Healthy California for All
Commission Meeting
July 8, 2021
Meeting Synopsis

Note: a video recording of this meeting can be found at: video recording of July 8, 2021 Healthy CA for All Commission meeting.

Commissioners in attendance: Mark Ghaly, Sara Flocks, Jennie Chin Hansen, Sandra Hernandez, Rupa Marya, Andy Schneider, Carmen Comsti, Antonia Hernandez, Richard Scheffler, Jim Wood, Anthony Wright, Bill Hsiao, Will Lightbourne, Don Moulds, Richard Pan, Cara Dessert, Bob Ross, Peter Lee (commissioner biographies can be found here: Healthy California for All Commissioner Biographies)

1. Welcome and Introduction

- Virtual meeting protocols and roll call
  - Karin Bloomer, a member of the consulting team, reviews the virtual meeting protocols and conducts roll call for the commissioners.

- Introductory remarks and agenda overview
  - California Health and Human Services Agency (CHHS) Secretary, Dr. Mark Ghaly welcomes the group and frames the work of the commission as follows:
    - I want to continue to encourage open conversation among members of the commission. At the same time, I will call on different commissioners to bring their interests and areas of expertise into the conversation in a way that helps connect more dots and keep the commission focused on overall goals.
    - Today's agenda begins where the June meeting left off. Commissioner Bill Hsiao spoke at length about his work in Taiwan but did not get to dive into the Vermont model. In today's first segment, we will hear from Peter Shumlin, Governor of Vermont from 2011 to 2017 when the state was promoting a single payer model. Governor Shumlin will share Vermont's experience and answer commissioner questions.
    - The second segment will be anchored by a panel of three commissioners—Peter Lee, Sandra Hernandez and Anthony Wright, who will discuss systems of accountability and the levers California can use to achieve our goals.

2. Follow-up on Unified Financing Direct Payment Models

- Secretary Ghaly introduces Peter Shumlin, former Governor of Vermont, and asks a few framing questions: What specifically did Vermont try to do? What was missing that didn't allow you to get to the finish line? What might you have done differently? And regarding federal permission, collaboration, and waivers, what is your experience with that?
- Presentation by Governor Shumlin:
  - In politics there are factors you don't control as well as the things you do control. External factors we faced included the recession and loss of seats and control in Congress to Republicans who ran against Obamacare. We were also trying to build a statewide health care exchange, and the federal contractor ran into implementation challenges that raised a credibility challenge: Vermonters had a hard time trusting our administration to revamp the entire health care system when the exchange had such challenges.
  - Internal challenges included covering out-of-state employees (as Vermont was using an income tax and payroll tax to fund the plan) and having to raise taxes each year at the same level as health care insurance premiums. Even the progressive senators and legislators were asking behind closed doors, do we really have to do this all at once? Are we really going to have to raise taxes every year at the same level as health care insurance premiums, less the one-time savings we get for greater efficiency?
  - California may have more room for savings as Vermont had already driven out for-profit hospitals and relied primarily on one nonprofit insurer.
  - Vermont got the first waiver in America to allow the entire state, including Medicaid and Medicare enrollees, to switch from fee for service to an outcomes-based payment system. The CEOs of the biggest hospitals and rural community providers were on board, but then a Republican governor came into office. The legislature realized they had to get cost under control first, regardless of the system. The takeaway is to simultaneously move to single payer and control costs, while delivering better, healthier outcomes by incentivizing providers through an outcomes-based payment system.
  - Governor Shumlin recommends the commission review the January 24, 2017 report prepared by the health agency in his administration, published by UMass Medical School, to help understand some of the things to figure out regarding federal and state relations to make this work.

- Commissioner discussion of barriers faced by Vermont:
  - Question: How have things evolved regarding the state-federal relationship? Answer: Most funding for health within any state comes from the federal government. Laying groundwork on cost containment is important. This is an opportune time to move forward because of the Biden administration. Working through the details on financing is key. Vermont obtained a federal waiver that

provided flexibility around use of Medicare and Medicaid funds. Anya Radar Wallack, who advised Vermont, can provide more details.

