



**Healthy California for All  
Commission Meeting  
December 9, 2021  
Meeting Synopsis**

Note: a video recording of this meeting can be found at: [video recording of December 9, 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, Don Moulds, Richard Pan, Cara Dessert, Bob Ross, Michelle Baass (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 (CalHHS) Secretary, Dr. Mark Ghaly, welcomes the group and acknowledges the receipt of a recent letter from Assemblymember Kalra and other members of the Assembly and the Senate, asking the commission to look at financing options and implications of AB 1400, and commits to responding to that. He gives an overview of the agenda and runs through the next steps for the commission. By December 13, commissioners will receive a draft report outline with comments due by December 20th. Between December 10 and 20, commissioners will receive a follow-up survey around goals and values where there was some disagreement or areas that needed clarification, The survey will also seek input on next steps and priority actions toward unified financing. The results will be used to inform the report. In the next 4 to 5 weeks, Secretary Ghaly and his team will put together the draft report. There will be a meeting in January, date to be determined, to discuss the report. In February, there will be a final meeting to review the report.

- Follow-up conversation: Long Term Services and Supports
  - Secretary Ghaly tees up the follow up conversation on Long Term Services and Supports (LTSS). Unified financing (UF) on its own won't change the trajectory around LTSS - it can go a long way to make things more certain and reliable but does not transform the system. The pandemic revealed the need to evaluate services on reach (isolation of the elderly), equity, and quality. The goal of unified financing, in addition to a simpler, more affordable approach, is to have a system that focuses on the values and propositions this commission has lifted up.
  - Commissioner Jennie Chin Hansen will speak to her experience running the Program of All-Inclusive Care for the Elderly (PACE) and where she sees opportunities to innovate with UF. Secretary Ghaly highlights a few projects the state is working on. The state has set up the Office of Medicare Integration and Innovation at the Department of Health Care Services (DHCS) to look at the missing middle—Medicare beneficiaries who struggle to meet basic needs. The state also created the Aging and Disability Resource Connections process which created a central location where people can get information on LTSS settings and community supports. In CalAIM there will be a number of changes in how Medicaid handles its role as a primary payer of skilled nursing and other long term care facilities. There is also a lot being done with the Master Plan for Aging.
  - The analytic assumptions previously modeled are based on work from the Congressional Budget Office (CBO). LTSS benefits would be available to those with one or more limitations of activities of daily living (ADLs). The benefit would cover both community-based, as well as institutional, long-term care, and the focus would be on having no cost sharing. The CBO estimates LTSS along these lines would increase the National Health Expenditure (NHE) by about 5%. The consulting team built those assumptions into the presentation shown last month. Like many of these calculations there is a considerable degree of uncertainty that would need to be fine-tuned with further specification of California's approach.
  - Commissioner Chin Hansen shares remarks on LTSS: The elderly population continues to grow, 1 in 5 are already 60+ years old, and the fastest growing demographic is 85+-year-olds which comes with increasing cognitive and physical health issues. In addition to health care, they need assistance to live their lives in a safe and dignified way. Longevity is a wonderful gift, but it comes with other perils - being able to care for oneself, having other health conditions including cognitive losses if not a full-on Alzheimer's diagnosis. The focus is often on access to health care (seeing a doctor, getting care, emergency room if needed), but this is the tip of the iceberg, and not just for the elderly but for people with disabilities. Who are the people who would need long term services and supports? People who experience a life-changing event, such as a car accident, major fall, a

stroke, etc.; and, children born with disabilities and people with behavioral health issues over time. As the elderly population grows, cognitive issues and people with multiple medical conditions grows. One example of a gap is when a patient is discharged from a hospital to their home, they go from highly supervised care to being at home. That gap can be filled by LTSS, making sure they have food, transportation, medications and that someone is checking on them over the next 24 to 48 hours. These services are not typically thought of as clinical services, but they support clinical as well as functional outcomes. There are programs like Adult Day Services, home health agencies and direct care workforce. These are not designated as clinical fee-for-service services, but without them people would return to the hospital, increasing costs. It requires a transformative way to think about it to mitigate unnecessary medical services. LTSS is a sleeper issue, often it gets left off. Chin Hansen urges commissioners to check out the Master Plan for Aging report on LTSS. Perhaps 5% of Medi-Cal population needs LTSS, but 50% of Medi-Cal costs are associated with this group. The LTSS insurance industry started with lots of companies, but now only a handful remain because of the cost issue. 85+ is the fastest growing demographic as proven in the latest census, and 40% will have cognitive issues, including dementia which has direct costs on health care. What's the end goal? A system that produces peace of mind, that people can live as well as possible, avoid unnecessary care in hospitals and emergency rooms, and gives families a chance to stay engaged with their loved one's care while allowing them to continue working. During the pandemic, people in PACE experienced less than 2% of the deaths of those that occurred in nursing homes or assisted living.

