



HEALTHY CALIFORNIA FOR ALL

Accessible, Affordable, Equitable, High Quality, Universal

Virtual Commission Meeting

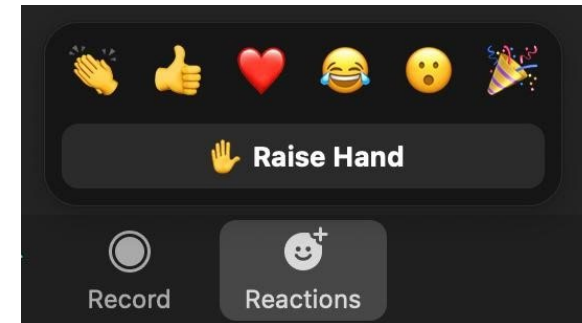
September 28, 2021

Virtual Meeting Protocols



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- This meeting is being recorded.
- Commissioners:
 - You have the ability to mute and unmute and the option to be on video.
 - Please mute yourselves when you are not speaking.
 - To indicate that you would like to speak, please use the “raise hand” feature:
- Members of the public:
 - You can listen to and view the meeting.
 - During the public comment period, you will have access to the “chat” feature for written comment, and you can use the “raise hand” feature to request to speak. You can also email comments to HealthyCAforAll@chhs.ca.gov.
 - Public comment provided during the meeting will be a part of the public record.



Opening Remarks

Mark Ghaly, MD, Commission Chair and Secretary
of California Health and Human Services Agency

Today's Agenda



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- Updates, including next steps related to Goals/ Values/ Propositions survey
- Discuss racial equity and the actions and design decisions most crucial to assure a future health care system that provides equitable outcomes for all Californians

Upcoming Meetings and Next Steps



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- October 11: Provider payments
- November 4, December 9, January 12
- Remaining agendas to be finalized but will include
 - Options and considerations related to non-Federal financing
 - To pave way to Unified Financing, what could state invest in today?
 - Transition issues
 - Review and accept final report

Goals/Values/ Propositions Survey



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- General agreement on most propositions
- Many excellent suggestions about where to elaborate or how to improve language
- Wide agreement on values and propositions related to integrated and coordinated care, payment as a tool for accountability, program sustainability and equity
- In some areas, most notably whether and how health plans and/or risk-bearing intermediaries should be included in a future system, there was wider divergence

Values/ Propositions Next Steps



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- Summary of survey responses will be posted at Healthy California for All web page in connection with this meeting
- Language will be refined, new propositions added, and a follow-up survey administered following October 11 meeting
- Commissioner input will inform Values and Propositions included in the Commission's final deliverable



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Presentations and Discussion

Opening Remarks

Antonia Hernandez, JD

President and CEO of the California Community Foundation

Equity is a Priority



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- Dignity and respect for all is a core element of equity.
- Language access will be an important benefit element because of our State's linguistic diversity.
- Ensure COVID-19 vaccine and care are available where people live and at times/places convenient for them.
- Include immigration status as a significant factor in the design of unified financing.



Affordability and Equity

- Affordability is a primary element of equitable design.
- Low-income Californians believe that those who can afford to pay more should support a system of unified financing.
- Co-pays and transportation were costs that prevented people from seeking care.