- While there will be winners and losers under such a major shift, Vermont's strategy was to build a coalition among players who realize that the current system isn't sustainable for them or for their organizations. This includes business people, insurers and others.
- Vermont's plan was not to compel ERISA employers to drop their coverage but rather to impose payroll taxes and income taxes to pay for the Vermont plan that would be an incentive for all employers to participate. Engaging employers who are paying disproportionately while their competitors skimp on health care may be one place to look for support.
- Question: How did Vermont approach the question of getting control of the Medicare and Medicaid funds? It seems the programs pose different problems for state flexibility. Answer: Vermont got an 1115 waiver by incorporating the same benefits (or better) as Medicare, and then that pooled money could be included in their single payer waiver.
- To increase the viability of a unified financing approach, consider tying implementation to concrete cost controls. The challenge is to move the health care system to one that spends less money, more in line with wages, yet produces better health outcomes. Vermont elected officials were ready to vote for tax increases, but not if those increases were going to follow the pattern of recent health care premium increases.
- This is the land of Prop 13. If you want to stay an elected official, you've got to think carefully about imposing taxes on people. We can all give the speech on the benefits of single payer, but is that argument enough to cause a legislator to approve tax increases? Answer: Yes, if the plan includes cost controls and you can pass the financing plan. If you just do the financing in isolation, no rational legislator is going to move forward.
- Question: California has a remarkably diverse population with enormous inequities. Many parts of the delivery system have not moved effectively yet to an outcome-based system of reimbursement for providers. How would you have done that in Vermont? Answer: Through a provider network, including everybody, not just doctors and nurses, but chiropractors, mental health providers, school systems, etc. that receives a per capita payment to care for a huge cluster of patients. Use computer modeling to measure the outcomes carefully and accurately. That would result in a system where everybody collectively works together to keep people healthy.
- Question: What advice do you have on the aspect of civic engagement, community engagement, public support? Answer: A process for community engagement and cultivation of public support is a central part of moving toward a single payer system. Members of the public need to be engaged on why changes are needed and how to make them as effective as possible.

- Private interests have incentives to maximize profits and revenues that do not align with the public good. The challenge is to develop a system that rewards health and healthy outcomes, not corporate returns.
- For state leadership to move such a major change, leaders need to have credibility and people need to be confident that the government can execute effectively. Details are important and can trip up a process.

3. Advancing Accountability, Integration and Care Coordination under Unified Financing

- Commissioner discussion
  - Secretary Ghaly frames the conversation: How do we achieve accountability? How do we use some of the tools that we have in place today, build on those that work, and set aside or improve those that have not been as successful? Rather than have this discussion be about intermediaries, let's talk about some of the attributes of systems that we can build upon to achieve the outcomes that matter for California. First, commissioner Peter Lee will describe how Covered California has worked within the confines of the current system to arrange for care for its enrollees. What opportunities are there to build on the existing system, and what new tools or strategies are needed?
  - Peter Lee:
    - The ends we want to advance are the quadruple aim – the Triple Aim of better health, better health care, lower cost, plus better patient experience. It's not about the financing, it's about advancing these outcomes. Our current system has four major and different systems: Medi-Cal, employer sponsored insurance, Medicare, and Covered California, which bridges the gaps between the other coverage sources. Each one has tried different ways to advance the quadruple aim.
    - First, affordability is good news. We're at 93% coverage throughout California. Medi-Cal provides good protection, their consumers don't have financial impediments to care. Covered California with new subsidies means that lower income people pay no or low premiums and get comprehensive benefits. But for affordability, employer-sponsored coverage (ESI) and Medicare are a mixed bag. In addition to 7% of the population without coverage at all (many are undocumented Californians), many people with ESI are underinsured, meaning that they have to spend a high percentage of their income on coverage and cost-sharing when they get care. Medicare is also a mixed bag; a lot of Medicare enrollees pay a substantial portion of their income towards health care. You have to consider both what people pay in premium and what they have to pay when they access health care services. But one of the things we've moved to improve is income-adjusting what people pay. Medi-Cal and Covered California do that, but ESI does not nor, largely, does Medicare.