- Secretary Ghaly highlights that LTSS is a sleeper issue the commission needs to keep on the top of its agenda. This is not only about health care, but life care. He invites Commissioner Baass, Director of DHCS, to speak on this, as well Commissioner Antonia Hernandez on the equity issue and cultural competency.
- Commissioner Baass confirms that two thirds of long-term care days in California are covered by Medi-Cal, and that the goal of CalAIM and UF would be to have one entity responsible for the entire continuum, providing the incentive to keep people at home with wrap-around services and supports, as well as having accountability to ensure individuals get the care they need where they want it. CalAIM is also focusing on community supports, such as the transition from a nursing facility into assisted living facilities, and what home modifications and other benefits can be provided to help people receive care where they prefer to be served, in the home.
- Commissioner Antonia Hernandez adds that this is not only an issue of equity but an issue of economics. It devastates middle class families when you have a disabled child or elderly parent to take care of. Looking at the

medical needs is not enough. As the population ages, this issue becomes more important. Cognitive issues will become more expensive. Currently only the wealthy can afford this. It disrupts families with people having to leave jobs to take care of a parent or child. The literature says it is cheaper to provide the services at home than at a hospital.

- Commissioner Scheffler comments: It is cheaper to provide care at home. In a nursing home it costs about \$120,000, in an assisted living facility \$100,000, and home care is \$60,000. The surveys say the majority would rather be at home. We need to consider cost - but by not providing it, there is also a cost. The cost to families, lost wages from not working, etc. Subtract those from the cost of the program because those are real costs to the state. The business community will understand this. The commission also needs to take a careful look at nursing homes, as the quality is not good. The commission should talk about improving the quality of care in the nursing homes we would spend public money on.
- Secretary Ghaly: The issue is not just about sustainable financing, but how do we deliver on values and goals. In September 2020, Milliman produced a report for DHCS around LTSS. Appendix B highlights efforts in California and other states. The countries that have had a long commitment to social involvement in LTSS opportunities have renovated and reformed their original approaches, things that started in the 1960s and 1970s got updated and refreshed in the last couple of decades; it's iterative, and it's changing based on evolving expectations, technology, and innovation.
- Commissioner Pan: LTSS should be part of any plan we come up with. In the State Senate, there was an underlying assumption we'd provide the same level of services as before, but due to the aging population in order to tread water there's an increase of 5% per year. If we do less, then we are cutting services. This doesn't account for innovation or other approaches, but based on demographic change alone, the costs are growing faster than GDP, which is important for projections. There is a tremendous need for this. Children with disabilities and their ability to live out full lives and even have a career is dependent on having access to these services. The reason Medi-Cal takes care of two-thirds of the cost of LTSS is because we don't have an alternative way of financing this. The workforce is tremendously underpaid, and there is a CNA shortage. With IHSS, we have worked hard to roll back cutbacks but it's a field where financial rewards for workers are minimal. Medi-Cal is not the best payer, and this needs to be addressed.
- Commissioner Comsti: People with disabilities should be able to live with dignity and independence in their communities. The major problem with LTSS is the bar is really high. People go into poverty in order to get on Medi-Cal so they can get services. We can't create huge barriers for people to get LTSS. The slide showed that if there is one need for

instrumental activities of daily living, that qualifies you. We should keep eligibility simple. With the continuity of care, it is a combination of medical and health care services and other supports. We can't create tiers of care where we're pushing the burden of care onto unlicensed family members. It's not just about paying people who provide the services more money, which we need to do, but we need more licensed professionals in the home and more community-based services - we can staff up regional centers so people can get community-based services. We must work on workforce issues which requires investment. This frees up time, particularly for women who have taken up this burden. The modeling showed that this will actually save money in the long run.