COVID-19 and Equity



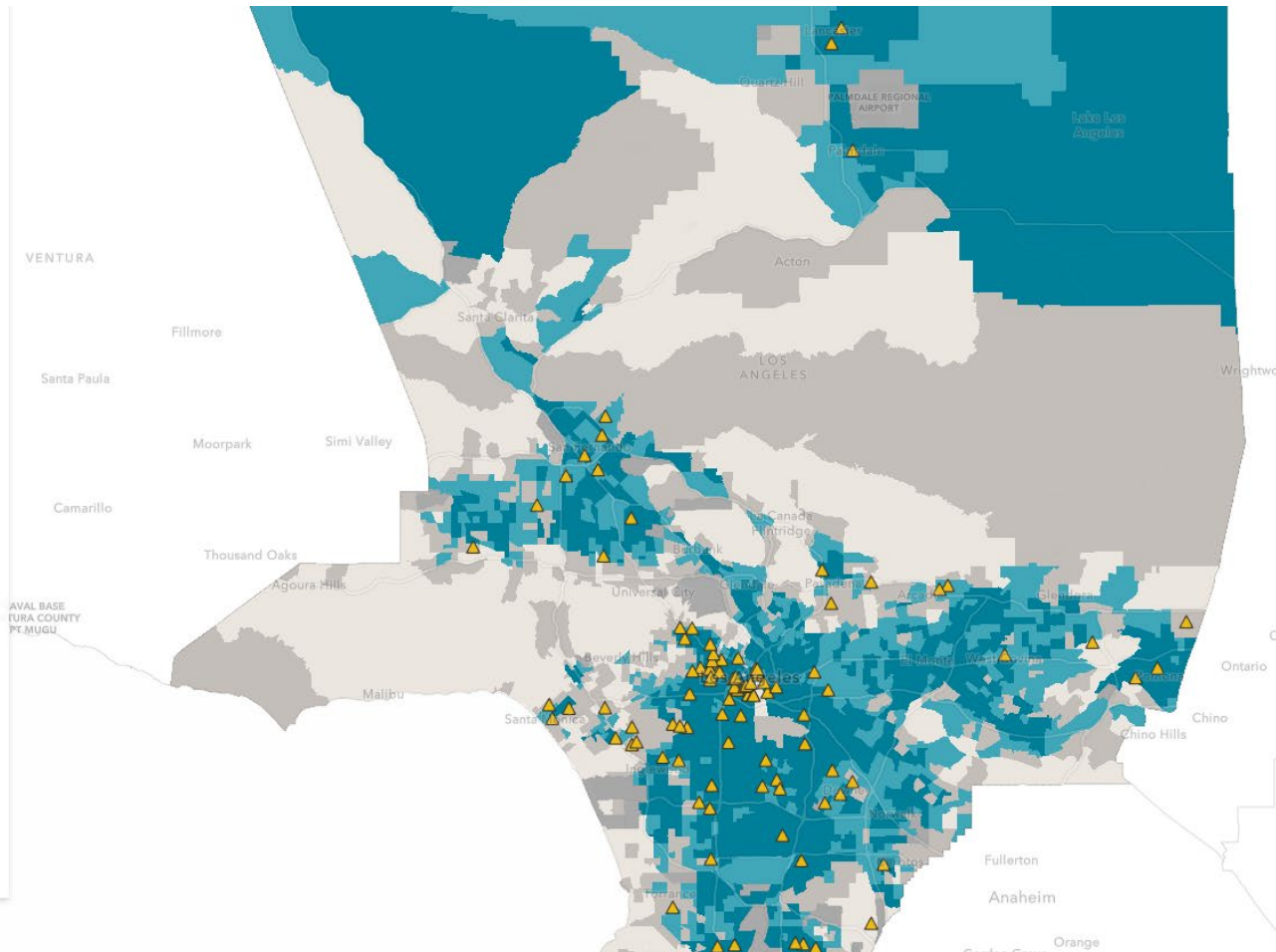
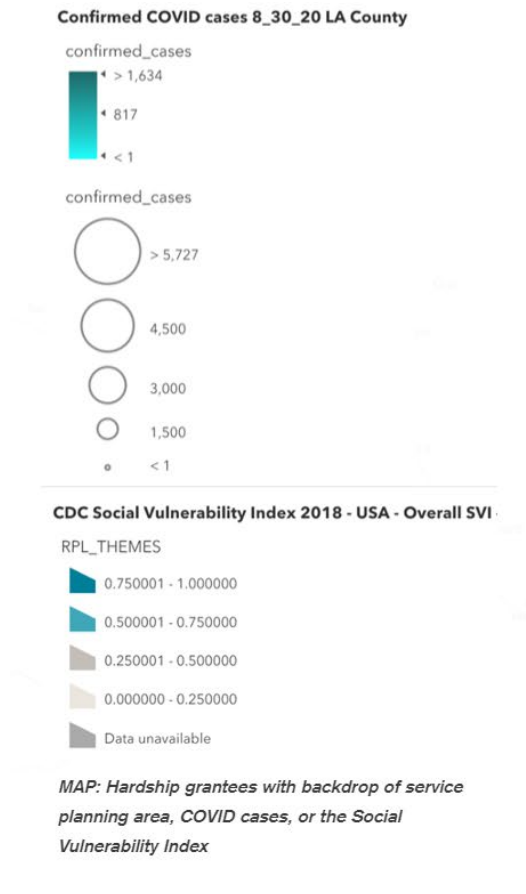
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- COVID-19 and structural racism exacerbated health inequities.
- Language and online access were barriers experienced by low-income Californians especially people of color.
- Community Health Workers, promotores, and other trusted communicators bridged these barriers to equity.
- Use of health equity indices guided resource allocation.

