Healthy California for All
Commission Meeting
September 28, 2021
Meeting Synopsis

Note: a video recording of this meeting can be found at: video recording of September 28, 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, 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 introduces the focus of the meeting:
    - The focus of the meeting is racial equity and the structural and power dynamics that lead to disparities and inequities, a topic requested by many commission members. There will be upcoming meetings on October 11th (on provider payments), November 17th, December 8th, and January 12th. Topics being considered are non-federal and state generated funding, ERISA, workforce, transition challenges and opportunities, and things we can invest in today, while we pursue longer term goals.
- Commissioner survey on goals, values, and propositions
    - Secretary Ghaly highlights the main points from the Goals and Values survey for commissioners, noting general agreement on most propositions particularly relating to integrated and coordinated care, payment as a tool for accountability, program sustainability, and equity. He notes there was disagreement in if/how health plans and/or risk-bearing intermediaries should be included in a future system. He notes the survey responses will be posted on the HCFA webpage. After the October 11th meeting, he will

send out a follow-up survey with refined language and new propositions for commissioners to react to.

- Commissioner Comsti requests the survey responses to be posted in full, as it is important for the public to know everything the commission is saying about these questions. She also suggests defining terms more clearly, as things like integration and coordination mean different things to different people.
- Commissioner Chin-Hansen brings up the importance of defining terms, and permission, access, and privacy concerns. She notes the importance and complexity of coordination of care for the elderly and recommends that often a real, concrete example helps clarify the concept.
- Commissioner Hsiao asks about the “how,” and if the commission will focus on that, such as how to equalize the supply side, and the cost of that, particularly with culturally-sensitive services and providers.
- Secretary Ghaly responds that the final report will be a unified financing playbook that describes the “what” and some of the “how,” and that more details may be offered alongside the main report.
- Commissioner Flocks brings up the issue of financing and what/how things get paid. For a sustainable system we need to look at tradeoffs. An equitable system and redistribution of resources will result in winners and losers. Regarding payment as an accountability tool, providers that charge whatever they want won't get to anymore, and that's a tradeoff they will be upset about. If we focus more on primary versus specialty care, there may be a tradeoff with fewer specialists available. This is an important piece to the report whether it's a chapter or appendix.
- Secretary Ghaly notes the playbook will have significant attention on the question of tradeoffs. What are we talking about trading off, and what do we juxtapose against one another? More time will be spent in the surveys and report talking about that. Commissioner Wood mentioned the focus on affordability, which lends itself to making sure it's sustainable. He also notes, regarding the goals and values survey and social determinants of health, that commissioners struggled with how much on the shoulders of health delivery system that should be. Are we going to accept that our social service systems don't do as much as they could? It is an interesting theme to continue to work through. It is one thing to talk about it and another to implement it.
- Commissioner Pan notes he wasn't ready for some questions in the survey, as they were not yet discussed in the group, and that the survey didn't explicitly state if health care is a right or entitlement, which would insulate it from excessive budgetary pressures. During the great recession there was a budget proposal to cap Medi-Cal visits to 10 per year no matter what, if you got dialysis weekly, you got 10 visits that’s it, and it actually

passed in the budget. When a proposal is built, we need to say it is an entitlement, and how we support it as an entitlement.
    - Secretary Ghaly thanks commissioners for their feedback on the survey, that the survey language will be refined, and that the results will be posted in full.

2. Racial Equity and Health System Design

- Secretary Ghaly begins the conversation on racial equity and design decisions that can be made in a unified financing system. He shares the experience of a direct focus on equity in the context of the COVID response. Partnerships between well-off areas in Monterey County helped out more agricultural communities in Salinas Valley, investing in testing, clinical partners, and transportation. It demonstrates how using data can help move the needle on these issues.
- Presentation by Commissioner Bob Ross on racial equity, race, place, and power. (View the Presentation on Advancing Racial Equity and an Anti-Racist Health System):
    - Slide 16: Commissioner Ross shares a few quotes from the CDC and World Health Organization to highlight that 1) Health is not determined primarily by access to health care or the quality of health care, but by historical, structural, and systemic community conditions and the policies that shape them, and 2) power is a social determinant of health, and any serious effort to reduce health inequalities will involve changing the distribution of power, and 3) measuring success has to be rooted in racial disparities.
    - Slide 17: What are the key elements of a health system where race/racism no longer result in inequitable outcomes?
        - Race no longer determines health, wellness, or socioeconomic outcomes.
        - Californians of all demographics, geographies, and backgrounds rate the health system highly.
        - Health providers/healers reflect the demographics of people they serve.
        - The health system is broadly defined to include/link to non-medical influencers of health, such as education, food, transportation, housing.
        - The health care sector is an active partner with other sectors in eradicating root causes of structural inequities, not just the manifestations.
        - The community has an active role in overseeing health resource allocation and system design.
    - Slide 18: Multiple reports recommend key systems changes to center race equity in the health care delivery system.
        - National Academy of Medicine - An Equity Agenda for the Field of Health Care Quality Improvement: 1) Increase patient trust and involvement, 2) Increase community engagement and truly value the health of populations, 3) Reward organizations for equity, 4) Improve data, 5) Create new measurement strategies, 6) Improve leadership and culture.

