Healthy California for All
Commission Meeting
October 11, 2021
Meeting Synopsis

Note: a video recording of this meeting can be found at: video recording of October 11, 2021 Healthy CA for All Commission meeting.

Commissioners in attendance: Mark Ghaly, Sara Flocks, Jennie Chin Hansen, Sandra Hernandez, Andy Schneider, Carmen Comsti, Antonia Hernandez, Richard Scheffler, Jim Wood, Anthony Wright, Bill Hsiao, Michelle Baass, Rupa Marya, 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, reviews the agenda and upcoming commission meetings on November 17th, December 9th, and January 12th – noting the topics to be discussed are not yet finalized. A revised and expanded survey for commissioners on Goals, Values, and Propositions will be sent out in the next few weeks.

2. **Provider Payments**
   - Secretary Ghaly introduces the primary topic of the day, provider payments in a unified financing system, asking three questions: Who do we pay? How much do we pay? What are we paying for? He notes the current system is a patchwork of funding streams with different reimbursement arrangements to support different populations. This fragmented financing creates inequities and complexity. Hospitals and physicians are paid more for serving privately insured patients, different payment mechanisms provide incentives for different types of care, which makes it challenging to advance goals of access, quality, and equity. For providers, the patchwork of funding and uncertainty about how much one gets paid for certain types of care, including preventative services, means no matter

how well-intentioned, providers spend a lot of energy trying to understand and work around payment arrangements rather than having a reliable, guaranteed flow of funds. Under unified financing, the distinctions among Medicare, Medi-Cal, and private insurance would be eliminated, and reimbursement rates to providers would not depend on a patient's income, employment status, race/ethnicity, or other characteristics. The speakers will focus on some of the innovative ways progress has been made toward aligning payments with better outcomes in terms of quality and equity, and how unified financing can open doors to even greater progress, as well as what transition issues and timing considerations may arise in moving towards a unified financing system. He frames the upcoming conversations with a question: How could payment arrangements be reimagined and rebalanced to drive us towards high-quality, equitable, accessible, and affordable health care for all?

- Presentation by Don Moulds, CalPERS Chief Health Director, on health care spending and cost drivers (View the Presentation on Setting the Stage: Costs, Cost Drivers, and Getting More from Our Investment in Health):
  - Slide 8: Health care spending as a percentage of GDP in the US has risen from 6.9% in 1970 to 17.7% in 2019.
  - Slide 9: Health spending growth has outpaced both inflation and economic growth of the United States economy over the last 50 years.
  - Slide 10: The U.S. spends the most on health care (16.9% of GDP vs 12.2% in Sweden, the next highest, 9.8% in the UK).
  - Slide 11: Comparing health outcomes, disease burden is higher in the U.S. than in comparable countries (26k per 100k, vs. 20k per 100k in the UK, the next highest, and 18.9k for the comparable country average).
  - Slide 12: The U.S. spends the least on social services and the most on health care spending. Other comparable countries spend almost twice as much on social services than health care, and in the U.S. it is the opposite (16% health care/9%social services vs. 12%/20% in France).
  - Slide 13: CalPERS health spend: $9.6 billion spent to purchase health benefits in 2020, 1.5 million members, $6,457 annual health spend per member.
  - Slide 14: A graph shows where the money goes: 18% prescriptions, 27% inpatient, 10% ambulatory surgery, 7% office visits, 7% emergency room, 7% medical prescriptions, and 4% preventative care, to name some top expenditures.
  - Slide 15: From 2015 to 2019 prices increased by 18.3% while the cumulative growth in utilization was only 3.6% over the same period. Spending is driven by costs not utilization.
  - Slide 16: Higher costs do not equal higher quality.
  - Slide 17: He notes the cost variation in California based on location.
  - Slide 18: Health care markets don't fully value quality or quality improvement, efficiency, prevention, care coordination, or equity.

