HEALTHY CALIFORNIA FOR ALL

Accessible, Affordable, Equitable, High Quality, Universal

**Healthy California for All**
**Commission Meeting**
**August 25, 2021**
**Meeting Synopsis**

Note: a video recording of this meeting can be found at: video recording of August 25, 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:
    - Today's discussion is on systems of accountability exploring 1) systems of accountability to assure improved equity, quality and access, and 2) systems to better integrate behavioral health and assure accountability. Two key questions: Under unified financing, what dynamic will lead to improvements in equity, access and quality? In the system of accountability you imagine, what would be done, and by whom, if progress toward goals of equity, access and quality are not advancing as hoped?
    - The final report will include commissioner agreement and differing opinions, but progress is being made on common goals, values, and propositions. A survey will go out to commissioners to get initial feedback. The final report should focus on "how" to get to single payer financing more than "should" we. Commissioner's input on analytic methods and assumptions has been noted and after further commission discussion we will consider whether aspects of the analysis merit adjustment.

- On September 21, there will be a webinar to discuss the preliminary findings from the community engagement process sponsored by The California Endowment, California Health Care Foundation, and California Community Foundation. The next meeting of the Commission will be on September 23. On September 28, we will convene an additional session on racial equity.

- Update on community engagement
  - The community engagement process is underway, gathering a diverse set of opinions, including a random sampling of 1,500 Californians with incomes below 250% of the federal poverty level. In addition, in concert with 40 community-based organizations, interviews have been conducted in English and other native languages, to reach the underserved both in urban and rural communities.

**2. Systems of Accountability, including Behavioral Health**

- Secretary Ghaly shares a definition for accountability, "When an individual or an entity experiences consequences for their performance or actions." He frames the conversation with four questions to keep in mind: Who is being held accountable? Who are they accountable for? What are they accountable for? And what are the levers to assure accountability? Dr. Ghaly introduces Commissioner Lightbourne and State Medicaid Director Jacey Cooper to present on behavioral health integration and accountability.
- Presentation by Jacey Cooper (View the Presentation on Behavioral Health Integration and Accountability):
  - Slide 15: DHCS is California's Single State Agency for Medi-Cal, CA's Medicaid Program, and for federal behavioral health funding. $125 billion annually in public funds, serving ~14 million Californians. Prior to the Affordable Care Act, mental health services were primarily "carved-out" and provided through counties. In 2014, CA elected to adopt an optional benefit expansion, which expanded behavioral health services available in Medi-Cal. Multiple DHCS programs are responsible for behavioral health services and supports: Health Care Delivery Systems: Medi-Cal Managed Care and Fee-for-Service, Medi-Cal Behavioral Health (Specialty Mental Health and Drug Medi-Cal), Community Services (publicly funded, non-Medi-Cal programs), Licensing and Certification (private and publicly funded facilities).
  - Slide 16: A summary of public funding for Community Behavioral Health Services (as of March 2020) is presented: Local Realignment Revenue ($2.7 billion), MHSA/Prop 63 ($2.0 billion), State General Fund ($1.0 billion) Federal Funds ($5.0 billion) for a total of $10.7 billion. $8.8B for County Behavioral Health, $1.9B for Medi-Cal Managed Care.
  - Slide 17: Regarding non-specialty vs specialty mental health services: As defined in State law, Medi-Cal MCPs (managed care providers) are

responsible for providing covered non-specialty mental health services to adult beneficiaries with mild to moderate distress or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders, as well as beneficiaries with potential mental health disorders not yet diagnosed. Consistent with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate under Social Security Act (the Act) § 1905(r), Medi-Cal MCPs and County Mental Health Plans are responsible for providing all medically necessary mental health services for beneficiaries under the age of 21.

- Slide 18: The county MHPs (mental health providers) provide SMHS (specialty mental health services) in the least restrictive community-based settings to promote appropriate and timely access to care for beneficiaries. The SMHS covered under the 1915(b) SMHS Waiver are defined in California's Medicaid State Plan and include a range of interventions to assist beneficiaries with serious emotional and behavioral challenges. These services are as follows: Mental Health Services, Medication Support Services, Day Treatment Intensive, Day Rehabilitation, Crisis Intervention, Crisis Stabilization, Adult Residential Treatment, Crisis Residential Treatment Services, Psychiatric Inpatient Hospital Services, and Targeted Case Management.
- Slide 19: SUD (Substance-Use-Disorder) Services: Covered services provided under a Drug Medi-Cal Treatment Program or a Drug Medi-Cal organized delivery system (DMC-ODS) use criteria adopted by the American Society of Addiction Medicine (ASAM) to determine the appropriate level of care for substance use disorder treatment services. A full assessment utilizing the criteria adopted by ASAM is not required for a beneficiary to begin receiving services. Consistent with the EPSDT mandate under Social Security Act (the Act) § 1905(r), Medi-Cal MCPs and counties are responsible for providing all medically necessary SUD services for beneficiaries under the age of 21.
- Slide 20: Health Care Delivery Systems: Managed Care Plans (MCP) and Medi-Cal Fee-for-Service delivery systems are responsible for the provision of medical/surgical services, pharmacy benefits, preventative substance use disorder services, and non-specialty mental health services. 1) Non-specialty mental health services: Individual and group mental health evaluation and treatment, including psychotherapy, family therapy and dyadic (July 2022); psychological testing, when clinically indicated to evaluate a mental health condition; outpatient services for the purpose of monitoring drug therapy; outpatient laboratory, drugs, supplies and supplements (excluding antipsychotics); and psychiatric consultation. 2) Select substance use disorder (SUD) services delivered in primary care settings, such as tobacco cessation services, screening, brief interventions, and referral to treatment, and the primary care management of opioid use disorder. 3) Prescription Drugs, 4) Emergency Services, regardless of diagnosis, including mental health and

SUD, 5) Transportation to all Medi-Cal services, including specialty mental health and SUD services.