    - California Pan-Ethnic Health Network - Centering Equity in Health Care Delivery and Payment Reform: A Guide for CA Policymakers: 1) Center equity in quality/payment, 2) Engage patients, families, and caregivers, 3) Strengthen culturally and linguistically appropriate care, 4) Improve and integrate physical, behavioral and oral health care, 5) Hold health plans/systems accountable, 6) Improve social determinants of health.
    - Commonwealth Fund Task Force on Payment and Delivery System Reform - Advancing Racial Equity in Health Care: 1) Stratify, report, use data by race and ethnicity, 2) Develop, test, and scale payment and delivery models to reduce disparities by race and ethnicity, 3) Encourage health systems to confront racism in their policies and programs, as well as to meaningfully engage and empower the communities they serve, 4) Expand, diversity, and train the health care workforce, 5) Assess and develop protections against racial bias in health care technology.
- Slide 19: The three dimensions of advancing equity in a unified financing system: race, place, and power. Race: Significant disparities in health outcomes and lifespan exist between different racial and ethnic groups. Place: Population health outcomes can vary significantly by zip code and the range of community assets and conditions that differ by geography. Power: The ability of individuals and communities most impacted by structural inequities to exert control over the conditions shaping their lives, including:
    - setting agendas
    - shifting public discourse
    - influencing who makes decisions and what those decisions are, as well as how resources are allocated
    - cultivating ongoing relationships of mutual accountability with decision-makers that change systems and advance health equity.
- Slide 20: Big Idea #1 Race: Measure and invest in reducing health disparities caused by inequities.
    - As the three reports identify, better measure, publicly report, and hold systems accountable for closing race/ethnicity health disparity gaps.
    - Commissioner Scheffler suggested one approach - to risk-adjust provider payments:
        - Such risk-adjusted payments could initially be based on the Healthy Places Index (HPI), used by CDPH to create an equity metric during COVID. The HPI can be used with other equity metrics to pay more to providers practicing in communities experiencing the highest disparities who can demonstrably show progress in closing gaps.
        - Such payments could create incentives/pathways to a) create a more diverse, inclusive workforce that reflects the demographics of these communities and b) proactively reach out to people disenfranchised from the health system.

        - At the same time, over time, the entire health system should be accountable for identifying and closing disparity gaps everywhere – not just a subset of communities.

- Slide 21: Big Idea #2 Place: Invest in communities that have been historically under-resourced and most affected by racist policies and practices, resulting in poor health
    - Specify a portion of total health expenditures – say, 5-10% – and invest them in communities that rank in the bottom quartile using an equity metric with the Healthy Places Index.
        - Other states - including Arizona, Nevada, Oregon, Ohio - are leveraging a portion of Medicaid dollars for community investments
        - CalAIM is a great start for addressing health related social needs – e.g., paying for asthma remediation, housing navigation, medically tailored meals, etc.
        - Demonstrations around the state are showing how to connect health care with broader social services and public health
    - Support a diverse, inclusive workforce, drawn from local communities and housed in local communities.
- Slide 22: Big Idea #3: Power: Shift power from institutions to community
    - Create and fund Regional Equity Councils/Accountable Communities for Health comprised of and governed by multiple sector and community stakeholders who work together to address the root causes of inequities. As independent entities, such Councils could serve as vehicles of accountability for the health system
    - Strengthen existing health organizations' governance by including more members of the community in positions that have power. Regularly solicit meaningful, authentic community input, including on reforms, and establish mechanisms to report back to communities
    - Require health plans to contribute to locally governed Wellness Funds designed to address health inequities and improve community health
- Slide 23: Examples of Big Ideas in Action
    - Idea #1: Blue Cross/Blue Shield of Massachusetts is measuring racial and ethnic inequities and including equity measures in contracts and payment programs with clinicians
    - Idea #2: The Oregon Health Authority Transformation Center requires coordinated care organizations to reinvest a portion of their net income or reserves on services to address health inequities and the social determinants of health and equity
    - Idea #3: California's Accountable Community for Health (ACH) Initiative includes 13 local ACHs comprised of community members and multiple sectors dedicated to improving community health and health equity - e.g., The East San Jose PEACE Partnership, co-chaired by the local

