than eighty percent of SPDs did not know that they had a right to continue to see their current providers.[2] Many providers serving SPDs had no knowledge of the continuity of care protections, refused to participate in continuity of care, or were uneducated about how the protections applied.[3] Plans improperly denied requests for continuity of care and failed to inform their members of these rights. In sum, the lack of continuity of care in the SPD transition was distressing and left many in the consumer community distrustful of the State's capacity to transition additional beneficiaries into new health programs safely.

With the lessons learned from the SPD transition, we believe DHCS has an opportunity in this next transition to strengthen continuity of care protections and develop guidance so that these protections are more available and exercised by beneficiaries.

Further, we note that continuity of care can include both continuity of services and continuity of provider relationships. Since there are different rules that govern when enrollees have the right to continue a service, and when they have the right to continue seeing providers with whom they have relationships, DHCS should clearly explain the difference, and spell out which rules apply in which circumstances. Continuity of care protections need to be clear to plans, providers and enrollees.

In addition, we note that DHCS has recently released a draft All Plan letter on continuity of care that does not mention the LIHP Transition. Many of the signatories to this letter have also submitted feedback on that letter. We urge DHCS to include the LIHP Transition in that letter, so that Medi-Cal Plans can understand the continuity of care protections that apply to all populations that will be enrolling in the next six months.

Summary of Key Comments and Recommendations

1. We note that four issues raised by stakeholders at the June 28th meeting – a) the need for a comprehensive definition of "Primary Care Provider" to mean clinics as well as medical professionals; b) applying the continuity of care protection for prescription

[2] *See* Cal. HealthCare Foundation, *Briefing – Transitioning the SPD Population to Medi-Cal Managed Care* (March 28, 2013), www.chcf.org/events/2013/briefing-spd-transition-managed-care.

[3] *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, TRANSITIONING BENEFICIARIES WITH COMPLEX CARE NEEDS TO MEDICAID MANAGED CARE: INSIGHTS FROM CALIFORNIA (June 2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8453-transitioning-beneficiaries-with-complex-care-needs.pdf.

medications from the SPD transition to the LIHP transition; c) including county LIHP and Medi-Cal personnel and managed care plan member services staff with providers in webinar trainings about the transition; and d) the need for close collaboration between DHCS and Covered California – garnered consensus support from the Workgroup. We trust those issues will be addressed accordingly by DHCS in the final Continuity of Care Framework.

2. We are pleased that DHCS is exploring ways to work with LIHPs and Plans to transfer enrollee data. These transfers should happen as early as possible, and in a format that facilitates continuity of treatment, prescriptions, and completion of scheduled services, while protecting patient privacy.

3. We also encourage DHCS to develop and publicly post a crosswalk of ***all*** providers and benefits widely and early to facilitate continuity planning, and also to make its network adequacy reviews available to the public.

4. We commend DHCS for allowing enrollees to continue seeing specialists for up to twelve months, and suggest that DHCS also permit transitioning LIHP enrollees to continue their relationships with providers of ancillary services and primary care. DHCS should make this process as simple as possible, and should hold LIHP providers harmless if a transitioned enrollee seeks care from them without first requesting continuity from the Medi-Cal plan.

5. With respect to the Special Populations identified by DHCS, we urge DHCS to extend continuity of care standards for "carved-out" services, particularly in their impact on persons living with HIV and persons treated for mental and behavioral health issues, and that non-traditional means for communicating about the transition be coordinated among the state, LIHPs, the provider and plan communities, and community based-organizations to ensure that LIHP enrollees who are homeless are informed of the transition.

6. We also strongly urge DHCS and the LIHP Transition Team to consider the distinct issues that may face LIHP enrollees in the rural counties that are scheduled to switch from fee for service Medi-Cal to managed care on October 1, and allow for the possibility that LIHP Transition notices in those counties may need to be specially tailored in those counties depending on the progress of the managed care expansion.