- This all paints the picture of the co-dependencies of these systems. One is responsible, so if you have someone going into the emergency room with a serious mental health condition, the managed care plan is the one responsible for paying, but it's the counties who are responsible to make those connections and that warm handoff to ensure that the follow up is happening. They need to be aware that the emergency department visit took place, that the primary diagnosis was either mental health or STD, and then connect them into that follow-up treatment. This allows for some constructs regarding accountability.
- Slide 21: Medi-Cal Behavioral Health Delivery Systems: For different delivery systems (Managed Care Plans, Fee-for-Service, Specialty Mental Health and Substance Use Disorder, responsibilities for service delivery, legal authority, financing and provider network are summarized.
- Slide 22: Other Community Based Behavioral Health Services:
  Mental Health Services Act (aka, Prop 63)
  Mental Health Block Grant
  Substance Abuse Prevention and Treatment Block Grant (SABG)
- Slide 23: County Behavioral Health Financing
  Bronzan-McCorquodale Act - Realigned responsibility to pay for community mental health services provided to indigent Californians from the State to the Counties.
  1991 Realignment was a legislatively-driven effort initiated in 1991 that approved a half-cent increase in state sales tax and dedicated a portion of vehicle license fees to fund local community mental health services.
  2011 Realignment codified the Behavioral Health Services Subaccount that currently funds SMHS, DMC, residential perinatal drug services and treatment, drug court operations, and other non-DMC programs.
  MHSA revenues, established by Proposition 63, which passed in 2004 and is generated through a 1% surtax on personal income over $1 million, are allocated directly to counties and have helped to significantly fund rehabilitative and preventive mental health services to underserved populations.
  A portion of local revenue generated from property taxes, patient fees, and some payments from private insurance companies is used to fund mental health services, referred to as a Maintenance of Effort (MOE).
  The use of SABG funds only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse.

- Commissioner Lightbourne provides additional context:
  - Publicly funded systems are supported by Medicaid, the Mental Health Services Act, behavioral health block grants, county realignment revenue, and just approved in the recent budget is a $2.5 billion dollar infrastructure fund to

build out behavioral health infrastructure. That funding is intended to go to counties and tribes. What would be affected in a simple unified system?

- The county has the responsibility to integrate public health, mental health, substance use disorder/treatment, IMD institutional services, and county human services systems, particularly programs that serve children, the aged, and disabled. Regarding tax and financing, the state supported counties with the 1991 realignment and the 2011 realignment where the state created new revenue sources and directed them to counties to operate a range of health and human services. This was codified constitutionally so they would have this guarantee. MHSAA is by public initiative and constitutional, so the movement of those resources has to be put into that context. It's not impossible to do, since ACA expansion and the state through the Medicaid program assumed responsibility for indigent health care.
- As we consider a unified financing system, we must account for who owns the revenue, and who is the presumed delivery system. Is that carved back into a unified system, moving it from a county responsibility, and does that serve the policy goal and the social outcome goals that we would consider desirable?
- A question arises as to how we integrate that work with the reforms that are currently underway, that are not contradictory, but are not on a certain timetable, or complete in terms of detail. For example, the CalAIM initiative, which is a very conscious and deliberate effort to say how do we bring together physical health, behavioral health, social care, to address the social determinants of health in many ways represent the building blocks to a unified system. As we develop the recommendations from the commission, it would be useful to keep those initiatives in mind so that they're supportive. Those are the waivers that we are right now negotiating with the federal government.
- We're also in the process of re-procuring all Medi-Cal managed care plans. 85% of the 14 million people covered in Medi-Cal are in managed care, through CalAIM, and that is projected to increase to 95% by 2027. The re-procurements for the commercial plans will be applied to the non-commercial plans in 2024 with five-year contracts anticipated. There's the issue of integrating with that planning timetable. As the commission starts to write our recommendations, these questions and considerations will need to be addressed.

- **Commissioner discussion on systems of accountability & behavioral health**:
  - Secretary Ghaly tees up the discussion, inviting Commissioner Ross to speak on accountable communities for health and how they might serve a role in helping California achieve deeper integration of behavioral health, and Commissioner Wright to speak to the attributes of those systems that have driven disintegration of care, and what we can change. Dr. Ghaly brings up the case of someone with severe and persistent mental illness with complex medical needs that systems don't think to serve or fail at serving. The commission must grapple with the imprecise nature of care with a diverse

provider system driven by different players who come in at different times and all get paid differently. Underfunding and wait times are an issue for behavioral health services and many groups have a hard time meeting the timely access standards we aspire to. If the commission can figure out the issues with the most complicated and least among us, it can take on most other issues. Secretary Ghaly notes the Children's Behavioral Health proposal for kids under 25 years of age, that puts $4.5 billion towards this effort over the next five years to ensure behavioral health and wellness services for young people in California.