- Commissioner Marya: A whole system of care is what we need for chronic users of health care. As a hospital-based physician, I see people languishing in the hospital because they have Medi-Cal and the state ends up eating the cost. Nursing homes won't take patients because they're prioritizing private insurance coverage. 40% of individuals over the age of 85 will get dementia. Dementia is not a normal facet of aging - it is caused by stress, air pollution, debt - with medical debt being a major cause of bankruptcy. Our health care system should not exacerbate things we are trying to treat. The impacts of structural racism are an independent variable in dementia as well as a toxic food system. These are variables we can focus on to decrease the chance of getting dementia. Many people are also living in homes that are not healthy or safe which is another factor.
- Commissioner Flocks: The Milliman appendix looked at financing of LTSS but didn't take into account that the system is financed by unpaid labor, disproportionately by women and people of color. It's basically a regressive tax. There's a cost to the economy and productivity and contributions to the workforce. The commission should monetize that and include a figure for unpaid labor and cost to the economy included in the report.
- Commissioner Moulds: CalPERS runs a long-term care program with 115,000 policy holders. There was a 52% rate increase this year and more projected next year. This is driven by the cost of institutional care, and most people in the program want to be in their homes instead. CalPERS is developing an alternative benefit design rolling out towards the end of next year, an aging-in-place benefit that policy holders will hopefully voluntarily move into. CalPERS also manages health care for many of their LTSS members, who have the highest health care costs. Often those managing LTSS are not thinking about the health care side, and when a health issue arises, they kick them over to the health care side in an uncoordinated way.
- Commissioner Ross asks Commissioner Chin Hansen to provide a sense of the projected health labor workforce shortfall for long term care and aging; a five- to ten-year number that gives a scope of how big the projected workforce issue is going to be.

- Commissioner Chin Hansen: The report on the California Future Health Workforce shows that California is going to be shy about 650,000 direct care workers alone, not including mental health and primary care. There is also the workforce in programs that serve older adults, such as nursing homes and assisted living. The turnover rate is oftentimes 75 to 120%. PHI, a national organization that covers this workforce, has more accurate information. But it's a big issue, hard enough in acute care and worse in chronic care.
- Secretary Ghaly highlights the comments by Commissioners Flocks and Scheffler regarding the informal family workforce and cost of that to society, tying it back to equity and poverty.

## 2. Ensuring a Smooth Transition

- Secretary Ghaly introduces the next part of the conversation around transitions. There are challenges, opportunities, barriers both in the administrative transition and emotional transitions. What bridges will help us get from where we are to where we want to go? What steps would exert the greatest leverage in making an effective transition to unified financing, on the financing side, workforce, and data and IT platforms? What is the role of current players and how does that change? There is a lot to decide on design decisions, and the timeline of design decisions will help inform transition priorities. Many important initiatives and building blocks are already underway, including work on claims data transparency and collection, but in regard to LTSS and other areas, it is not enough. There are also other foundational investments that have been made by the state to prepare for this process. He invites three commissioners to speak.
- Commissioner Comsti speaks to transition issues: The primary goal is to achieve high quality health care for all California. When talking about the transition, the needs of patients and patient care needs to be front and center. Any temporary inconvenience to providers, agencies, and regulators is an acceptable price to pay to end the pain and suffering of patients caused by a fragmented system of care. There is complexity in transitioning a system fixated on market principles and profit to a system that meets the needs of all patients. Change on this scale can be daunting but we should not be afraid of challenging the status quo as we know what will happen if we don't change. Health care costs will continue to rise, and insurers and employers and corporations will continue to find ways to increasingly pass on cost to patients, patients will continue to avoid care because they can't afford it, and people will continue to suffer. The cost of delaying a transition is high. The state should meaningfully engage the public on transitioning to unified financing. Public comment for the commission is short and we need a process for public input in the transition. I suggest an additional meeting, not during business hours, for the public to comment on the commission's draft proposal. The legislature is asking for help to get a financing plan on the table, so this should be a primary focus in these last meetings. Another consideration in the transition is