7. The notices to consumers and information for counties and providers regarding the transition, as contemplated by the Transition Team's Communication and Outreach Plan, must be carefully drafted and disseminated widely so that those directly affected by the transition know what to expect and understand how to access care and ensure continuity of services in 2014. We anticipate the opportunity for the public to review the notices in a timely manner.

Our comments and recommendations are discussed in further detail below.

1. ***We look forward to the final Continuity of Care Framework including the stakeholder recommendations regarding the use of the term "primary care provider;" the cross-over application of the continuity of care provision for prescription medications from the SPD transition to the LIHP population; the addition of county personnel and managed care plan staff to the training webinars originally contemplated for providers about the LIHP Transition; and plans for close coordination with Covered California.***

We were pleased to see that at the LIHP Transition Workgroup meeting on June 28th the following issues raised by Stakeholders appeared to garner immediate consensus support from DHCS and the LIHP Transition Team.

- That DHCS's use of the term "primary care provider" ("PCP") for continuity of care linkage purposes encompasses medical homes and clinic providers as well as individual providers. As pointed out by several stakeholders, the continuity of care provisions regarding linkage of PCPs from LIHPs to Medi-Cal managed care plans must take into account that some LIHPs assign enrollees to medical homes or clinics, as opposed to individual medical providers. DHCS staff agreed and assured the Workgroup that PCP is a general term and DHCS intended it to include clinics and medical homes as well as individual providers. DHCS agreed that final guidance regarding the LIHP Transition and Continuity of Care provisions will be revised to include not only PCPs, but also medical homes and clinics.
- With regard to prescription medications, it was noted that in the SPD transition there is a specific continuity of care provision at Welfare and Institutions Code Section 14182(b)(22) that provides beneficiaries with the protection of 30 days of continued access to prescribed medications after enrollment in a plan, and that it is appropriate to apply this provision to the LIHP Transition. This process is laid out in the answer to question 17 in DHCS's FAQ on Extended Continuity of Care for SPDs, which was developed with extensive input from stakeholders who were on-the-ground helping

transitioning individuals during the SPD transition in 2011 and 2012. These stakeholders identified prescription continuity as a major problem in that transition, finding that despite the protections in statute, plans and providers lacked clear guidance on how to implement the law to ensure that plan enrollees had continued access to necessary prescriptions as they moved from fee-for-service Medi-Cal to managed care. These protections are particularly important for enrollees with HIV, since antiretroviral medications are carved out of most managed care formularies. DHCS should have a clear plan for continuity of these carved out prescriptions. There seemed to be general agreement on this issue and we look forward to seeing that provision explicitly provided for in the Continuity of Care Framework.

- The current Continuity of Care Framework contemplates webinar trainings for providers on the LIHP Transition. A lesson learned from the SPD and Healthy Families Transitions is that in addition to providers, county and state staff must also be trained and given FAQs in advance of notices to enrollees to ensure that beneficiaries receive consistent and accurate transition information. Furthermore, in addition to the county personnel and providers, DHCS should mandate training to all managed care plan frontline staff. An All-Plan letter would be insufficient in this instance. During the SPD transition, advocates found that the plan and its agent IPAs were the most common roadblock for patients *and* providers in obtaining authorization for continuity of care. Advocates spent considerable time educating plan member services, grievance departments and IPAs about the plan's obligations under continuity of care requirements. In order to give full meaning to the twelve-month continuity of care allowance, DHCS must make it is as easy as possible for patients and providers to request that authorization. The best way to achieve this is for DHCS to require that all relevant managed care staff are regularly trained and updated on continuity of care provisions. DHCS agreed that such trainings will be available to county personnel and frontline managed care plan staff as well as the provider community.
- As envisioned by the current Continuity of Care Framework, DHCS and Covered California will continue to collaborate and share information to ensure continuity for LIHP enrollees who move to coverage in Covered California. We are pleased that both agencies have affirmed that the continuity of care protections laid out in the draft will apply to those enrollees who transition to Covered California. We encourage DHCS to work closely with Covered California to ensure that both agencies deliver clear and consistent messages about the transition. In particular, DHCS and Covered California must ensure that all outreach trainings and materials account for the needs of those with HIV and other special populations. DHCS and Covered California staff both agreed to work together on these issues.