- Commissioner Ross:
  - We must get bolder with our thinking and sense of scale. To address health equity, and consider behavioral health, there are three things our health system has never addressed that we've got to infuse and immerse within a systems transformation approach: the matter of race, the matter of place, and the matter of power. If we're not centering race, place, and power, we're going to fall short on addressing inequities. The history of racial injustice affects our health care delivery system. Zip code is a powerful predictor of life expectancy, and that's where the conditions come in. Those most adversely impacted by the system's inability to address equity reveals what we need to fix about the power dynamic.
  - Efforts to modernize are showing us how to build incentives for the true drivers of health from an equity standpoint: payment requirement mechanisms to reach out to community and public health departments, providing for navigators and community health workers for affordable housing and transportation needs, incentives for healthy foods, CalFresh. There are models around the country, and in California, on the power and accountability aspect to integrate physical and behavioral health more effectively. Washington, Oregon, Colorado, North Carolina, Rhode Island are experimenting with health equity zones. Health equity zones in California are 13 accountable communities for health initiatives, public private efforts to bring to center the community experience in the delivery of health care. A briefing from the accountable communities for health effort here in California might help the commission see how folks are beginning to experiment with these kinds of partnership models.
  - The commission needs to make sure to go beyond the typical advisory council of health care delivery and focus on those that are most severely impacted. Communities and grassroots organizations are at the table holding the system accountable for racial, racially equitable delivered care and we should focus not on efforts driven top down from health insurance companies and health plans, but from the grassroots experience up. It is important to make sure those voices are involved and immersed into accountability and not just in some advisory function.

    - In discussing cost through the experience of the most impacted individuals, and through a racial equity lens, including behavioral health, California must look at our expensive prison system. Spending $100,000-150,000 per year to incarcerate, with a percentage of women there as a result of trauma: we are treating too many people with behavioral health issues in our prison system. That is a place where enormous costs are realized.
- Secretary Ghaly queues up Commissioner Wright to speak (and indicates that next he will ask Commissioner Pan, as a physician leader and legislator to speak about CalAIM.)
- Commissioner Wright:
    - There's lots of reasons why health care costs more in America, the work of the Commonwealth Fund and others shows that other industrialized countries spend more on social safety nets, and if we don't invest in these areas it metastasizes in the health care system.
    - The evidence is pretty clear about how our system can be better: it needs to be universal, everybody needs to be in, we need to center this in racial equity, and we need to have behavioral health as something that we think about as an integrated part of health care, rather than as an afterthought.
    - We can require the health plans to provide mental health parity, but what does that mean? On the public side, even with single payer, it's fairly complex. It may be helpful to hear more about the extent to which these bifurcations exist, some for historical reasons that we can move away from. It used to be that the Medi-Cal program was for certain people and now anybody under a certain poverty level is eligible. CalAIM is removing the vestiges of some of these historical reasons. Many of these bifurcations are largely based at the county level. How much of behavioral health should have its own focus with its own section or division versus how much should it be integrated?
- Commissioner Lightbourne:
    - It is important to standardize understandings of what is the access point for care, and to standardize what is that quality of care. That's an accountability structure that works bi-directionally.
    - What other things outside of "health" that are intrinsically local, do we need to keep a tight engagement with? For example, most of the incarcerated people in California aren't in state prisons, they're in county jails. Whatever is proposed must be capable of working with the nuances of local decision makers around law enforcement issues.
    - To the extent that we want to see behavioral health capacity developed and increased, one can argue that the state should do it all. But on the other hand, because of the local control over land use and other issues, this would be difficult. Social care institutions and social determinants are exclusively operated at a local level; human service systems, housing, support systems are all local. The question arises, can it even be done at

the state level? It is important to create accountability structures that are effective and reasonable, but at the same time, realize the nuances of being in an awfully big state.

- Commissioner Pan:
  - Not only do we have stigma issues, but we also have access issues because if you have language barriers, access to mental health is difficult. When we talk about unified financing, we say unified financing. But what else is unified? And where's the direction coming from? That's an accountability issue. How much is local versus state versus federal? It is noted that local county behavioral health departments are still paying for a fine that the federal government imposed on them for not being accountable for the Medi-Cal money they spent.
  - Regarding the $4 billion for Children's Behavioral Health, we're using our Medi-Cal managed care plans to help us do this integration, and that's one of the requirements. The commission has had discussions about the role of these intermediary organizations. But frankly, we're moving more people into managed care to better do this. And we need to think about why. Not just to get better outcomes, but because we need someone to coordinate this. We decided instead of DHCS doing it directly, operating through Medi-Cal managed care plans would be closer to the ground, as some are county organized and other ones have infrastructure already in place. How do we weave these together, looking at different parts that exist in law?
  - In terms of who's responsible: the counties have certain responsibilities, do the state and federal governments have other responsibilities? And how do you align all these things up together? If we create unified financing, how much flexibility for innovation will there be regarding who is in charge of the money? Do we try to standardize things across the board? Do we allow variation? Variation often means disadvantaged communities get the short end of the stick. The people in power have an advantage if we let variation play out. But if we stamp out variation, we lose the opportunity to innovate and come up with different solutions. How do we develop the system to create this flexibility?
- Commissioner Comsti:
  - Commercial plans have been abysmal in terms of mental health parity. If you aren't eligible for Medi-Cal you often get nothing. Insurers often don't pay or underpay for behavioral health as it is not profitable. This is an important issue to underscore. We need to guarantee a right to behavioral health care and that's the importance of having a unified financing single payer system, so we have a single standard of care everyone is guaranteed. When we get rid of fragmentation, we can use those savings to expand benefits for everyone.
  - Regarding racial equity, we do not have enough culturally competent providers. It's not about creating risk-based payments to make sure that