making it fair for workers in health insurance and administration, making sure they receive preferential hiring in the new system to help it get up and running quicker. It is important to ensure they get wage replacement, job training, job placement benefits and educational supports. We can fund a just transition and achieve cost savings. We should not fall into the false dichotomy between fee-for-service and capitation. Single payer proposals include a healthy mix of payment options for providers: global budgeting for hospitals and other institutional providers, both drug prices and negotiations, and options for salaries for doctors and doctor groups in addition to fee-for-service. Doctors may go for salaries and not want to do fee-for-service at all. On a procedure level, to transition to salary payments, doctors and doctor groups would negotiate and enter into a contract with a system, agreeing to a negotiated salary based on the kinds of services they perform. There could be step systems for salaries to appropriately adjust for inflation. Doctor groups could provide monthly/annual budgets, report billable hours, report on services provided, or require a minimum number of patients - all of these could be built into conditions of participation. There could be prorated salaries if doctors fall below a minimum range. The system can perform audits to ensure doctors are not either under- or over- providing services related to their peers. The negotiation of all this could be done after legislation is passed, establishing a new system while the state is applying for federal waivers. Questions about care management and resulting care coordination and quality improvement are raised when transitioning away from capitation. Current structures have a fiduciary duty to financial interests of health plans, and their job is to reduce financial risk. Some of this is managed by people who are not health care professionals, and some is managed through algorithms and artificial intelligence. This is a fundamental conflict we are moving away from by going to direct payments. A system without risk-based payment places care coordination directly in the hands of professionals without burdening their decisions on care with financial risks. We can pay doctors for care coordination, consultations, or any time they engage in care coordination with other members of the health care team. Regarding oversight we don't have to reinvent the wheel. DMHC or OSHPD could fill some of these auditing, data collection, and oversight roles, like doing independent medical reviews. A standardized plan could have standardized reporting requirements and conditions of participation for billing practices. Auditing becomes much easier and there would be greater transparency, and we could monitor for coding practices and utilization. We need to transition as quickly as possible to ensure maximum cost savings. In Taiwan, 90% were enrolled in 10 to 11 months. Once legislation is passed, we can start establishing the necessary regulatory and governance structures. As we apply for federal waivers, we can start payment negotiation processes with providers and get providers to enter into agreements with the system. The longer we wait, the more people will needlessly suffer.

- Commissioner Wright: Simplicity is one of the touchstones that is attractive about a universal system with unified financing. The transition is incredibly complex and that must be acknowledged. We need to keep and earn the trust of the public in this process to make this work. Many have experience with the ACA transition with many lessons to offer. The sooner California can offer tangible benefits to the public, the better. The sooner that is offered, the harder it will be to take away, which is one lesson learned from the ACA. There is a tension between this intention and the time needed to set up systems and make sure there is a smooth launch. One way to resolve that is to use existing systems and infrastructure to make it easier to get going and provide security and familiarity for patients and providers. But using existing systems also means potentially inheriting the problems we're trying to move away from. Starting with a new system could get us more quickly to the goals of a unified system but also means a bigger lift getting startup programs embraced, both the issues of ideological and industry attacks and the natural public resistance that can come from switching away from the status quo. If a bill is passed, that is not the end of the political battle; regarding the ACA, there is a book called *The Ten Year War*, so it is an ongoing battle that is important to acknowledge. The system will need to be resilient to those types of issues, whether it is court battles, fights with the federal government, or efforts to sabotage different areas. Another question to raise is how we deal with the scale of California and if all the issues in different parts of California can be resolved on the same timetable. The issues in Los Angeles versus rural areas are different with different providers and systems in place. Should implementation be driven by a set timetable or some other criteria? And should that be variable by region? Do we want to have it all start on one day? In government there is a predilection of starting January 1st, and it may not be a good idea to start during a holiday season. If single payer was passed, there are many things that can be done while waiting for federal approval; that time should not be wasted. Maybe that should be by program. If Medicare is the hardest to get, should we start with the non-Medicare population? Or with benefits like dental or long-term care? That is something to think creatively about. In the context of the report, we should not just lay out the decision points we need to make, but the detailed punch list of things we can move as soon as possible, such as setting up a universal provider directory and initial contacts and communications. How do we move to global budgets and all payer rate setting? Typically, we would want to do this with the power and authority of a single payer purchasing entity, but under existing authorities we can move in this direction as a prelude to unified financing. That time would be important to lessen significant variations between regions and providers with regard to what we pay and how we deal with disparities. That might involve looking at those on the upper end of those payment variations and how to improve those on the lower end, especially those in public programs where reimbursement rates need to be adjusted upwards. How can we get everybody a card attached to their medical records and have that universally distributed? We



can work on these infrastructure challenges to prepare for the final transition steps. In terms of workforce, it is important to think about not just scaling up but changing the mix of the workforce, with more primary care doctors for example. These are things the report can detail, categorize, and sequence - and this sequencing can happen as soon as possible. As Secretary Ghaly mentioned, many of these things are already underway.