We look forward to seeing the above recommendations reflected in DHCS's final Continuity of Care Framework.

2. ***DHCS should work with LIHPs and managed care plans to transfer enrollee data as early as possible while respecting patient privacy, and in a format that facilitates continuity of treatment, prescriptions, and completion of scheduled services***

We urge DHCS to work with the LIHPs and managed care plans to find the most efficient way possible to ensure that all parties have the information they need as soon as possible, in a format that is useable to them. We appreciated the discussion at the June 28 stakeholder meeting about the best way to ensure that plans have the data they need as early as possible to facilitate continuity of care. We understand that there may be legal barriers to transferring enrollee utilization and treatment authorization data from LIHPs to Medi-Cal plans directly before the effective date of enrollment in the Medi-Cal plan. To the greatest extent allowed by law and with due consideration of enrollee privacy, we urge DHCS to explore possible workarounds that will allow the LIHPs and plans to communicate directly once enrollees are assigned to a plan, so that they can arrange for "warm hand offs" of enrollees where changes in providers are necessary, and make advance plans for continued treatment, prescription coverage, and completion of any scheduled services.

3. ***DHCS should develop and publicly post a crosswalk of providers and benefits widely and early to facilitate continuity planning, and should publicly post its network adequacy reviews of Medi-Cal plans.***

In the draft plan, DHCS states it will "develop a comparison of LIHP to Medi-Cal Managed Care benefits, formularies, and authorization requirements." Based on the meeting on the 28th, we understand that this comparison will take the form of a "crosswalk" that will explain how each LIHP matches to each Medi-Cal managed care plan in each county in terms of benefits covered and provider networks. We applaud DHCS's plan to create such a tool, which will allow LIHPs and Medi-Cal plans to identify gaps where particular attention will be needed to ensure continuity.

We remind DHCS that its analysis of formularies for potential differences related to continuity of care must be a detailed analysis and should include dosing schedules. Many LIHP enrollees who had previously received Ryan White-funded care experienced problems accessing the drugs they needed when they needed them when they joined LIHP. While most LIHPs had antiretroviral medications on their formularies, some drugs that had different dosing schedules or required special authorizations. These differences forced some enrollees to go without vitally important medications for a short time, seriously endangering their health. DHCS should work

with the LIHPs and Medi-Cal plans as soon as possible to understand where there is a potential for gaps in this next transition, and begin planning to avoid those gaps.

We are pleased that DHCS's crosswalk will pay particular attention to differences in mental health care and HIV/AIDS care. These populations are at special risk of experiencing adverse health outcomes if they experience a gap in coverage, and their care needs also tend to be more complex such that they will require special attention. DHCS should identify other populations with complex medical needs, such as individuals with cancer, who will require special attention to avoid devastating gaps in coverage. That said, the crosswalk must compare ***all*** benefits and provider types, to ensure that LIHPs and Medi-Cal plans have the information they need to arrange for continuity of care for ***all*** enrollees.

In addition to sharing the crosswalk with LIHPs and Medi-Cal plans, we encourage DHCS to publish this tool on its website. Other stakeholders, especially those who will be counseling LIHP enrollees about their transition options, would greatly benefit from having access to the crosswalk. We anticipate that many CBOs and advocates who work with populations with chronic conditions, for example, could use this tool to help enrollees understand which plans will contain their specialists and hospitals. And again, where there are gaps, either in terms of providers or services, sharing the crosswalk will help to ensure that CBOs and advocates who are trusted sources of information for low income communities will be better able to focus their counseling and help LIHP enrollees access care without any gaps. For example, for enrollees with HIV, the State Office of AIDS and the Ryan White network of "assisters" who will be helping clients with transition should have access to the crosswalk in order to provide detailed counseling to clients about their plan selection and continuity of care options.