the existing providers provide culturally competent care. Frankly, we just need to train more people and educate people from the community to serve in those roles as licensed health care professionals. When we go to a single payer system, we will better understand where the gaps are. Lastly, talk therapy is not appropriate for everybody. By educating and opening up the stream for people who have lived the experiences from communities that don't have mental health care, we can start to change the nature of how mental health care is practiced.

- Commissioner Marya:
  - California and the US at large have been organized through racial capitalism. There are issues around the distribution of resources and power, and that impacts health broadly. Currently California is on fire, we're in a multi-decade drought, we have energy issues, and health. Our water, soils, lands, health and energy have all been controlled by industries in California that have been unregulated. Private industries that have derived a great deal of profit, and those costs have been externalized into the health of the public. The public health has suffered because of the food industry. The ag industry uses the most water in California and we haven't rethought or regulated that at all. We haven't changed what we're doing in the Central Valley. Now the Klamath River, the salmon are dying. All of these things are hopelessly interconnected. We can't talk about one without talking about them all. Now with millions of unvaccinated kids around the country going back into schools, these things are intersecting in a way that we are grossly underprepared for. Any effort to try to ameliorate them through incremental change, to try to keep these private industries in place that have been profiting off the backs of providers and patients is unconscionable right now.
  - When we talk about behavioral health, that flexibility, that innovation that is hyper localized, let's put that together with the comments of letting those frontline communities lead. Let the impacted communities tell us exactly what they need for their mental health, let them lead. Let's get the private insurance out of California, because it will constantly frustrate our advancement, not just in health care. But in agriculture, in our working lands, our soils, our water.
- Commissioner Marya recommends that the commission look at AB1400. Secretary Ghaly notes that the commission's focus is not on active legislation and that the goal has been to strike a balance between that and bringing in core components of AB 1400. He also notes the commission makes decisions but will keep revisiting them.

- **Systems of accountability to assure improved equity, quality and access**
  - Secretary Ghaly invites Commissioners Scheffler and Flocks to describe the system or systems they think would need to be in place under unified financing

to achieve the outcomes and address the issues we care about. The key questions to discuss are: Under unified financing, what dynamic will lead to improvements in equity, in access and in quality? In the system of accountability you imagine, what would be done, and by whom, if progress on goals of equity, access and quality are not advancing as hoped?

- Commissioner Scheffler presents to the group:
  - As soon as we begin to talk unified financing and what would improve access and quality, equity comes up. In September we will do a deep dive, but to start the conversation, it starts with theories of social and distributive justice. This means health care is distributed according to need and not based on a person's personal characteristics, economic or social position. That is the basic formation of health equity that is used in the National Health Service in the UK, and in Canada, and other high-income countries. But even with that, disparities still exist. Funding is allocated in these systems on a calculation of need, which means more resources often go to poor individuals and communities. We need to eliminate disparities and include social determinants of health related to zip code, transportation, housing, income, education and food access. In a unified financing system that uses risk-based capitation payments, we can adjust the payments for these key factors. Risk based capitation will only need to occur at the organizational level to ensure there is a budget for populations; individual providers could still be paid on a fee for service basis.
  - An integrated delivery system, in comparison to the fragmented fee for service system, is when all providers – doctors, nurses, physician assistants, pharmacists, frontline health care workers – work together as a team. They share medical information in one patient record and there's accountability and responsibility for the patient's outcome. Resources are more coordinated. It avoids a lot of duplication and produces savings in the health care system.
  - California has the most integrated delivery system in the country. Over 65% of the providers are already in risk-based plans. Over half the doctors are in medical groups whose size is at least 30. There are 80 accountable care organizations. The Medicare program is at 70 to 80% capitation. At the federal level, most people in Medicare are choosing Medicare Advantage, around 40% in California.
  - The second question: What dynamics under a unified financing system will lead to improvements in health equities? Our ability to measure health disparities will improve dramatically if we use one uniform data system. Individuals can be followed over the life course and equity could be traced. A unified system could cover everybody with the same benefits. Race, culture, gender, social economic position would play no role. Eliminating the overly complicated and incomprehensible paperwork to sign up for benefits and access to care will also be eliminated, and that would help

improve disparities. Access would be improved for those who have limited resources, as economic barriers are removed. If this system was financed by a progressive tax, it would improve the distribution of income and enhance financial equity. At the highest level, the state would be accountable for health equity, with input from all groups, especially those at the community level.