- Slide 19: Some things we've tried: bundled payments, hospital readmission penalties, accountable care organizations, cost control commissions.
- Slide 20: One of the biggest challenges for payment reform is that success with containing costs in some areas often results in cost drivers shifting to other areas.
- Slide 21: Key considerations: 1) Universal financing may create an environment that is more conducive to cost control. But right-sizing costs will require a distinct cost control strategy. 2) Unified Health System Financing alone may not bridge the gap between U.S./CA health outcomes and other wealthy nations; addressing forces outside the health system is critical.
- Slide 22: He ends with some key questions for the commission: What key strategies should we employ to right-size health care spending? Which of the payment models we employ in our current health system translate under unified financing? Which do not? What great payment models should we be looking to steal from other countries – e.g. the United Kingdom's National Institute for Health and Care Excellence (NICE)? Understanding that much of what drives health status sits outside of the health care system, what is our strategy for improving health? Should our goal be reducing health care spending to free up resources for, say, better social supports, or should we be trying to address other needs through the health system?

- Dana Gelb Safran, Sc.D., President and CEO of the National Quality Forum presents on value-based payments and health equity. (View the presentation on Value Based Payment & Health Equity: Can We Advance These in Tandem?)
  - Slide 25: In 2007, leaders at Blue Cross Blue Shield of Massachusetts (BCBSMA) challenged the company to develop a new contract model that would improve quality and outcomes while significantly slowing the rate of growth in health care spending. The Massachusetts health reform law (2006) caused a bright light to shine on the issue of unrelenting double-digit increases in health care spending.
  - Slide 26: Key components of the AQC model that made it unique: 1) Accountability for quality and resource use across full care continuum over a five year period, 2) Controls for cost growth (global population based budget, shared risk 2-sided symmetrical, health status adjusted, annual inflation targets set at baseline annually and designed to significantly moderate cost growth), 3) Improved quality, safety, and outcomes (Robust performance measure set creates accountability for quality, safety and outcomes across the continuum, and substantial financial incentives for high performance and for improvement). If a typical budget was at that time about $350 per member per month, that means up to $35 per member per month, times 12 months a year times at least 10,000 members required to have actuarially sound budgets meant that there were millions of dollars in upside earning potential based on quality performance.

- Slide 27: An overview of what those quality measures looked like, including ambulatory and hospital measures in order to reflect the continuum of care that a provider should be accountable for. Both of those settings included a set of process outcome and patient experience measures. On the ambulatory side, the outcome measures were triple weighted, as they reflected the most important goals. Quality and accountability models, or Value Based Payment Models, have roughly the same measures in them today that the AQC contract had in 2007, and that this needs to be updated.
- Slide 28: The results achieved were across the board in adult chronic care, the process aspects of ambulatory care, pediatric care, and the outcomes that were triple weighted. She notes these outcomes were not possible without thinking of patients outside of clinical settings, where patients have to change behaviors, take medications, change their diet, etc. How they did that was to practice patient-centered care, thinking about how barriers (cognitive, environmental, financial, motivation) and could be addressed.
- Slide 29: The result was that some of the long-standing disparities in care associated with socio-economic status were narrowed. In this model, it did not adjust for social risk factors and in performance, as it was not fair to set a lower standard of care due to socio-economic status.
- Slide 30: A team at Harvard Medical School was tracking the impact on cost and quality in a very rigorous way. And in the eight-year outcomes, results found that the 10% trend savings on average had been achieved through the AQC, relative to the counterfactual of the absence of the AQC.
- Slide 31: When it comes to addressing social risks, we should be adjusting payment, not performance scores. Those who are serving a disproportionately lower income or higher social risk population should receive greater resources to apply to the care for that population, and/or upfront and/or enhanced performance payments based on the degree of difficulty of achieving a given level of outcomes for a population that has higher social risk.

- Joshua M. Sharfstein, M.D. presents on global budgets (View the presentation on All-Payer Global Hospital Budgets)
  - Slide 34: Since the late 1970's, Maryland has had rate setting for hospitals (a commission gives a rate card to each hospital, and everyone pays those rates). Medicare paid Medicare rates in 49 states and districts and paid Maryland rates in Maryland. The two strings attached were all payers had to be treated equally and Maryland's prices couldn't rise faster than the national rate of growth in prices. That was the fuel for Maryland's fee-for-service system where every hospital got a rate card. In 2014, one of the strings began to pull on the system and Maryland couldn't keep its prices down. To rethink the system, working with the hospitals, Maryland decided to try global budgeting. Instead of a rate card, they gave each hospital a budget for the year. If they prevent illness, they get the financial benefits right away. The hospital gets the benefit if fewer people get sick. Previously, in areas with

higher health care needs (from many preventable issues), hospitals got paid more, but in a global budgeting system, there is a stronger alignment and more incentive for prevention.