- Commissioner Hsiao: The goal of unified financing is to give equitable, affordable, and high-quality health care to improve the health of California. But the system must be sustainable. There are several foundations that are needed. These building blocks are based on international experience, as well as what Vermont had to do. First, to be affordable and sustainable, the state needs to set a prospective global health expenditure budget. What that does is close the checkbook. Right now, there is an open checkbook for the health plans and the providers. That's why health care costs rise so fast. As well as why the US is spending the most among all the advanced nations. Massachusetts led the way to close that. Second, California must address the inadequate supply in the underserved areas. You don't open up the dam until the irrigation channels are built. Otherwise, that water just floods some areas or gets wasted. This is particularly relevant to rural and central California. One idea is to build community centers. Third is developing the appropriate workforce. Commissioners Comsti and Wright elaborated on that. Training is necessary, even with consumer education for the existing practitioners so they can be culturally sensitive to the patients they're treating and caring for, and it takes a long time. Fourth is negotiations. This requires facts for both sides to base their arguments and their positions on. California has required hospitals to report their cost down to the cost centers. But it doesn't get down to every service or procedure. We need cost accounting certified by a certified public accountant. Hospitals must identify their actual costs for each major service they deliver. Then you can know: Which hospitals are inefficient? Which ones are more efficient? What's the appropriate price, or capitation, or fee-for-service to pay these hospitals? California can move that through executive order. Fifth, California needs to develop and establish a purchaser alliance. Right now, Medicaid/Medi-Cal negotiate. Medicare is dictated by federal rules. A purchasing alliance could negotiate with the drug pharmaceutical industry for lower drug prices. There are two other important points: First, California needs to develop a uniform clinical records system. The technology is there, and it can save money by removing duplication of tests, visits, or drugs. Kaiser does this already, and this is the experience in Taiwan, Germany, and Canada. Second, California needs to develop a uniform data system for claims/payments to monitor what each major provider and doctors is doing. This can help prevent fraud and abuse in claims that could save 8% or more of the health expenditures. That will make unified financing more affordable. And more people will say, "Okay, this is a system that's much better, and will not cost me more money." That's a major selling point of a single payer system. Those things

could take two or three years to develop. Commissioner Hsiao urges the commission to consider these building blocks and move them as soon as possible through executive action, budget allocation, or legislation. These building blocks will enable a much more affordable and sustainable system.

- Commissioner Scheffler shares his six-point plan. First, with any transition there are winners and losers. We must identify who is going to be better off and who is going to be worse off looking at the providers and the patients and other actors in the health care system. What are the equity issues that we want to deal with immediately and forcefully when we make this transition? Second, the system must be sustainable with some budgeting and cost control mechanism. There is a proposal for an Office of Health Care Affordability, which hopefully gets passed. It is important to keep in mind the scale. California is the fifth largest economy in the world, and its health care system is bigger than the budget of most countries, there are only 26 whose total budget exceed the size of the health care budget in California. The enormity of the money that we would be moving around is going to cause tremendous shocks in the system, affecting employment, the opportunities, the benefits that people have. This transition will likely take 3 to 5 years given the scale. The average spending in California per capita has been lower than the per capita spending in the United States for many years, and much of this is attributed to that integrated delivery system. But we can do better and need to think about what the next generation is. What is the new integrated delivery system? What can we reimagine that system to be? We're not satisfied with the current one that has lots of good things, but many things that need improvement. The commission should weigh in on this and start to develop policies and legislation to improve this delivery system, including the payment system. We don't just want to pay for care, we want to pay for value, which means high quality care. How do you do that? And how do you develop that in the new health care delivery system for California? And to sustain it we need a tax plan, and we need to pass it. The legislature has said don't send us a plan that you can't finance. For them, job one is to see the financial plan. They want to see where the money is coming from and how we're going to get there. That has to be in the initial phase, because if not, all of this work will end up on some shelf somewhere. Workforce is another integral component to the new delivery system. And those two things go together; you can't have a workforce and train it unless you know what you're training it for. And we want to train it for the new health care delivery system in California, which to me uses integrated plans, and how is that going to work? And who are they going to be? The commission is going to have to take on the issue of what is the role of the state? And what is the role of the private sector? And is it one or the other or a combination of both? The report has to confront it. And it's a very different transition scenario if we're thinking of this being a state-run health care delivery system. Do we want some of it run by the state, as we have now, and some of it run by the private sector? Is there a mix that we're comfortable with? Who should do what?