Similarly, DHCS can facilitate continuity of care by ensuring that all stakeholders know as much about the Medi-Cal managed care plans' provider networks as possible. To this end, DHCS should post its network adequacy reviews on its website. By making the plans publicly available on its website, DHCS will allow stakeholders to better understand where there are gaps in provider networks, and advise LIHP enrollees accordingly about options to continue care with an existing provider or make other arrangements to seek care out-of-network. This information will be particularly important in the Rural Expansion Counties where stakeholders will need to make advanced plans for provider continuity in counties where Medi-Cal will be delivered through a managed care model for the first time this year.

4. DHCS should allow transitioning LIHP enrollees to continue their relationships with providers of ancillary services and primary care, for up to twelve months.

We appreciate that DHCS plans to give LIHP enrollees the option to request to continue seeing specialist providers for up to twelve months when certain conditions are met. This option will be critically important for LIHP enrollees with chronic conditions, who may receive more care from specialists than a PCP. We suggest that DHCS also extend the option to request ongoing services from providers with whom transitioning LIHP enrollees have relationships to include providers of DME, laboratory, and other ancillary services, as well as primary care providers.

LIHP enrollees, especially those with disabilities or chronic conditions, have long-standing relationships with providers of DME, laboratory services, occupational therapy, home health, chemotherapy, and much more. By limiting the right to continued care to specialist providers, LIHP enrollees are likely to experience serious gaps in coverage. For example, enrollees with HIV and co-morbidities must receive regular laboratory services to monitor & treat their medical conditions. These enrollees should have the option to continue seeing their existing laboratory providers to avoid a break in receiving these services that could seriously adversely impact their health.

Continued access to providers of DME is similarly important for LIHP enrollees with disabilities. Studies of the SPD transition found that over a quarter of SPDs using DME found access more difficult when transitioning to managed care.[4] DHCS should allow continued access to ensure that no enrollee is forced to do without needed equipment like a wheelchair or hearing aid due to confusion about which provider can offer the service.

DHCS should also allow LIHP enrollees to continue seeing their primary care providers when their primary care provider is not part of any Medi-Cal plan network in their county. Just like the provision for specialists, this option could be limited to twelve months, and the PCPs would have to have an existing relationship with the enrollee, accept plan payment, and lack disqualifying quality of care concerns. While many LIHP enrollees with chronic conditions rely heavily on specialists, some also receive the bulk of their care from a PCP. Some enrollees have long-standing relationships with their PCPs, who are intimately familiar with their medical conditions. If those PCPs are not part of any Medi-Cal plan in their county, these enrollees will have to abruptly change providers and hope that a new PCP can get up to speed on their medical conditions rapidly. To allow for a more gradual change, DHCS provided for up to twelve months of continuity with PCPs to children transitioning from Healthy Families to Medi-Cal. The

[4] See e.g., CARRIE GRAHAM *ET AL.*, THE EXPERIENCE OF SENIORS AND PERSONS WITH DISABILITIES WHO TRANSITION TO MEDI-CAL MANAGED CARE 29-30 (Cal. HealthCare Found. 2013), www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20Sacto03282013SPDsTransitionMediCalManagedCare.pdf.

same principles apply in this transition, and LIHP enrollees should have the option to continue seeing their PCPs.