- Slide 35: Fee-for-service hospital reimbursements are expensive and are poorly aligned with improved health outcomes. They also threaten the viability of hospitals in many areas. By contrast, global budgets: 1) Provide stability to hospitals, allowing them to shift services based on community needs, and 2) Create a way for hospitals to “make money” through prevention. This created an incentive to invest outside the walls of the hospital and make partnerships in order to be successful under their core payment model.
- Slide 36: In Maryland, global hospital budgets have led to 1) Care redesign efforts, 2) Coordination with primary care, 3) Regional prevention efforts (including housing investments), 4) Population health goals (initially diabetes, overdoses, childhood asthma, and maternal health outcomes). One CEO said, "We started asking ourselves, why do we give phone numbers and not appointments? The previous motto was 'we'll always be here for you' and the new motto was 'we hope to never see you again.'" That’s what it means to switch to a global budget. He tells a story of a crisis in which a school had fired all the school nurses in the health department, and the CEO of a hospital in the county stepped up to hire all the nurses for the schools. Based on the global budget, they figured they could run the school health program and break even and reduce the number of kids coming into the hospital for asthma.
- Slide 37: Maryland Top Line Results: Initial 5-year results, 2014-2018, $1.4 billion in Medicare hospital savings, $869 million Medicare TCOC savings, 1.92% average all payer hospital average annual growth per capita. 98% of Maryland hospital revenues were moved to population-based payment. 51% reduction in complications, better-than-national Medicare readmission rate.
- Slide 38: RTI Evaluation: 1) Hospitals were able to operate within their global budgets without adverse effects on their financial status, 2) Admissions for ambulatory care sensitive conditions declined in both the Medicare and commercial populations, 3) Low-income Medicare patients and those with chronic conditions had more favorable outcomes, 4) Need for additional coordination with community providers, particularly in areas like behavioral health.
- Slide 39: Lessons from Maryland: 1) All-Payer global hospital budgets are a viable health policy reform to control costs and improve outcomes, including community health, 2) An important benefit is stabilizing financially vulnerable hospitals, 3) Incentives alone do not necessarily lead to changes in care delivery, but they can help, 4) States should consider pairing global budgets with plans for care delivery transformation. Key metrics can cover community health and health equity, 5) The alignment between hospitals and their communities can have benefits well beyond clinical care provided inside a building.

- Commissioner discussion
  - Secretary Ghaly thanks the presenters and asks two questions: "What has prevented the Maryland experience from being scaled?" and "How have these strategies worked out in an urban setting?"
  - Dr. Sharfstein responds: In Maryland all the hospitals are facing the same incentives. One major challenge is getting all the hospitals on the same system. Some hospitals are doing incredibly well under fee for service. Hospitals with enormous market shares that dictate prices and essentially print money in the basement, they don't want to switch to global budgeting. In Maryland they are looking at hospitals and where patients are going, looking at shifts over time and adjusting the budgets accordingly.
  - Commissioner Sandra Hernandez notes the question of where the health care system ends and the social service system expands is a profound policy question. Reducing health care costs in policy doesn't mean we will increase spending in social services. In California there is this problem that Medi-Cal pays rates abysmally low for providers and so you get this perverse notion of "I'll take care of more Medi-Cal patients but cost shift to another part of the system." It's compelling to have it not matter if one had Medicare or Medi-Cal, etc. by compensating care for all patients equally. Global budgets are an elegant solution to focus more on prevention. Investing in behavioral health challenges is an area the commission needs to investigate more.
  - Commissioner Lee notes lower cost does not mean worse quality, and that quality is the issue. Currently the likelihood of getting the right care at the right time is about 60%, and in health it's not just a matter of right sizing, it's where we spend. We don't reward providers or delivery systems for doing things that aren't high margin. We don't reward primary care; we reward interventions. We don't reward prevention or care coordination. This is independent of unified financing or not. This is a multi-dimensional problem under any financing system. Payments should be looked at in a way that consciously puts the thumb on the scales towards things like primary care, towards prescriptions that provide more benefit, not just the newest thing that a pharma company can charge a lot for, things that are doing better for more people.
  - Commissioner Scheffler notes that a public and a private model can both produce excellence and that more attention needs to be paid in how others do accounting. The U.S. health care budget includes nursing homes and home health care, in most western European countries that's in the social services budget, so the data needs to be looked at more carefully to do an apples-to-apples comparison. They still spend more on social services, but the numbers will change significantly. In Medi-Cal when you pay for transportation, that is generally paid for in the social services budget. That balance is important, but we need to be more precise in looking at it. Prices matter, and spending is more than price times quantity, it has to do with the mix of services, for example primary care versus specialty care, or high or low tech, and that is