Department of Public Health and a grassroots CBO, oversees a Wellness Fund housed at the county medical center foundation.

- Slide 24: Three Dimensions of Advancing Equity: Data & Strategy
  - Race
    - Data: Tracking disparities
    - Strategy: Incentives to close gaps
  - Place
    - Data: Equity metric using Healthy Places Index
    - Strategy: Community driven investments
  - Power
    - Data: Presence of community voice in decision-making
    - Strategy: Processes for meaningful community engagement, voice, and accountability
- Slide 25: The challenge for the commission is do we have the courage to create the nation's first at-scale racially equitable health system? In five to ten years what would that health system look like? Commissioner Ross shares his own experience with racial profiling and discrimination while at medical school and how impactful and humiliating that experience was, remembered vividly 40 years later. This is what structural racism does. It has an unhealthy impact in the moment, it is racially traumatizing. And it has a tail. It can endure.
- Secretary Ghaly thanks the commissioner and highlights the word "endure" - how the implications of structural racism endure and how the work done here in the commission will endure and have the chance to transform not just the patient care experience but people who work in this new system.

- Presentation by Commissioner Antonia Hernandez on equity and affordability. (View the Presentation on Equity and Affordability):
  - Slide 10: Commissioner Hernandez highlights the importance of dignity and respect as a core element for equity, as well as language access, convenience (care available where people live), and immigration status. When someone walks into a medical office, the first thing they ask you is, do you have insurance? Think about the feeling if you don't.
  - Slide 11: Affordability and Equity
    - Affordability is a primary element of equitable design.
    - Low-income Californians believe that those who can afford to pay more should support a system of unified financing.
    - Co-pays and transportation were costs that prevented people from seeking care.
  - Commissioner Hernandez urges the commission to be visionary but notes patience is needed to have people buy into it. The commission must focus on how it will be presented, for example: Health care is a civil right, a human right.
  - Slide 12: COVID-19 and Equity
    - COVID-19 and structural racism exacerbated health inequities.

    - Language and online access were barriers experienced by low-income Californians, especially people of color.
    - Community health workers, promotores, and other trusted communicators bridged these barriers to equity.
    - Use of health equity indices guided resource allocation.
- Slide 13: Commissioner Hernandez shows an image of LA County showing the impact of COVID and where The California Community Foundation funded, displaying the impact of equity in a visual way.
- Secretary Ghaly sums up both presentations and highlights a few key points to set up the discussion: 1) the role of using payment to drive certain goals and attributes of the health system, 2) accountability for current and future outcomes - to shift the impact of zip code on health, and 3) the importance of a culturally competent workforce.
- Commissioner Moulds speaks to how other wealthy nations spend more on social supports, food support, housing support etc. But notes it is problematic to put that on the health system – as it is already expensive, and nobody knows if it is the most efficient mechanism for investing in housing and food supports, etc. The health system has not shown itself as an efficient system, yet to get to better outcomes we need to think about the interplay between social supports and health systems. We cannot create a health system that makes up for the fact that we underfund these other systems. Engaging these other systems is going to be critical to getting to more equitable outcomes.
- Commissioner Dessert notes the Community Engagement findings on the importance of dignity respect, particularly for English language learners, trans, LGBTQ who are encountering a health care system that was not designed for them. She echoes a comment by Commissioner Ross on how our health system cannot eradicate 400 years of structural racism, but one key element is community decision-making in making it better. She recommends a menu of options (measures and levers) for accountability to ensure providers have some degree of competency, regional councils, and a roadmap and number of options to make sure these communities are centered.
- Commissioner Wood notes when we talk about equity there are a number of factors, 1) we found during COVID, getting data on certain communities is difficult, as our systems are not as robust as we'd like. Data was at the top of each Race-Place-Power issue. Once we understand where, we can understand why. 2) There are outside influences that affect health outcomes: soft drinks, alcohol, tobacco, with companies that push these into communities of color, so we may want to consider a tax on soft drinks etc. to use on prevention and treatment, which historically has been pushed out by outside influences. 3) Part of provider conversation, how are we going to focus more on primary care? In all other countries with a unified financing system there is disparity, two-thirds primary and one-third specialists, and in this country it's the opposite. One reason is the high cost of education for medical