California Community Foundation Grants for COVID-19 and Equity



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HERE, Garmin, SafeGraph, FAO, MET/NASA, USGS, Bureau of Land Management, EPA, NPS | Centers for Disease Control and Prevention/ Agency for Toxic Substances and Disease Registry, Geospatial Research, Analysis, and Services Program | U.S. Bureau of Reclamation, California Department of

Include Immigration Status



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- Coverage expansions for all regardless of immigration status are a core element of our work.
- Public charge had a chilling effect on immigrant families' and residents' use of benefits.
- Public benefits enrollment and utilization are essential to addressing poverty among immigrant Californians.
- Immigration reform is an ongoing strategic priority.

Advancing Racial Equity and an Anti-Racist Health System

Robert K. Ross, MD
CEO, The California Endowment
& Healthy California for All Commissioner

“Health is not determined primarily by access to health care or the quality of health care, but by historical, structural, and systemic community conditions and the policies that shape them.”



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“Power is a social determinant of health.” A World Health Organization report concluded that, “Any serious effort to reduce health inequities will involve changing the distribution of power within society to the benefit of disadvantaged groups.

“The way we measure success has to be rooted in reducing racial disparities. And just because you achieve a universal outcome doesn't mean that it necessarily has an equal impact on the people who are structurally disadvantaged at the outset. If we achieve progress, the question is ‘How is that progress having an impact on reducing racial disparities, reducing barriers for people of color and creating improvement in their ability to live well?’ – Community Engagement Interviewee

Key aims of a reimagined health system where race/racism no longer result in inequitable outcomes:



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1. Race no longer determines one's health, wellness, or socioeconomic outcomes
2. Californians of all demographics, geographies, and backgrounds rate the health system highly
3. Health providers/healers reflect the demographics of the people they serve
4. The health system is broadly defined to include/link to non-medical influencers of health, such as education, food, transportation, housing
5. The health care sector is an active partner with other sectors in eradicating the root causes of structural inequities, not just the manifestations
6. The community has an active role in overseeing health resource allocation and system design

Multiple Reports Recommend Key Systems Changes to Center Race Equity in the Health Care Delivery System



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National Academy of Medicine: *An Equity Agenda for the Field of Health Care Quality Improvement*

1. Increase **patient trust** and involvement
2. Increase **community engagement** and truly value the health of populations
3. Reward organizations for **equity**
4. Improve **data**
5. Create new **measurement** strategies
6. Improve **leadership and culture**

California Pan-Ethnic Health Network: *Centering Equity in Health Care Delivery and Payment Reform: A Guide for California Policymakers*

1. Center Equity in **Quality** and **Payment**
2. **Engage Patients**, Families, and Caregivers
3. Strengthen Culturally and **Linguistically Appropriate** Care
4. Improve and Integrate Physical, **Behavioral** and **Oral** Health Care
5. Hold Health Plans and Systems **Accountable**
6. Improve **Social Determinants of Health**

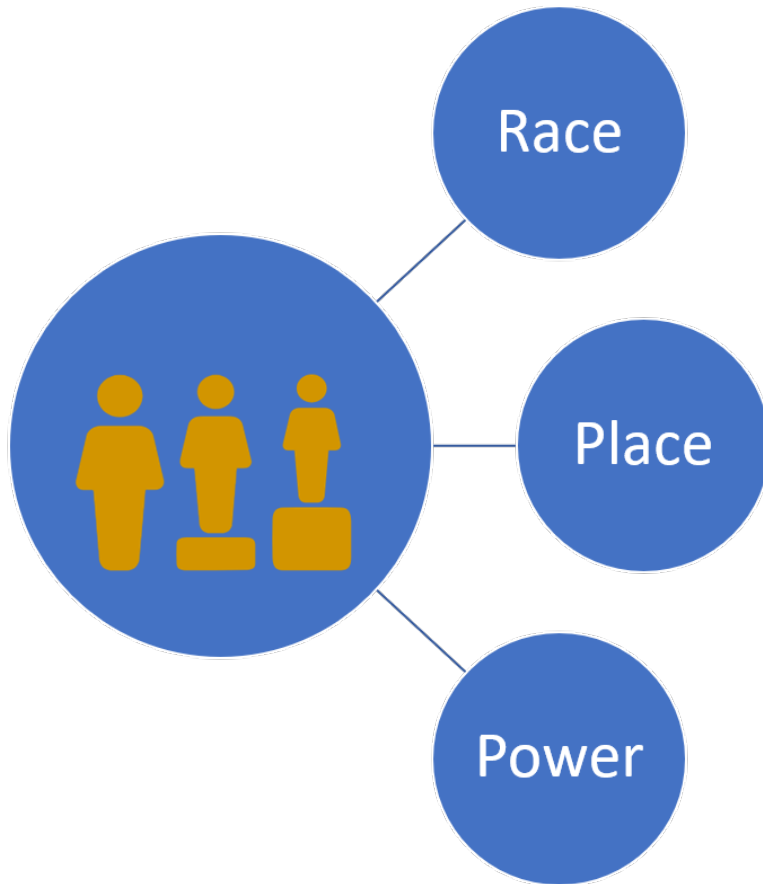
Commonwealth Fund Task Force on Payment and Delivery System Reform: *Advancing Racial equity in Health Care*