The process for requesting to see an out-of-network provider with whom an enrollee has a preexisting relationship must be, ***in all cases***, simple and streamlined to prevent disruptions in care. DHCS should seek to avoid situations where a beneficiary is passively enrolled into a Medi-Cal plan on January 1, and then is unable to complete a scheduled appointment with a LIHP provider on January 3, when she doesn't realize that the provider is out of her plan's network and, perhaps, doesn't understand that her coverage has changed. DHCS should work with plans and providers to allow providers to immediately verify that continuity provisions apply. If a question about the right to continued access to the provider cannot be resolved at the point of service, the default should be to provide continuity until a determination can be made.[5]

Further, we encourage DHCS to offer an additional safety net hold-harmless provision that would allow out-of-network providers to provide urgently needed care and still be reimbursed in the event continuity of care provisions do not apply. During the SPD transition, many out-of-network providers provided unreimbursed care to beneficiaries to prevent disastrous disruptions in care. Many other out-of-network providers discontinued treatment in fear they would not be reimbursed. A hold-harmless provision would ensure beneficiaries do not lose access to critical care during the transition period.

5. ***For the Special Populations identified by DHCS, we urge DHCS to extend continuity of care procedures to "carved-out" services, particularly in their impact on persons living with HIV and persons treated for mental and behavioral health issues, and that non-traditional means for communicating about the transition be coordinated among the state, LIHPs, the provider and plan communities, and community based-organizations to ensure that LIHP enrollees who are homeless are informed of the transition.***

According to the Draft Continuity of Care Plan, DHCS is proposing that continuity of care provisions "are limited to physician services that are the responsibility of the [managed care plan] and are not applicable to … services carved out of managed care." CoC Draft Plan at p.2. This poses a serious concern for LIHP enrollees receiving treatment for mental and behavioral health issues and for persons living with HIV. Specialty mental health services for persons suffering from serious mental illness are carved out services, as are antiretroviral drugs. County

[5] A good model is the continuity of care provision in Medicare Part D. It provides that if a beneficiary presents a newly written non-formulary prescription at the pharmacy during the continuity of care period, and the pharmacy cannot determine at the point of service whether the prescription is for ongoing drug therapy, the pharmacy must fill the prescription and the plan must cover the fill. *See* CENTERS FOR MEDICARE AND MEDICAID SERVS., MEDICARE PRESCRIPTION DRUG BENEFIT MANUAL, CH. 6 AT 30.4.3 (2010), *available at* www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf.

public health departments oversee substance abuse services operate under a similar carve out arrangement. The experience of the SPD transition to Medi-Cal is again informative. Advocates report that some SPDs were improperly terminated from county mental health services when they transitioned to managed care because providers mistakenly believed that they were no longer under managed care, or county providers sought to shift responsibility for care to managed care plans by reclassifying a person's health status down from a serious mental illness. Ensuring continuity of care for these vulnerable populations is critical, and we urge the state to provide additional guidance on the parameters of the joint roles that counties and plans will have in providing mental and behavioral health services and HIV medications to the Medi-Cal expansion population.

With respect to the homeless population, we urge DHCS to consider the input offered by some stakeholders regarding the importance of exploring the possibility of using non-traditional means for communicating with this subset of LIHP enrollees. We recognize that some of the reports from the SPD transition indicated that written communications in the mail were the most effective methods of informing beneficiaries about the transition to managed care. But we note that LIHP enrollees are a very different demographic than the SPDs, with many LIHPs largely comprised of persons who receive county general relief or general assistance and are transient. With no fixed address, mailed notices may be of little use to these populations. We are pleased that DHCS plans to coordinate with those LIHPs that have a way of identifying among their enrollees those who may be or have a high likelihood of being homeless and work with community-based organizations that have regular and direct contact with them, i.e., at homeless shelters, food banks, libraries, to disseminate information directly or via non-traditional noticing methods such as email or text messaging to a mobile phone. We encourage DHCS to share "best practices" of reaching these populations with all LIHPs.