- Next, let’s talk about health and health care, the biggest casualty of the fragmented system. There have been improvements. Health plans can no longer avoid people who are high risk, and they’re now required to spend money on health care. But, there’s no entity that is concerned about a person’s health across their lifetime, and no one's responsible for health of a population. We have a fragmented system that thinks short term. With fee for service, dis-integrated, fragmented care, you get more services delivered but not better health outcomes. Covered California selectively contracts with health plans; even so, we see big variation, even within capitated systems. Kaiser does a good job on quality but other carriers don't do as well.
- This means that someone needs to look over the shoulder of the plans to monitor and assure outcomes. Covered California with its 2 million lives has to work in alignment with other purchasers, decide on measures to collectively hold plans and providers accountable, work together to promote primary care, exchange data, and address disparities. These are essential elements that, absent a unified system, have to be pursued through alignment.
- Finally, related but distinct from consumer affordability, is the system attribute of overall cost. We’re at 18 or 19% of GDP spent on health care, all in, for three reasons. 1) We spend more on administrative activities; 2) we spend a lot more on drugs; 3), and we pay health care providers more. We pay specialists more, we pay primary care doctors twice what they make in Europe, and nurses are also well paid compared to other nations. The levers available to Covered California to address underlying costs are too small. We have to get folks out of fee for service and into pay for value and systems of care, but the changes in cost that result will be on the margins. As Governor Shumlin said, unless we address underlying costs, it's hard to do the rest. Down the road, the big solutions for costs involve global budgeting and common pricing, and both pose big political challenges. But without addressing those, we don't have the solutions to promote the system we need.
- We need to build systems that don’t reward more health service use for its own sake, but are pushed to take care of a population over time. The organization of care takes work. It can be done in big systems or in accountable care organizations with teams led by primary care providers working with other clinicians.

- Sandra Hernandez
  - The population that needs behavioral health care – by which we mean both mental health and substance use disorder care – has a disproportionate disease burden. Considering morbidity and mortality rates, people who have serious mental illness and/or substance use disorders, regardless of what system they're in, largely succumb to physical health-related

diseases. At the same time that we spend a disproportionate amount on this high need, high cost population, we actually get very poor outcomes. For this population in particular, care coordination and care integration are absolutely critical.

- We don’t have clear goals with respect to health outcomes and we have not agreed what is important to measure and to report within the delivery system. Diverse sources of funding come with requirements for many different process measures. We report how many people show up for a visit. But today we don't report, for example, how functional is that individual? How able are they to go and get a job? How able are they to maintain family relationships, and therefore be in a stable housing situation? Today’s deeply fragmented behavioral health system has not agreed upon quality measures, by and large. We have a few measures related to inpatient psychiatric admission (e.g., did you have a follow-up psychiatric appointment), but these are not population based nor monitored over time. From the perspective of the patient's full self, we don't have integrated information systems and data systems. Members of the public need to be able to see what works and what doesn't on any particular intervention or outcome measure that we care about. Today, we put the biggest burden on our most disenfranchised populations to find their way through a maze of behavioral health programs. We need better data, we need better measures, we need full integration.
- Today, with so many different financing streams, there is no single point of accountability. With so many different funding streams, federal state, local hyperlocal, grants, all of those require their own version of reporting. And so we end up with a population that's wildly underserved with very severe inequities. All the shortcomings are exacerbated significantly when considered through an equity lens.
- Based on demonstration programs, for example for the quarter of a million Californians in whole person care, the common theme in terms of attributes for success is care integration and care coordination. So then the question becomes, well, who does that? And who is best to do that? And how do we make sure that our information systems allow care coordination to be as seamless as possible? Today’s information systems in the area of behavioral health are rudimentary at best. We need to establish responsibility for care integration and coordination and make sure that there is accountability with transparency.
- Having fewer funding streams would help, but that won't be sufficient. Access to behavioral health is atrocious. For people who need substance abuse treatment, only a small share get it. A minority of people with mental illness get access to mental health services at all. Workforce issues contribute to the challenges. We need to address both specialty access and integration of behavioral health care within primary care settings. We

also need to reduce stigma, which would be more likely if everybody was in an integrated, coordinated system. Behavioral health is ripe for improvement on many fronts.