- California's response to the pandemic that allocated resources to the local level did include measures of health disparities, and we may want to elaborate on how this was done. Given the racial and cultural diversity of California, eliminating disparities will be a real challenge. California is the wealthiest and most diverse state in the union with the highest linguistic diversity, second highest in race and ethnic diversity, and the fourth most unequal distribution of income. This suggests that California both has enormous disparities, as well as the resources to address them.
- Plans and providers need to be held accountable for health equity. A way of doing this might be the creation of a health equity score for plans and providers. Those with unacceptable scores would have their resources and payments reduced. The UK has recently created an observatory for race and health, which monitors health inequities, and funds research to address them. France has done the same. Both focus on actual policies that can be used to address health disparities. The commission might consider recommending a similar monitoring and research approach, as well as recommending action steps. Using health equity scores for integrated delivery systems, we can adjust their payments by the equity scores to address the social determinants of health.

- Commission Flocks presents to the group:
  - In terms of access, we want universal coverage, which means people are getting the care that they need when they need it without a financial burden. When we talk about quality, this means medically, culturally, linguistically appropriate care where there is not a misuse and overuse or under treatment that improves health outcomes. With equity, as Commissioner Ross said it is about race, place and power. It also involves social and distributive justice as Commissioner Scheffler noted. It doesn't mean that we're looking at distributing our health care resources and care equally to everybody. But that there is a redistribution of these resources so that we're addressing the legacies of racism and biases of prejudice that are built into the health care system. With all of these we will need to discuss cost containment.
  - When we talk about accountability, to be successful we need a system that is equitable and high quality, but also sustainable. Every dollar we spend in our health care system comes out of a worker’s pocket. Under unified financing it's going to be coming from taxpayers, or in the form of budget cuts. We need to have cost containment and budget at the root of

everything. We need data to set a baseline so we know what we're measuring, can see change over time, and be able to identify where the improvements are happening and where we need to see changes. One of the advantages of unified financing is we can finally have a statewide unified look at our health care system. Right now, we have fragmentation and a lack of transparency on prices. We can finally bring together a lot of this data and think about what we need to collect in order to set up systems of accountability.

- In looking at the Office of Health Care Affordability proposal, it revealed we don't have an entity that looks across the entire health care industry, from insurers, providers, hospitals, drug companies. That's what we need in terms of data—unified data. To get to equity, we need to collect information on race, gender, gender identity, income, and all the data points on users of the system. We need to look at performance measures for health systems, for medical groups, down to the very granular individual provider level, so that we start to make improvements, if need be, or find models that are really working. We need an analysis of where our resources go, and where we have medically underserved areas. Where do we have health systems and health facilities that have all the most high-tech equipment? Where are the providers who are multilingual, who are culturally appropriate? Where do we not have those providers or a mismatch with the population? We need to set up these systems so that we can have accountability.
- For levers, we need to focus on payment systems and payment reform, looking at other countries where they regulate prices and what people are paid. Medicare is a publicly available transparent system with a baseline we can use to build upon. Whether we're doing it as capitation or global budgets, or some other system of payment, it needs to be standardized and transparent. And then we can have a conversation about where we need to have additional payments to achieve equity, to reward and value quality or to increase access.
- Care coordination is important. There are going to be inequities in people's ability to navigate the system and inequities in how they can advocate for the kind of coordination that they need. This doesn't need to be done by insurers or health plans or managed care organizations. We don't need to have financial risk bearing intermediaries in the system. There was a New York Times article about price transparency, where they looked at the five most powerful insurers and found that they got surprisingly unfavorable rates for consumers. So, what are insurers doing? They can't get good prices. They're denying care. Is there a way that we can take some of the good roles, the managing care, and take it out of profit, and have a new role? There could be a role for integrated health systems in care coordination. There could be a role for community-based organizations,

unions, clinics, nonprofits, in doing this kind of care coordination, as a benefit under this new system, as wraparound, supplemental care.

- Unions are a good example but not the only example of a trusted organization with access to workers or to patients. Union organizers can go into workplaces and talk to people about wellness, see who has a chronic illness and might need more assistance in either navigating the system or having adherence to protocols or to medication. When we open up networks, there will be people that need a navigator and guide, and maybe it needs to be from someone who's there in other arenas of their lives that is trusted. We see the benefits of this with vaccines during the pandemic, and this is something that could be formalized.
- In terms of savings, outside of payment, there may be a need in governance of the unified financing system to have additional funds to our goals in terms of access quality and equity. There have been proposals for health equity funds in the Department of Public Health or racial justice funds within the Department of Public Health, where we think about what are some of the social determinants of health that are standing in the way of us meeting our goals? And how do we get money outside of payments to get there? This might entail looking at capital budgets or resources or technology.
- There is a huge workforce need for linguistically and culturally competent providers. Professor Hsiao's 2011 article on the Vermont system is recommended for suggestions about how you get medical students and health care workers to go to in other areas. For example, repaying student loans, but also home loans. Do people want more days off, less administrative burden, increased salary? We need to create these incentives to make sure that we have enough health care workers and needed workforce to staff the system, and that they are in the right places.
- In terms of accountability, besides having unified financing and unified data and health information technology, we need to have a unified or at least a collaborative, regulatory regime. Part of that is going to be a governance question. We have a lot of regulatory and licensing entities already. The state can be accountable and the governing board. Whoever is making decisions about unified financing is accountable to the people who are paying into the system. Any entity that is receiving payment or profit from the system should be accountable. This means consequences. Can we do a performance improvement plan? Can there be a part of the regulatory body saying we want you to succeed in the system? How do we come in there and help? This is something that they've talked about in Massachusetts, with their soft cap on growth. Is there a model there? And then if not, what are the consequences and what levers does the state have?