professionals; once educated as a specialist, there is very high debt, so they go into an area where you can earn the most. We need to incentivize these specialists into certain communities and find a way to pay for health care providers education upfront. We don’t spend enough money on prevention, diabetes is out of control especially in communities of color - but industries fight against prevention, afraid it might affect jobs. The legislature feels it can't vote for a tax because someone's job might change. These are the external issues that affect health care that are a drain on the system in the long run.

- Commissioner Scheffler, regarding the goals of the commission, recommends ranking health equity as number one, with everything in the report framed through the lens of health equity, because our health care system needs to do the greatest good for the greatest number of people and to do that you start with the group that isn't being treated fairly or equitably in the system. That is likely the group with the highest health care needs. If a system is designed to deal with the needs of those treated unfairly and unjustly, it will work for the rest of us. It is important to prioritize them, no doubt that there's tradeoffs, no doubt that money matters, but what really matters are the fundamental changes we want to incentivize, to restructure the health care system to deal with inequities, to reduce waste and inefficiency and use those dollars to improve equity and fairness in the system.
- Secretary Ghaly invites more specificity. How do we pay? How do we train the workforce to treat our diverse state? How do we use data and accountability? He urges the commissioners to share details on their experience using systems to deliver on these seemingly difficult-to-achieve equity principles.
- Commissioner Comsti highlights the community voices report and how low-income communities of color identified affordability and the complexity of navigating the system as the two biggest problems, which are related to dignity and respect. Affordability and complexity can be answered by a unified single payer system where there's one plan, one network, and no barriers to care. There wouldn't be as much of a need for navigators. It's also important to fund the pipeline to train more people from underserved communities of color, as well as pre-licensure programs, funding two-year associates degrees for nurses so we aren't allowing hospitals to waive staffing ratios. In terms of longer-term solutions, if we're going to put funds toward health equity, we can't just give money to health care corporations. We shouldn't just look to payment incentives but relook at how we fund our hospitals and facilities. One idea is institutional global budgets to understand what the health care needs are of individual hospitals, patient populations, particularly with safety hospitals in rural areas. We can't create incentives that allow hospitals to game the system. It's inadequate to address health inequity. One example how risk adjustment can be gamed is the six False Claims Act case cases against Kaiser that the DOJ just intervened in. They are potentially systematically upcoding to game the diagnostics code. So, we need to be careful.

- Commissioner Sandra Hernandez notes the COVID experience with the Equity Index was a good start but hampered by a lack of good integrated data across systems. Racism impacts education, housing, transportation, and food programs. The health care system cannot tackle them all, but can do a better job at intersecting the data systems. She recalls during the AIDS epidemic the money was going to communities based on case rates and the decisions about how those dollars were spent was done by councils or community leaders, which didn't interface with hospitals at all. In the early days of the HIV epidemic there was not much that hospitals could do. Covered California has been as successful as it has because that system was built with profound accountability, in large part because there was an even floor for people to step up and say, this doesn't work. And this shouldn't be this way, and bring plans forward and say why haven't you met this metric? And what are you doing on this front? Our Medi-Cal program doesn't have that. We support stakeholders to give input. There's legislative accountability for spending. But there really isn't a platform within the Medi-Cal program, which is the largest public program serving low-income folks in the state, by which local initiatives or commercial plans or consumers or patients could say, how is this program working? And how can we make it better? This idea rattles a lot of people because we're saying power needs to change. There's real power in giving voice to people to make these systems more accountable.
- Commissioner Pan shares his own experience with racism against Asian-Americans during COVID and notes Asian Americans are often neglected when it comes to data. Data needs to be disaggregated, as not all Asian Pacific Islanders are the same. He stresses the importance of supporting primary care doctors, highlighting a few reasons why they are diminished: 1) we don't honor primary care physicians, 2) medical school debt, 3) structural racism and misogyny. When designing a unified financing system, it is key to consider power dynamics. When concentrating too much power into one body, the stakes go up. We need a system where communities can adapt to their own needs without changing the whole system.
- Commissioner Baass notes equity is a fundamental principle in CalAIM, highlighting some concrete examples: asthma remediation, housing, navigation, medically tailored meals, community health workers, and in terms of workforce, the addition of doulas and other specialists. To the question of whether the health care system should be the one to address this, CalAIM is proposing that the health care system be the glue, partnering with public health departments, justice partners, ultimately recognizing a person's situation has a direct impact on their health. Regarding Dr. Ross's frame on place: prisons, juvenile justice systems and sites serving the homeless are particular places we need to double down and get to. Coordinated and community-based care is needed to stabilize these individuals in their community. In terms of accountability, managed care plans must demonstrate