something to consider. It shows up in the percentage of total spending that goes to hospitals, 33% in the U.S. and 36% in California, and even 3% matters a lot, as most of the money in the health care system is spent in hospitals. 26% to physicians, 20% nationwide. Adjusting payments for disparities is important and the idea of global budgets is a good one. A few questions: 1) If it is such a good idea, why aren't other states doing it? 2) A lot of the success in Maryland was dependent on Maryland getting their waiver, which could be a big lift in California, and 3) What happens if a hospital runs out of their budget? Do you fire the hospital administrator? Do you give them more money?

- Dr. Sharfstein responds: One reason Maryland was able to move forward was due to the waiver, the way it ties everyone's finances together so there was a shared risk everybody was facing, and the way people in Maryland think about working together with a statewide solution. While it is unlikely for California to get a waiver, it may not be necessary. The fee for service system is going away because of global budgets, that's where the $900 million in savings came from. One thing that made it easier was the hospitals were financially similar and stable going in because of 40 years of rate setting. But in a state like California, hospitals' payment differentials are so severe, poor hospitals feel like they're getting locked in at a level at which they cannot survive. So, some way of right sizing the budget for those hospitals is going to be necessary. He notes he did not know of any hospital that ran out of money under global budgeting. Unlike Great Britain, the budgets can be used for things outside the hospital, so it's a different orientation where the system can adjust to shocks and move money around if necessary.
- Commissioner Wright notes that the current analysis is that the market doesn't work at the individual level where patients do not have the ability to say no; they are often in a monopoly situation when trying to get the care they need. And it doesn't work at the macro level where what we pay for services is not related to the cost, quality, outcomes, or equity but rather who can avoid sick people and who can attract the highest margin. We need to get away from the game of hot potato in our health care system and toward something where all providers are in. If we are holding hospitals accountable for the health of a community, all hospitals need to be in, or there's issues of shifting and game playing. He asks Dr. Safran with regard to their AQC contracts being voluntary, what would the results have been if it was not voluntary? And with regard to cost, there was a cost commission: could you talk about the relationship between what was going on systemwide there? To Dr. Sharfstein, what are the challenges in scaling this up, not just in terms of size but complexity of the California market, and would that lead toward a more regional approach or some other way to address this?
- Dr. Safran responds: On the voluntary issue, there was a sizable share of the provider network opting in, 25% even in the first year, and most within four years. Between 2009 and 2013, the federal government was showing signals

that Medicare was going to go in that direction, so that may have influenced uptake. Also seeing the providers that were doing better after the first two years encouraged more uptake. It was also important to work with providers who came into the model; that extra support was an incentive. In terms of potential gains, the fee for service system was more starved compared to the gains of coming into the contract. Regarding the cost commission, that did not play as much of a role in rapid uptake. But the cost commission had an important impact on slowing the overall rate of growth in health care spending. The penalty of payers or providers going over the spending growth of the state GDP was being called out in front of the cost commission, which was a big motivator.

- Commissioner Pan notes that we have to start off with right sizing. If the global budget is too low or too high, it's a problem. Right now in the UK, nurses are about to vote for a nationwide strike as the National Health Service is not willing to give them a pay increase. Regarding the interface between health care and social spending, the political will for doing that is important to consider. It is challenging in California to increase social service spending. On the health care side, it is also difficult to get spending increases for primary care and prevention. That political will to right size will be an important consideration. He notes in the example of school nurses, in a unified system with the school system, they fired everyone, and the private entity picked up the cost. It is important to keep in mind who makes the decisions, public or private. When we think about what we have to spend our money on and where it goes, you can think about population in terms of risk: the healthy population, people with chronic conditions that are common (which we have a lot of measures for), and people with chronic rare diseases with higher costs, and we don't have a lot of measures for them as they are rarer. When we think about trying to do value-based purchasing one could argue it doesn't make sense to capitate for prevention. Should we pay for it when it's done as long as it's done at the proper frequency? What do we do about the rare diseases when it comes to payment in the global budget?
- Dr. Safran responds: In the AQC contract everything was in, including rare conditions, and they did not have great measures for them. In the commission, they are giving a lot of thought to the role of bundled payments. The idea of negotiating one condition or body part at a time seems like an incredible headache, with issues of fragmented care and so forth. However, there is some thinking right now, as part of how MedPAC works, about how we can define a parsimonious set of bundled payments that could be valuable as complements to a global budget construct.
- Dr. Sharfstein responds: It's important that the health care system provides the best care to people who are incredibly sick and pushes the envelope of discoveries for the next generation of treatments. The best way to think of it is we want a health care system that provides appropriate cutting-edge, high-