1. Stratify, report, use **data** by race and ethnicity
2. Develop, test, and scale **payment** and delivery models to reduce disparities by race and ethnicity
3. Encourage health systems to **confront racism** in their policies and programs, as well as to **meaningfully engage and empower the communities** they serve
4. Expand, diversity, and train the health care **workforce**
5. Assess and develop **protections against racial bias** in health care technology

Three Dimensions of Advancing Equity in a Unified Financing System



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- **Race:** Significant disparities in health outcomes and lifespan exist between different racial and ethnic groups.
- **Place:** Population health outcomes can vary significantly by zip code and the range of community assets and conditions that differ by geography.
- **Power:** The ability of individuals and communities most impacted by structural inequities to exert control over the conditions shaping their lives, including
 - setting agendas
 - shifting public discourse
 - influencing who makes decisions and what those decisions are, as well as how resources are allocated
 - cultivating ongoing relationships of mutual accountability with decision-makers that change systems and advance health equity.

BIG Idea #1 RACE:

Measure and invest in reducing health disparities caused by inequities



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- As the three reports identify, better measure, publicly report, and hold systems accountable for closing race/ethnicity health disparity gaps.
- Commissioner Scheffler suggested one approach - to risk-adjust provider payments:
 - ✓ Such risk-adjusted payments could initially be based on the Healthy Places Index, used by CDPH to create an equity metric during COVID. The HPI can be used with other equity metrics to pay more to providers practicing in communities experiencing the highest disparities who can demonstrably show progress in closing gaps.
 - ✓ Such payments could create incentives/pathways to a) create a more diverse, inclusive workforce that reflects the demographics of these communities and b) proactively reach out to people disenfranchised from the health system
 - ✓ At the same time, over time, the entire health system should be accountable for identifying and closing disparity gaps everywhere – not just a subset of communities



BIG Idea #2 PLACE:

Invest in communities that have been historically under-resourced and most affected by racist policies and practices, resulting in poor health

- Specify a portion of total health expenditures – say, 5-10% - and invest them in *communities* that rank in the bottom quartile using an equity metric with the Healthy Places Index.
 - ✓ Other states - including Arizona, Nevada, Oregon, Ohio - are leveraging a portion of Medicaid dollars for community investments
 - ✓ CalAIM is a great start for addressing health related social needs – e.g., paying for asthma remediation, housing navigation, medically tailored meals, etc.
 - ✓ Demonstrations around the state are showing how to connect health care with broader social services and public health
- Support a diverse, inclusive workforce, drawn from local communities and housed in local communities.

BIG Idea #3: **POWER:** Shift Power from Institutions to Community



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- Create and fund Regional Equity Councils/Accountable Communities for Health comprised of and governed by multiple sector and community stakeholders who work together to address the root causes of inequities. As independent entities, such Councils could serve as vehicles of accountability for the health system
- Strengthen existing health organizations' governance by including more members of the community in positions that have power. Regularly solicit meaningful, authentic community input, including on reforms, and establish mechanisms to report back to communities
- Require health plans to contribute to locally governed Wellness Funds designed to address health inequities and improve community health



