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Transmittal via email to: HealthyCAforAll@chhs.ca.gov

Dear Secretary Ghaly:

As a Commissioner, thank you for the opportunity to provide input on the Healthy California for All (HCFA) Commission's consultant team methods and estimates presented at our May 21st meeting. I acknowledge the complexity of this work. My goal is not to challenge the team's assumptions or figures, rather it is to appreciate that as the authors noted, "all estimates are subject to substantial uncertainty". Moreover, as you noted, the substance of our deliberations is what will be key to moving a unified financing agenda forward.

In that spirit, I would like to make one request, which is to analyze a third scenario for modeling, in addition to the two shown on Slide 11. This scenario could be compatible with either of the two modeled scenarios (direct payments to providers or health plan risk adjusted capitation), and most importantly, promote health and racial equity:

This scenario would take a specified portion[1] of total health care dollars to fund a new type of intermediary variously called Recovery and Equity Councils[2] or Accountable Communities for Health[3], which would be responsible for:

a) linking individuals with health-related social needs to community resources, such as housing navigation, food, transportation
b) facilitating partnerships and alignment among and across organizations and sectors
c) addressing root causes of poor health (social determinants of health), including structural racism at the community level; and

[1] The Oregon Health Authority pays annual cash awards equal to 4.5% of the total amount of funding for Medicaid insurers in 2020. Awards are tied to measures that include nutrition and physical activity, kindergarten readiness, and certain social determinants of health (SDOH). While these are investments are incentives for the SDOH, they do not include funding to support a community-driven infrastructure. In 2021 the Authority is placing a greater emphasis on health equity in the list of measures as well as considering creating equity zones in its next federal waiver. Similar to ACHs that serve a defined geography, the director of the Oregon Health Authority recently commented on health equity zones stating that "At the core, we believe in the importance of ensuring that any added resources aimed at ending inequities are directed by the communities facing those inequities." (The Lund Report Newsletters, October 4, 2020 and July 12, 2021)

[2] See CalMATTERS Commentary, May 27, 2021, that includes links to Brookings and George Washington University thought leaders' writings on this idea

[3] See https://accountablehealth.gwu.edu and https://cachi.org

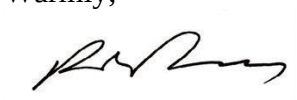
d) serving as a vehicle for authentic consumer engagement, community accountability, and oversight of the health system. In addition to the health care sector, participants governing the new intermediary would come from public health, social services, education, local businesses, community-based organizations, residents, and other relevant entities.

This innovation could affect the rate of growth of health spending in the long run by going beyond "curbing rates of increase in prices[4], and reducing low-valued care, fraud, and abuse" (slide 12) by building on existing models to fully integrate primary and secondary prevention interventions that can moderate the trajectory of a range of community and chronic conditions, behavioral health problems, trauma, etc.

These type of intermediaries are in line with both CMS's[5] and your agency's[6] respective philosophies. While it is important to debate whether or not to retain health plan/system intermediaries, we **need to *re-imagine* how we are delivering care** if we are to truly transform our health system *and* address inequities beyond quality disparities. My colleagues and I recently put forth a CalMatters Commentary to advocate for the type of innovative intermediary I am proposing here. I would be happy to provide additional documentation of support from thought leaders in other states, think tanks, and academia for this type of approach if that would be helpful.

I would be pleased if this request and analysis are made public.

Warmly,



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Commissioner, Healthy California for All Commission

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[4] Are there mechanisms to curb rates of increase in prices beyond price setting under UF especially if managed care is unwound?

[5] The CMS Evaluation of Accountable Health Communities Model (2020) states: "Given the complexity of these disparities, any solution requires a multi-sectoral approach that includes federal, state, and local governments, community-based organizations, and private industry."

[6] Health & Human Services California's Comeback Plan 2021: "The May revision charts a path to a system where social services – such as housing supports, food and childcare – are linked to health and behavioral health services." (pg. 1), and with respect to CalAIM: "This proposal recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach that targets social determinants of health and reduces disparities and inequities." (pg. 4)