    - Our workforce needs are going to skyrocket, not just in in frontline health care providers, but also in the number of people we're going to need in the public sector to be able to do the administration, claims administration, oversight, and regulatory authority. And that is somewhere we can develop career ladders. We don't have a session on workforce, but I do think that that is an incredibly important part because it is very hard to distribute resources if we don't have enough people with the skills needed.
- **Commission discussion on systems of accountability to assure improved equity, quality and access**
- Secretary Ghaly queues up Commissioner Hsiao to speak to how the Taiwanese system is held accountable? Who's being held accountable and by whom? And what are the consequences when somebody isn't meeting them? And then queues up Commissioner Chin Hansen to speak regarding lessons or concepts around accountability from how the PACE program evolved over time.
- Commissioner Hsiao:
    - Taiwan's political leaders realized health expenditure is going to be a major expense and the people who have to pay usually say “I don't want to pay more,” the people who want to get the benefits or payments say “I want more benefits or I want higher payments,” so Taiwan moved to design a system that takes the government out of the middle. That design is basically a board where the payers, beneficiaries and providers are represented and then negotiate. The government may set a maximum ceiling, the greatest increase could be XYZ. This is how to produce a balance between the people who want more and higher pay, and the people who must pay as well as insulate the politics, the special interest groups. It is strongly recommended that California think that way. The Federal Reserve for example is still responsible to the legislature, but is semi-independent, accountable for the results. The board or agency sets things you want them to be held accountable for, but lets them devise the best way to achieve it.
    - To achieve the goals of equity, it should be measured and the agency who runs it should be held accountable. Who below the government agency is held accountable? With a unified financing agency, the power you have is money power, so use the payment system. Create incentives, down to the county level and the provider level, to focus on what patients need. The delivery of care and quality of care are done by providers and managed by the counties. To do that, we have to think about the financial constraints. How do we actually produce efficiency from the system as well as improve the quality of care? That's in an integrated delivery system. We can criticize managed care, but there are ways to improve on it. We should not throw the baby out with the bathwater. Because we really need integrated

delivery as we noted with behavioral health. Integration is usually achieved by payment systems.
    - Allocate the revenue of the unified financing to every county based on a risk adjusted payment, but also take into account equity. If they have lower income, you give them higher pay. If their mortality, mobility, etc. rates are poorer, there's a greater need. That is what the UK and Canada are doing. We don't have to reinvent the wheel; first allocate down to the local level, then let our local community manage their money. That's the allocation formula.
- Commissioner Chin Hansen:
    - Is there a way to have payment go to a responsible entity? We were thinking county perhaps. There is a bottom-up way of thinking about both accountability and payment. PACE, the Program, of All-inclusive Care for the Elderly, is a fully risk based capitated program that started in low-income communities and focused on well-being and clinical outcomes for people who would normally go to a nursing home. For integration, you have one entity that receives a capitated amount from Medi-Cal and a capitated amount from Medicare, blended together. And the accountable entity is the program called PACE. There are 20 different entities here in California. It operates in this format of accountability from the federal, state and the PACE provider. It's a contract that crosses all three entities. Everything that's done for this population, PACE is responsible for. Whether it's for payment, quality, ethics, things like meals and transportation. It's a model that just takes care of a group of people who would normally be in a nursing home and in the end, about maybe 10% end up residing in a nursing home, but PACE is still accountable and responsible for their care. It's a voluntary program; you have to meet state criteria that you would be in a nursing home, but for being in this program. This is the model that comes about with accountability, and financing, and teamwork. The majority of PACE staff are community-based health workers who are culturally from the respective communities. The goal is to be the accountable entity. It is anchored on both the clinical quality standards that report up to all the licensing agencies, but it also has a community board. It is a system of care that follows you all the way to the hospital and to the home. The goal is to see that people get the care they need to live life best. During COVID, the death rate was disproportionately high for older people but for those in PACE programs throughout the country, it was far, far less. The ability to adapt to the needs of people is greater. This is one way of blending money, risk adjusted, as well as supporting an integrated team and being legally and ethically accountable to a group of people who are extremely complex. PACE is a great model with a higher quality of care at a lower cost; an appropriate example of accountability and how things can work.