tech care for those who need it, and delivers good community health results. There are a lot of things that don't fall into those categories. Using a pediatric care example, the money we spend for neonates that are low birth weight, when they leave the hospital we don't invest in systems that makes them unlikely to bounce back after we've spent millions for them to get through the first three to six months. But when you have a global budget, there is an incentive to invest in those things that overall help keep people from coming back. It's not about what you can bill, as fee for service drives innovation in a direction that doesn't always produce better health, and we want a driver for innovation that is oriented towards actually improving health and helping patients.

- Commissioner Moulds agrees with Dr. Sharfstein. In the U.S. we treat well the people with rare, complex medical conditions. At the Commonwealth Fund, there was a fellowship for a year called the Harkness Fellowship that brought over a mix of physician researchers, health economists and health system researchers, and they asked "Having been in the United States for a year, would you prefer to be treated in the U.S. or your home system" and most would prefer their home system, except in the case of a really rare disease in which case they preferred the U.S. system. There is a problem of scale in developing quality measures. But these are expensive one-offs and not the primary issue, which is chronic conditions that are preventable. The answer partially is going to be looking at the pharma side—at the expensive drugs required to treat these rare conditions.
- Commission Wood asks: Do any of the presenters think California should go in the direction of a fee for service model as part of the unified publicly financed provider model?
- Dr. Sharfstein responds “no,” as fee for service is not aligned for health, and from a public health perspective, we want communities healthier. Dr. Safran agrees; paying in ways that create accountability for cost, quality, and health makes it compelling to move away from fee for service towards some type of budgeted model. Commissioner Moulds also agrees.
- Commission Wood notes that it is also important in terms of equity, particularly regarding areas with the highest rates of opioid addiction and adverse childhood experiences. He notes the importance of data systems and how hospitals coordinate so we're not duplicating services, to make sure quality of care and appropriateness of care is happening. He asks Commissioner Moulds, of the 1.5 million people who are part of the CalPERS program, how many of those are retirees? Commissioner Moulds replies a little less than half. Commissioner Wood asks: As we transition to some other system, where we already have those benefits bargained, how do we do that? Commissioner Moulds replies that is not a short conversation. There are contracts by employers who offer those benefits that are not easy to tinker with.

- Commissioner Wood asks the presenters: We have the AQC's, cost commission, and global budgets; if you could wave a magic wand a few years out, what would you do to enhance the effectiveness of those? What's missing?
- Dr. Safran responds she is not sure they brought the PPO population in, as the contracts started out with HMO populations. Many skeptics were saying you can do this with HMO but not PPO, but this was done, and Medicare has as well with its ACO program. She would put the three together and complement that with hospital-based payment reform. A payment model for hospitals that would create accountability for hospitals to reduce and manage total cost of care, so hospitals would be motivated to support the success of provider practices in its market, at managing their AQC budgets. She would want the hospital to have the incentive to think hard before they admit a patient coming through the ER or treating the patient as an ER patient instead of an urgent care patient. Reforming hospitals' fee for service incentives, coupling these two types of budgeted models with a cost commission would be powerful.
- Dr. Sharfstein responds: We need more health produced for the money we're giving, which is a different value than a traditional metric of value. We want to see serious challenges get better in different places, and disparities reduced and more people with opportunities. The big picture is to make the community healthier. And that opens up all kinds of things health care can do. We want the health care system as a full partner in policies that make a community healthier.
- Commissioner Comsti notes when talking about single payer, it's false to equate it with fee for service. In her single payer proposals, there is a combination in order to get away from that attempt to stratify the payment structures. What is driving increased cost is prices and administrative costs, so the focus should be on fixing that. When thinking about social determinants of health, there is a philosophical underpinning to the discussion. What are the incentives we're giving towards providers? There is worry with risk-based payments, that economic interests will determine decisions rather than health as the primary focus. We need to be careful when thinking about market incentives to drive change in social determinants of health to drive changes in behaviors of doctors. This drive has created inequity in health care infrastructure, our resources have been stratified because of the economic incentives. That's how we get health care deserts, hospitals closing, and not investing in seismic retrofitting. When talking about payment incentives to meet quality outcomes and address inequities, remember payments are different than public investment. Public investment and directed targeted public programs to invest in health care are different than economic incentives through payments. When focusing on risk-based payments and focusing on metrics-based payments, we are increasing the administrative burden as well. That relates to hyper consolidation in the health care system that the FTC is