- Anthony Wright:
  - When we talk about a system of unified financing, we assume universality and broad mechanisms for cost control. What additional tools would need to come with unified financing to improve quality, to control costs, to reduce disparities, or to promote public health? What could we do in a unified system that is impossible in the current fragmented system?
  - We need to think about the system's incentives for patients and for providers. Suppose everyone is given a card and theoretical access to any provider at any time, but without any guidance about which providers were available, which ones provide better quality, which ones are more culturally competent, which ones are more appropriate to see with a certain medical condition or circumstance? Even in a vastly simpler system, we wouldn't want patients, and especially those who are at especially vulnerable medical moments, to be entirely alone and unsupported. Patients will need navigation assistance. Even in a world where we have no or minimal cost sharing, we can't let the default be "let the buyer beware." While sometimes more choices are good for consumers, we don't want to offer bad choices.
  - We'd like to see more and more people in a medical home, where they feel a sense of belonging. Even for people outside of a health plan – for example, people who remain uninsured including the undocumented – counties have established medical home programs, especially for people with co-morbidities, that help to coordinate care. There is potential for accountable care organizations to play such a role in the context of a single payer system.
  - A lot of Californians receive care through delegated model medical groups. Community health centers play a vital role in delivering care for an important part of the state's population. We need to consider how to preserve the best of these models. To do that, we need to decide what we want to encourage, what we want to mandate. One question is under what circumstances people seek care within a specific system and what ability do they have to move outside of it?
  - My hope is that the unified financing system or single payer system we create would assume functions such as aggregating risk and negotiating with providers that health plans play today. But allowing people to choose between systems of care might remain. Today, theoretically, health plans use networks, preferred networks, formularies, and other tools to steer patients to providers of greater value and quality. If a new single payer system does not use these tools, then what alternative mechanisms would ensure accountability and transparency? If a system or provider falls below a certain quality standard, how does the system respond without disrupting

care? What if that happens for the main provider in a certain area? If the unified financing/single/payer system uses tools like networks or formularies, what kinds of oversight will assure consumers are protected? For example, right now if people agree to a certain network, they have a right to timely access to care within a certain standard. And if that standard isn't met, they can go outside of that network to get the care that they need. Today people have a right to get a second opinion; if they are not able to get the opinion, they can get an independent medical review. Today consumer protection structures are imposed through oversight over health plans. If we enter a world without health plans, how would those protections be transferred into a new system?
    - Clear standards and safeguards and rights will be important for building trust with the California public and the electorate. An ombuds person or oversight agency, some other structure for keeping government accountable in the absence of a traditional regulatory system, will be needed, and that regulatory oversight structure should be proactive, not just complaint-driven.
    - On the provider side, if the providers are showing themselves to be particularly effective at say, managing diabetes or chronic conditions, how are they rewarded?
    - The final piece is we want the overall unified system to be focused on a population health approach. Rather than per patient or per procedure outcomes, we should focus on achieving healthy outcomes for the population overall. We may have multiple systems in an area, but still need to make sure that all those systems focus on root causes and invest in upstream public health interventions that can save the system money and prevent heartache and improve health for people.