6. ***We also strongly urge DHCS and the Transition Team to consider the distinct issues that may face LIHP enrollees in the rural counties that are scheduled to switch from fee for service Medi-Cal to managed care on October 1, and allow for the possibility that LIHP Transition notices in those counties may need to be specially tailored in those counties depending on the progress of the managed care expansion.***

We are very concerned about how the LIHP enrollees in the 28 counties that are scheduled to switch from fee-for-service to Medi-Cal managed care in fall 2013 will be notified of the transition and their plan choices. The rural expansion has already been pushed back from an original start date of June 1 to October 1. The plans in these counties are in the process of building their networks, and it is our understanding that in assessing network adequacy, the plans *are not currently taking into account the incoming LIHP enrollees.*

This is a grave oversight. We do not see how the plans can provide any assurance regarding network adequacy when they are only looking at the current number of Medi-Cal enrollees, as opposed to assessing network adequacy based on the numbers of people they will be expected to serve within three months of beginning Medi-Cal enrollment. The LIHP enrollment numbers are readily accessible by county and we see no reason why that information is not being taken into account by the plans and the state when assessing the adequacy of their networks. We urge DHCS to ensure that the health plans in these rural counties take into account the anticipated uptick in Medi-Cal enrollments due to the LIHP transition in determining whether the plans have a sufficient provider network.

DHCS and the LIHPs in these counties will have special work to do to ensure continuity when the details of provider networks are still unknown. We urge DHCS to pay special attention to these counties, and consider developing modifications to the transition process for enrollees in them. In particular, we recommend that DHCS consider modifying the notices that go to enrollees in the rural expansion counties to address the change in the Medi-Cal delivery system and to ensure that the information regarding the health plans furnished to the enrollees and their options for selecting a plan are clear. The timing of these notices may also need to be shifted depending on when the plans are ready to begin Medi-Cal enrollment.

7. ***Continuity of care provisions are of use only so long as enrollees and providers are aware that they exist and understand how to exercise their rights to receive continuous care, and for that reason, the communication and outreach plan for the LIHP Transition is critically important.***

According to the Kaiser Commission study on the SPD transition, beneficiaries who were surprised by the transition and were assigned to a plan had more difficulty with accessing care through their new plans and provider networks.[6] How LIHP enrollees are informed about the change in the delivery of their health care, their options in terms of plan choice, and their rights to continue with their treatment and their providers are clearly critical for a successful transition.

We therefore emphasize the importance of DHCS continuing to engage stakeholders in this planning process and that all communication and planning materials for the transition be shared with the Workgroup at the earliest opportunity in order to provide meaningful and thoughtful feedback.

[6] *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, TRANSITIONING BENEFICIARIES WITH COMPLEX CARE NEEDS TO MEDICAID MANAGED CARE: INSIGHTS FROM CALIFORNIA (June 2013), at p.4.

If you would like to discuss any of these recommendations, please contact Abbi Coursolle at the National Health Law Program (310-736-1652 or coursolle@healthlaw.org) or Shirley Sanematsu at Western Center on Law and Poverty (213-235-2638 or ssanematsu@wclp.org) to coordinate a call between DHCS and consumer advocates to expand on the suggestions set out in this letter.

Again, thank you for this opportunity to provide our input. We applaud DHCS for its commitment to providing continued stakeholder involvement and training to ensure that those transitioning from the LIHPs to Medi-Cal do not lose access to critical providers or services. We look forward to continuing to work with DHCS on the Transition.

Sincerely,

Abbi Coursolle
National Health Law Program

Shirley E. Sanematsu
Western Center on Law and Poverty

And on behalf of:

AIDS Project Los Angeles
Alliance of Californians for Community Empowerment
American Cancer Society Cancer Action Network
Asian Americans Advancing Justice – Los Angeles
California Pan-Ethnic Health Network
California Partnership
California Primary Care Association
Coalition of California Welfare Rights Organizations
Health Access California
The Health Consumer Alliance
Health Consumer Center of the Legal Aid Society of San Mateo County
Legal Aid Society of San Diego
Legal Services of Northern California
Neighborhood Legal Services of Los Angeles County
Public Law Center
Project Inform
San Francisco AIDS Foundation
Southeast Asian Resource Action Center