- Commissioner Wood:
  - Data is absolutely critical. We don't know what we don't know. We can learn about outcomes from how the money's being spent, and from that information we can demand accountability of providers and make sure that care is appropriate. We can also have a much better handle on costs. Who is getting the best value for what they're doing? Why is it that in San Diego, people pay 20% less for their health care, and get better health care than they do in far northeast California, a rural area? Why is that happening? Why are we not learning from that? If we are going to be successful with a unified and fiscally responsible payment system, we have to get our arms around the cost and bending that cost curve. We need to look at the impacts of consolidation, we need to make sure that health data information is exchanged freely so that as people travel throughout the state or between providers that they get information that is timely and appropriate so we're not duplicating services. With all of that data, we can now force accountability in many ways, because you know where it's going, where it's working well and where it's not.
- Commissioner Lee:
  - STEEEP: Safe, timely, effective, efficient, equitable and patient-centered care, which means culturally appropriate. At Covered California there's a whole range of ways we focus on accountability, anchored in data. All of the plans give all of their data, it is organized by race, ethnicity, and other factors. There is variable quality of care amongst the 11 health plans, so even Kaiser, which has demonstrably far higher likelihood of getting good outcomes, has variation from health center to health center. The health plans are accountable for how they promote care coordination, integration, are they in contract with ACOs. There needs to be an organizer. It doesn't have to be the health plan. There is a concern in having 70,000 individual doctors coordinating all this with their teams. There are mental behavioral health issues along with physical health, along with inpatient, along with outpatient. One person doesn't do that. There is concern with an enforcement approach that looks individualized, versus intermediaries. We need to figure out how do we classify them? How do we define them? And then how do we have the right data to assess what they're doing?
  - Building on Commissioner Flocks' comment, Unite Here doesn't employ the organizers of the care, they contract with, for instance, USC Medical School, to delivery care. They've got an intermediary there, but they're the payer, nonprofit, saying, here's how we're going to structure our benefits, and we're going to hold that intermediary accountable. In some ways, to use the Unite Here metaphor, we want the state of California to be sitting like Unite Here does, not by thinking about profit, but thinking about holding the intermediaries they're contracting with accountable to do the right thing at the right level. One challenge is data. The other bigger challenge is we

do a lot. At Covered California, 1.6 million lives, 2.5 million if you look at the individual market, and that's tiny. The benefits of a unified anything is common signals around payment and around accountability.

- 50% of Californians right now are on employer-based coverage. If a unified system is getting rid of that we better have a system that addresses those 50% of Californians' behavioral health issues. And for many of them, they aren't like the Medi-Cal mix. Medi-Cal is much more weighted towards people that need inpatient care. People covered through employers, are more apt to be people who want to keep out of those settings, and Carmen is right, there aren't enough providers. How are we changing payments so there's a stream of providers that are culturally sensitive? If we aren't thinking through all of these discussions about what works for the 50% of the people that now have employer-based coverage, this isn't going to work politically.
- The question was raised earlier about whole person care. In the commercial sector there are mental health carve outs, and you can't carve out from a human being mental health or behavioral health issues. That's why you need an integrated system, which is looking at all of it because if the finances are split up, you can't split a person up. Integration is needed because you can't separate out the behavioral and physical health issues.

- Commissioner Comsti:
  - When we're talking about accountability, the system and providers should be accountable to patients, and then the system and providers should be accountable for getting patients the health care they need. We must caution against saying that our accountability is to cost containment, which could lead us to placing that above the principles of equity, quality, and access. That shouldn't be the case. We need to be able to figure out how we can meet those principles of equity, quality and access without failing to get patients the care that they need. The way that the governmental board and the regulators of the system become accountable is through the universal guarantees and the single standard of care that we create under the law itself. All of this is really important, because what it means is that to get to health equity, we need structural changes to the system. Which is why single payer is the way to do this, to have a single high quality standard of care.
  - If we have roles for intermediaries, gatekeepers, whether they're insurance insurers or managed care organizations, what we're doing is building in fragmentation of care delivery and plans within the system. And this fragmentation by its very design will always results in unequal systems because there are different networks, different plans, and we can expect it to produce inequity. It is not a good idea to use risk-based capitation or integrated payment schemes to get to health equity, these are inappropriate systems of accountability. We can't assume that integrated

payment would result in integrated care, those are separate things, and these types of risk-based payment systems change the way that providers are basing their care decisions, they ask providers to be economic actors. That's why it's a poor system of accountability because providers become accountable to their financial risk and their pocketbooks rather than accountable to their patient or the doctor patient relationship.

- As an alternative, what else is there that we can have as a system of accountability? There are single payer proposals out there in AB 1400, with levers within the system to create systems of accountability so that we can regularly assess for equity, access, and quality. A unified system is better situated to create the regulatory framework to implement structural interventions. Statewide health planning would be much easier and more effective under a unified system with one plan, because there would only be one system and one set of rules. What we would do is first identify the health inequities and then direct the resources to begin the process of rebuilding our health care infrastructure.
- One of the things built into AB 1400 is a regular auditing and assessment system and built-in mechanisms to get funding out to different projects, whether it's creating more facilities or financing an individual facility for more staffing for safer standards of care, health and safety policies within those systems. This direct provider to system relationship would make it easier for regulators to demand equity, quality, and access requirements in the conditions of participation with providers.
- We can demand with these direct negotiations with providers, appropriate, culturally appropriate care: staffing, good jobs, fair wages, so that it doesn't come out of pockets of workers. That's why with the single payer system with the direct payments model, when the system is directly negotiating with the providers, we can achieve that because there is an accountability structure in terms of the contract between the system and the providers, and we can manage that as a whole because it would be transparent.
- Regarding the idea that we can fiddle with quality metrics or some algorithm to assess health equity, we need to be very cautious here, because this over reliance on incentives and quality metrics that incentivize different types of payments or health equity, turns into teaching to the test, and providers are less accountable to the individual patient’s need. We're really asking the providers again to profile individuals based on population statistics. That really interferes with the doctor patient relationship. If we have a health equity score, it could potentially penalize providers with low scores, because those providers care for sicker historically underserved patients. There's risk adjustment, but risk adjustment has its problems, not medical indicators, and other proxies can end up baking in racial biases, racial stereotypes, inequities in the provision of care. We need to be very cautious about these things. There have been a lot of studies on how these

algorithmic risk adjustment tools can cause and exacerbate health care inequities. The problems of health inequity are based on social issues and not medical issues. We need to be cautious about baking in these racial and other stereotypes when trying to address health inequity.