looking at right now. Risk adjustments, particularly socially based risk adjustments, we have to be careful about, because when we're talking about creating metrics based on social determinants of health, we have to build metrics on social stereotypes which embeds racial and ethnic stereotypes in our system. There was a big study about the health care algorithm that built in and used race as a proxy for cost and resulted in African-Americans receiving less care than their similarly sick counterparts. What do hospitals and providers use their increased risk adjusted payments for? There was an article last year that showed Medicare Advantage plans used that towards medical loss ratio rather than giving it back to the patients. This is why it is important to use global budgeting as a mechanism to incentivize transparency. We can look at the receipts to see what they're paying for to make sure it's being invested in care, prevention, and primary care, etc. This is a fundamental shift in how we look at hospital payments. In the commission's single payer proposal, we could potentially move that towards clinics outside the hospital model. We can create a single payer model that isn't based on risk and reducing costs because of risk. It is built on paying hospitals what they need to pay for their patients, a combination of historical factors and adjustments based on predicted increases of need, and making sure workers are paid fairly, prepared for pandemics and so forth. We can build these things within the budget. We can build in increases in payments that can be used to mitigate availability and accessibility problems. The beauty of global budgeting is we can target where the money goes to meet different patient populations. For individual providers there's a proposal to give an option for salaries, and that in itself is a concept the commission should discuss more. It takes away the problematic potential of fee for service. Higher transparency, better monitoring by a single payer system so we can do health planning over an entire state. The public sector can then target for programs specifically rather than let the market tease it out, as that has not been working. We don't want to shift the burdens of the health system on the private sector; it is important to keep public officials accountable for funding both social programs and public health programs. Health care corporations will be resistant, but that is why it is important to do it in a unified way. When we get the patients, the providers will come.

- Secretary Ghaly asks the presenters: What did alternative payment approaches do to administrative burden? What did you see in terms of transformations there?
- Dr. Safran responds that with this model they anticipated that providers might want to turn off things like utilization management but found the reverse—that they wanted to continue it, as they saw it as something that would support their success in the model. Administrative efficiencies were focused on, but that had less to do with the AQC model and more to do with multi-payer work to accomplish efficiencies of scale and other aspects.

- Dr. Sharfstein responds: There is a lot of efficiency to go to multi-payer from the anarchy of fee for service. When going to global budgets it added some complexity, but where the efficiency is, in a multi-payer environment, is on the clinical transformation side, like if a hospital is going to change a service, it works for everyone. It really allows the hospitals to say “what are we going to do better for this group of patients?” Then implement it for everybody.
- Commission Moulds replies: On administrative fees, they are negotiated as part of the contract and most contracts are flex funded. So if the plan in any given year makes more than the administrative fees pre-agreed upon part of the contract, the excess is returned to CalPERS.
- Commissioner Chin Hansen comments on making things happen: Rather than starting regionally, one approach coming from 25 years of PACE capitation is doing it by population. The contracts with Medicare are complex to unpack to blend into everything else. There may be wisdom in thinking about a population-based approach, starting off with payment systems that are needing to change, there may be a structural simplicity of looking at some of these system changes, doing it on populations other than those subject to ERISA, perhaps starting instead with Medi-Cal with women and children or even California Children's Services to limit complexity. It is just a question about execution.
- Dr. Sharfstein responds that is a wise question, as in many places there are different pediatric care systems, so you could imagine pediatrics goes first for different things, but it's so small relative to everything else that you might not get that much. The rest of the health care system might not be persuaded by this. To the other question of doing it by payer, starting with public payers particularly in a region where public payers are a large percentage of patients, that can provide a strong base. Similarly, if you're starting with 90% of kids in a pediatric system, you could start there. The goal is to bring as many people as possible into clinical transformation and to align the health care system fundamentally with the health of the community it serves.
- Dr. Safran responds that a large share of their network was willing to come in even at the beginning and that was because they were striking the sweet spot of having enough of their membership. They represented about 60% of their commercial book of business and 40% of their total book, which was enough to make it worthwhile, and not so much that it was frightening, betting the farm on a model they had no experience with. It could be the case that the provider systems in a market don't want to do this, if it's not going to be close to “all in.” But there may be some that want to test the waters with something big enough to make it worthwhile, then once that is figured out, bring in the rest. It may be that we have to test the waters to see what providers in different areas are up for.
- Commissioner Hsiao observes both Dr. Sharfstein and Dr. Safran are talking about contracting organizations, like hospitals or a network, and asks how