their ability to identify health disparities in access, utilization, and outcomes among racial, ethnic, LGBTQ groups.

- Secretary Ghaly affirms the importance of focusing on prisons, jails, juvenile detention facilities and the streets. He notes the efforts going on currently to stitch together the data for not just health, but health and human services. He notes the complementary efforts that have been started, but still need work.
- Commissioner Wright agrees we need to appropriately center these issues. It is difficult to imagine a system that would create more racial inequity than the current one, with a patchwork finance system where half of the people get their coverage through the type of job they have. There is wide variation in terms of the safety net, based on income or immigration status. Our health care system is an inequity-generating machine. Ten years ago, we had a system that allowed for the denial of people with pre-existing conditions. We have not replaced it with proactive incentives to help people address the conditions they have. We should be rewarding and providing more resources for the providers that are trying to address people with chronic conditions. Changing the financing structure of our health care system would be a big jump but is not sufficient. There will always be a role for culturally competent navigators and holding providers accountable to focus on areas that need more resources and infrastructure. We want to make sure there is a financing structure that at least can sustain the providers that it needs. It is sobering that even if you hold for income, education and other issues, racial and ethnic disparities with regard to health outcomes remain, which implies a need to be mindful of opportunities for implicit bias training, or looking at the structures of how we deliver care, and finding ways to address those. That's where the accountability comes in, and payment needs to be part of that accountability.
- Commissioner Ross is struck by the tension we need to manage between having and building a unified financing mechanism, which would be the hub of the system and then the spokes would be some level of regional accountability and coordination. He discourages going the way of the public school districts where there are a thousand of them. Could counties be that regional spoke? The power of payment is the overarching statewide glue of the system. The second observation is regarding workforce. There's $100 billion in federal funding coming to the state, out of recovery and other Biden Administration and congressional initiatives. And the trillion dollar plus tproposal that may or may not come out of reconciliation could be another source of funding. Is there a way we can be clever enough to get a couple billion of that to specifically address the health workforce pipeline, to jumpstart the public and private sector cooperation? The master planning process on the health workforce that occurred a couple of years ago is a report that largely sat on the shelf but should be looked at.
- Secretary Ghaly sums up the conversation, first agreeing with the importance of the workforce report and how the pandemic put some delays on that. He

notes equity isn't a lens, it's the lens and appreciates the commission's focus on power in the systems, providers, other leaders beyond health providers. Regarding workforce issues, there have been lot of ideas but we need to aspire to do more in terms of pipeline and development. We need to define and decide where workforce continuums have gaps, and what we might do to fill those gaps. He notes Commissioner Comsti's points about making the system affordable and less complex, reducing those administrative hurdles and barriers to care, and that we must consider how to combat strategies being used to either regulate or deny care. He commends the work at DHCS with the CalAIM work being done on this front. Data is a transparency tool that can act like a compass, helping see how to hold the system accountable around these important equity and disparity issues. The notion of community voice is key. Another issue is around payments to drive these outcomes, which may involve global budgets, which will be discussed in the next meeting. He notes the importance of the "human" side of Health and Human Services, and that we can do a lot more with those other levers as well.

- 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 September 28 2021 meeting.

3. Adjournment

- Secretary Ghaly thanks the public and commissioners for their investment of time, energy, and commitment to the process and adjourns the meeting.