- Secretary Ghaly invites commissioners to comment on the presentations:
    - We have lists of tools and dials, some cost more than others, and regardless of the payment system, capitated or incentive driven, some entity will be required to monitor and make sure we are delivering. We spend too much on administrative waste, and single payer can help fix this issue. Regarding monitoring, it is a waste of time to monitor without doing anything about it, so we must think about what levers we could apply, whether its resources or others, to address the deficiencies identified.
    - It's hard to have an integrated plan unless you have a capitated system, because you need the funding up front, in the amount of money per member per month, in order to invest in integrating the system. You also need to make sure that the payment is fair and risk adjusted, which means that if you have sicker patients, you get more money. Risk adjustment is not perfect, but it's better than nothing. You can also address equity concerns by adjusting payment by zip codes, for example, or other

measures of geography. To assure the health care system takes care of people in underserved areas, perhaps you give higher payments.

- On behavioral health and preventive care, we have a very uncoordinated system, people who have mental health issues may also have substance abuse issues or be chronically homeless. One of the benefits of a single payer system is more money to coordinate care for them.
- We don't spend enough on prevention. We spend a lot more on chronic disease management. We spend very little on diabetes prevention, but yet we spend billions of dollars to treat diabetes. This isn't just about a payment system and a delivery system. We need a coordination system to achieve the health outcomes that we're really looking for.
- Whether we provide one stream of funds or several streams of funds, it's not going to make a great deal of difference unless we have integrated systems. And unless the payment systems are supportive of population health outcomes, not just individual self-outcomes, it won't make a substantial difference. Integration of care and care coordination is the indispensable piece of a system of the future that we want to build.
- Community health clinics are a model of what we could be doing in terms of understanding the communities we serve, and then targeting the specific concerns of local areas.
- Regarding taking care of elderly people, the system should help an older person maintain their quality of living in the community. With that comes care coordination, care continuity and management, all wrapped together. There's a new phrase called the four M's of age-friendly care: mentation, medications, mobility, what matters to people. This frames the outcome we want.
- When we're talking about a direct payment model, it doesn't necessarily mean fee for service. Institutional global budgets could be paid quarterly to hospitals and other institutional providers, and then fee for service would only be an option for individual providers, which would represent roughly 20% or 30% of the care being provided. Those individual providers would ideally have the option of negotiating a salary with the system. There are creative alternatives to today’s managed care arrangements and financial incentives.
- For the most part, corporations, whether they're for profit or nonprofit, their business is to make money. The people who should be coordinating care are our primary care physicians, people in licensed medical professions and people who are actually treating individual patients, It's problematic to assume we need corporate structures to get to integration.
- One advantage of a single payer system is we can get rid of risk bearing intermediaries that have a financial incentive to deny care, and to manage care in a way that is profit driven for themselves. We need to distinguish

good managed care that actually does manage and integrate care, and promotes equity, and high-quality outcomes.
    - In California we have so many different languages that are spoken, immigrant communities and so forth with huge health disparities. We need to imagine what that looks like to fix these disparities. We need to make sure that there's some accountability for physicians in the care they're providing. Physicians might not be the appropriate ones to coordinate care. We want to free them up from administrative burdens to spend more time with patients. How do we figure out what institutions are best at coordinating care and guiding people through the system in ways that are linguistically and culturally appropriate?
    - There's no state body that's looking at the entire system as a whole. That's part of what we hope a single payer system will do.
- Secretary Ghaly summarizes: Today, I think we identified the attributes we hope to see our health care system deliver. We stretched ourselves on the unified financing approach and the levers and dials that we might need. Part of the challenge is trying to make sure we're not applying the same dials and levers to the same old system, but thinking about how they get applied to the new system. There is more to discuss on community health centers, ushering in a diverse workforce, integrated care, and how we model our payment system. We've set ourselves up to have additional conversations about how we blend these different opportunities, and what attributes and levers of the system we can instill to structure the outflow of dollars to achieve our desired outcomes.

- Public comment
  - Karin Bloomer invites verbal and written public comment.
  - Note: For a transcript of all public comment provided during the meeting, please go to Transcript of Public Comment from July 8 2021 meeting.

4. Adjournment

- Secretary Ghaly thanks the public and commissioners for the rich conversation and commits to organizing these issues between now and the next meeting.
- Secretary Ghaly adjourns the meeting.