does that hospital or network actually then motivate the practitioners to deliver the right outcomes? How does the hospital coordinate or integrate with primary care doctors? Do you look at that specifically? As we are emphasizing the importance of primary care and prevention, how do you assure your contracting and payment establishes that priority among hospitals and primary care practitioners?

- Dr. Safran responds that their contract was a primary care centric model. Even though it wasn't with primary care practitioners exclusively, it was providers, regardless of structure. In many cases it meant multi-hospital systems. But the orientation was toward a population that was defined based on primary care relationships. In some cases, before market changes unfolded, there were groups in the model that were physician practices without hospitals. That created some powerful market effects in terms of provider systems that were moving business that happened to have much lower prices. Moving business from one academic teaching hospital to another. There were some powerful effects of the combination of cost and quality incentives that the primary care and specialty care practices had as part of the AQC that are instructive.
- Dr. Sharfstein responds that there are a variety of ways hospitals responded in terms of how they structured their payments to others and to their employees and affiliated practices in general. Some smaller hospitals have been nimbler. Sometimes there can be a lag for the larger hospitals to adjust their overall incentives, which created some drag on the model. But that is definitely part of it for primary care. In Maryland there was a crisis in hospital payment that needed to be addressed. Initially the goal was a primary care model. CMS gave it for Year 5. The idea is to establish a parallel play in which hospitals are oriented effectively toward population outcomes, and the primary care doctor is oriented in the same direction. Then we are creating the hope that there are mechanisms for them to be engaged. This worked in rural hospitals because they realized they can do better if they can prevent readmissions and preventable admissions, so hospitals welcomed primary care, but it's not because they're all under one budget. Having them under one budget can work well in Maryland because the way it's developed, the goal is to incentivize them both in the same direction and hope they can work it out. Generally, there is a set of broad financial incentives and then there is a lot of flexibility for the health care system to work it out.
- Commissioner Scheffler notes that no one is suggesting that we want to have racially or culturally based payments, because that would be a mistake and could stereotype people. The way to deal with health disparities is at the community level. There are models that deal with communities rather than to stereotype various people who have health disparities. And you can get similar results. He emphasizes the point Commissioner Hsiao raised that other global budget models do not tell the organization, hospital, or provider how to pay their doctors or nurses, it gives them a budget and the flexibility to decide how

they want to do that. Kaiser, which is 30% of the market, gets a global budget because it has a capitation payment. And it primarily pays its doctors on salary with a bonus. A lot of the bonus has to do with clinically how well their doctor performs. Equalizing and saying that risk-based payments give an incentive to doctors is not understanding that each doctor does not get a risk-based payment; it goes to the organization. That needs to be clarified. Dr. Safran had a grand design for the solution and payment, and that is risk-based capitation. With the right incentives to produce quality and high outcomes with a cost control mechanism, we have a path forward to try to control costs and make care more accessible to Californians.
    - Secretary Ghaly thanks the presenters and commissioners and sums up the conversation. This is an exciting part of the unified financing conversation: about how to use payments and funding to deliver health, not just health care. The examples discussed today will be explored and other innovations and tweaks from the unique challenges in California will be explored in future conversations. He notes continued conversation about discussing AB 1400 and indicates that he will soon post some comments about the role of active legislation in the commission's work, and what the commission has already been done that is relevant to AB 1400, which will hopefully encourage additional conversation about some of the details recommended in that legislation.
- 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 October 11 2021 meeting.

3. Adjournment

- Secretary Ghaly thanks the public and commissioners and adjourns the meeting.