- Commissioner Wright:
  - What happens when we gave a risk adjusted amount to counties? We can try to design the ideal system, but also we have to think about the realities. In education, California allocates money to school districts, but school districts can raise some money on their own through their property taxes, etc. Other people walk away from the system, they still pay their taxes, but they buy private education. There's no single payer system which doesn't allow people to basically buy out of it. What can we learn from how we finance public education to looking at unified financing of health care?
- Commissioner Hsiao:
  - With unified financing, there is an equitable way to finance health care, but you need the next layer of administration. One suggestion from what the UK and Canada central governments have done is they allocate their money to different regions according to a risk adjusted but equity adjusted formula to say, we're going to compensate you, because your health status shows worse. There are underlying reasons for that, and you need resources to deal with that. Then you leave it to the local community or the region to find their own answers. Then the central government, in this case, California government, hold the counties accountable for it. And then you develop a monitoring system, as well as a penalty system, like the education system. However, in the education system, there is more independence given to local school boards. The state, when it allocates the money to the county, should have much tighter rules and hold them accountable for outcomes. And if they did not meet those outcomes, penalize them or require them to change their administration, and that's where the difference is. Every county will go down to the next layer, maybe contracting out these accountable organizations, maybe a new form of integrated delivery system.
  - If you want to integrate delivery, you need the agent, you need the organization to coordinate and motivate the providers to coordinate with their colleagues, with nurses, physician’s aides, with rehab centers, it's called a complicated production process. Somebody has to manage that. Regardless, if you call them intermediary or managed care, if you're going to have a coordinated production of the high-quality care, you need an agency there. That agency could be under the county law, the county manager locally, just like the County School Board may manage the school, different districts differently in California.
  - Politics and money can influence and distort the system. Distortions in Medicare come from lobbyists and powerful political groups. How can we

change that? We should really think hard about different layers of administration, not just at the state level, but down to some regional level, then down to the provider level. With each one, who is responsible? What are they responsible for? How do you create a power structure that will serve the patient's interests? Not somebody else's interests?

- Commissioner Schneider:
  - There is concern when talking about a program where money gets devolved from the state to local entities based on geographic characteristics. Regions or localities don't get sick, people get sick. Thinking back to PACE, the underlying driver of that arrangement is that individual Medicare beneficiaries who also happen to be dually eligible as individual Medicaid beneficiaries, have an individual entitlement to a defined set of benefits and it's enforceable. The funding stream gets blended, the PACE providers are accountable to the beneficiary and accountable to both Medicare and Medicaid. Individuals have rights in the current system and there is concern about transferring those rights to localities or regions.
- Commissioner Scheffler:
  - There seems to be more agreement than disagreement about the need to provide an integrated care delivery system. The difference is in how one might do it. We all agree integration offers higher quality care. All the studies say so and it happens to be more cost effective. The fear of it is this concept of a gatekeeper who has the power to tell you no, you can't get this care and there's nothing you can do about it. There are a lot of managed care organizations that don't have gatekeepers. They use primary care doctors to coordinate the care. That fear of a gatekeeper still has people concerned about an integrated delivery system.
  - It's impossible to have this team game without a team budget. If you were to distribute a budget, the first thing you'd ask is how many people are in the plan? That's a capitation because they get a certain amount of money per member per month. The risk adjustment part is simply to say that people in plans have different health risks. This is a very common way of allocating resources. There is a big difference when you go to the idea of the county. The capacity to do this in the 58 counties varies dramatically. It may be better to do it at the plan level. And not that the counties wouldn't have a role but to give the money to the organization that delivers the care. There can be direct contracting, but someone still has to collect the money, the benefits, pay it out, and make sure it operates. There is lots of good evidence that California is a leader in capitated risk-based integration.
- Commissioner Antonia Hernandez:
  - Regarding counties, the complexity of bureaucracies would make it difficult to achieve the goal of uniformity of quality of care. If we give that power to the counties it's going to be county by county, so from a practical, structural

perspective, we need to be mindful that we are trying to provide quality care to everyone in California.

- **Chair's reflections:**
- Secretary Ghaly summarizes a few key points, underscoring that California, due to its unique nature, will need to consider some parts of the delivery system in unique ways. California's size, existing variations in delivery and payment bring some risk of over-complicating. Unified financing provides opportunities to do things in the behavioral health and public health space that we wouldn't be able to do in a fragmented financing system. In the second part of the conversation around accountability, one unifying theme is that unified financing drives new opportunities around accountability, data, a standard approach and standard set of benefits, and then some real opportunity around the distribution of resources, whether financing or staff, in an equitable way. There's an opportunity to over invest to allow some left-behind communities to catch up. There is a lot of common ground, and all of this will be put together in summaries and those goals and priorities commissioners will be able to review and add to.

- 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 August 25 2021 meeting.

3. **Adjournment**
   - Secretary Ghaly thanks the public and commissioners for their input and rich discussion. He notes there will be some restructuring of the roadmap to flip the payment conversation and federal engagement conversation, and that will be what is focused on in September, then the payment conversation in October. There will also be a conversation and preview on community engagement.
   - Secretary Ghaly adjourns the meeting.