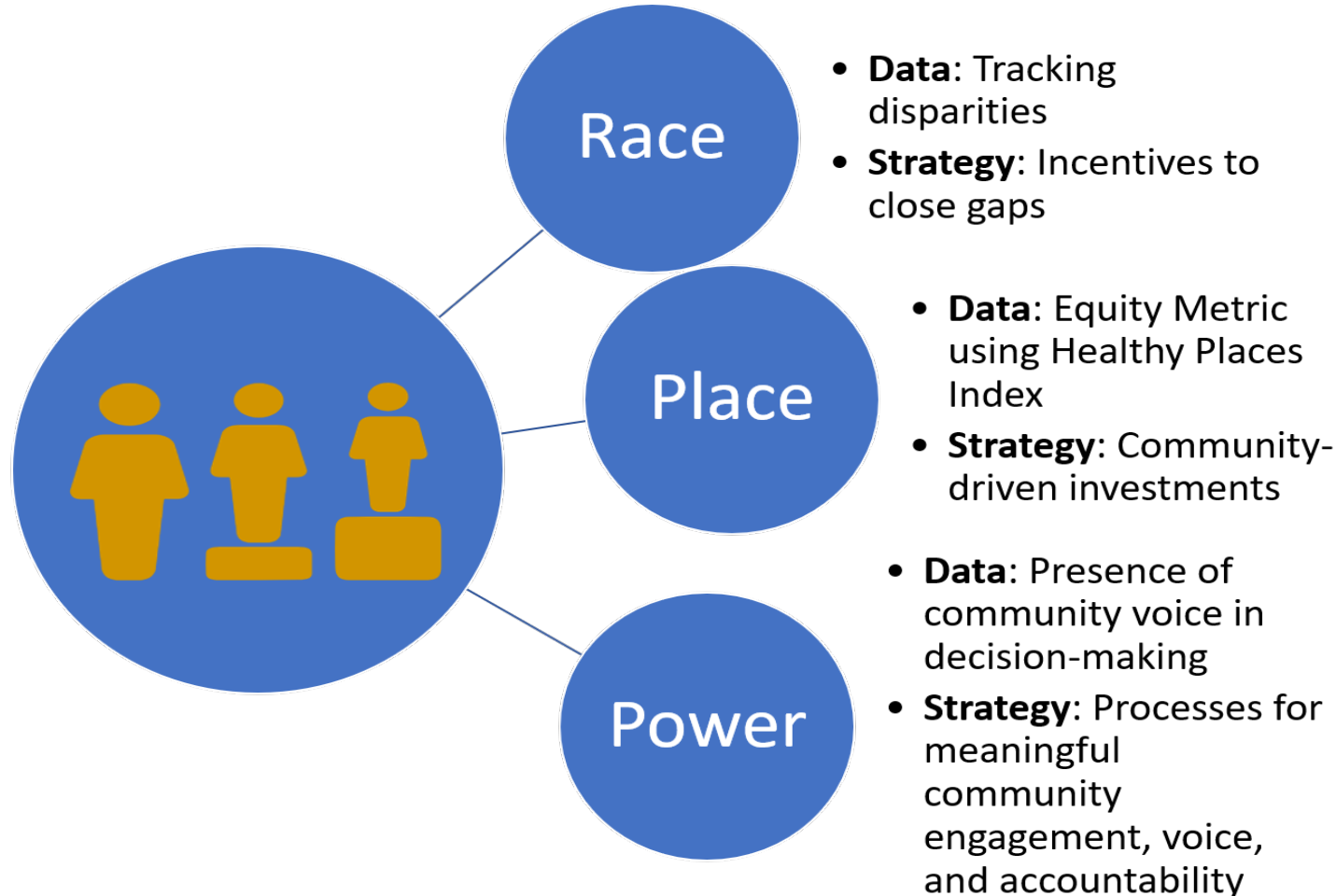
Examples of Big Ideas in Action

- Idea #1: Blue Cross/Blue Shield of Massachusetts is measuring racial and ethnic inequities and including equity measures in contracts and payment programs with clinicians
- Idea #2: The Oregon Health Authority Transformation Center requires coordinated care organizations to reinvest a portion of their net income or reserves on services to address health inequities and the social determinants of health and equity
- Idea #3: California's Accountable Community for Health (ACH) Initiative includes 13 local ACHs comprised of community members and multiple sectors dedicated to improving community health and health equity - e.g., The East San Jose PEACE Partnership, co-chaired by the local Department of Public Health and a grassroots CBO, oversees a Wellness Fund housed at the county medical center foundation.

Three Dimensions of Advancing Equity: Data & Strategy



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The nation's first racially equitable health system, in five years, will have.....



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Commissioner Discussion



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Public Comment



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Adjourn