- Commissioner Sandra Hernandez recommends looking at what was done with implementing Healthy San Francisco. Labor, the chamber, small business, hospital CEOs, FQHCs, and consumers were at the table. It was a data driven process and included a comprehensive set of benefits including behavioral health. It included employer contributions which did get legally challenged but were not overturned. It remains a popular program. Ease of use and administrative simplicity were important to gain early momentum. An existing non-profit health plan was used to implement it and do the marketing, enrollment, and assignment to primary care, medical homes and so on. There was not a new structure created and it is not the same scale of California, but there are lessons about how to stand up a program without health plans, and how do you leverage, govern, and finance it in a way that is sustainable. On workforce, in the Workforce Commission report with recommendations that came out a few years ago, CHCF commissioned an update to see how progress has been coming along, which may be worth looking at. That will tell us about the roadmap for our aging workforce for behavioral health and primary care. It does not address all the workforce we need, but it is comprehensive.
- Commissioner Flocks highlights comments by Commissioner Comsti about setting things in motion even before the report comes out, thinking about what can be put in place to build this foundation, whether it's an executive order, budget, or regulatory change. She also lifts up the comment that we don't need to recreate the wheel of regulatory agencies, that DMHC might go to having one plan. There is capacity that could be unleashed and opportunities for these agencies to do more things. One of the problems is that with such a fragmented system with holes in data and transparency, there is a fragmented regulatory system that exists without a central agency that's looking at the entire system, which is important to create a sustainable and efficient system. She supports creating the Office of Health Care Affordability as well as the building blocks Commissioner Hsiao mentioned, particularly noting the first block about setting a prospective health expenditure target and closing the checkbook, as it increases leverage in negotiation with providers and with the public to say this is going to be a responsible and efficient system. She also highlights the comment about getting all the facts, down to the cost of each service, as that granular data certified by accountants and accountancy firms enables reforms that are needed to create a sustainable and efficient system.
- Commissioner Pan recalls his experience with the ACA legislation and heading up the children's health initiative in Sacramento, bringing together five counties that were not yet served by a single health plan. Even though over two-thirds of the state are Democrats, there are more conservative areas of the state, and there has to be buy-in there. COVID has taught us if there's political division and people are not following along there are going to be problems, so we have to figure out a way to build enough of a consensus. He highlights Commissioner Scheffler's comments on the importance of a financing mechanism and getting consensus on

how to raise the \$200 billion needed in state revenue, or more if the federal waiver is not approved. He notes many people may not be happy with the health care system, but that a lot of people like the health care they have right now, recalling how in passing the ACA a key line to gain consensus was that you get to keep your doctor. These aspects are important to realistically pull together the political will to get this done. He notes that Medicare is shifting more to managed care plans. It may not be necessary to do it that way, but that is a current reality and it's important to understand that trend.

- Commissioner Baass: When seniors and persons with disabilities transitioned from fee-for-service to managed care, people were covered but there was a transition in that continuity and people wanted to keep their doctors. We will need to think through how we transition under unified financing in which the provider someone has today may not be the provider they have tomorrow.
- Commissioner Wood recommends illustrations for the report, and a centerpiece that breaks down what the system looks like now. What percentage of the population is on Medicare, etc.? He notes the 6 million people on ERISA plans, which we have no jurisdiction over. If we are not successful with a federal waiver, what do we do with Medicare? What about a system like Kaiser, which is a hospital, insurance, and provider? Do they cease to exist? He notes they manage 20% of the population. It's important to outline different groups of people, as we look at transitions and what kinds of outreach will need to be done. Not every consumer of health care is the same, and we have to bear that in mind.
- Commissioner Moulds confirms what Commissioners Pan and Wright said about lessons learned from implementing and passing the ACA, and that learning from San Francisco's programs would also be valuable. One takeaway from the ACA was that it's hard to take things back; the challenges were beaten back many times. He notes that many provisions within the ACA were widely popular but overall, the ACA was still viewed skeptically, which highlights the importance of public reaction and buy-in and the way this is communicated. San Francisco did a good job at that and may have lessons to share there.
- Commissioner Schneider: One thing the current state agencies that have a potential future role in this can do right away is practice more transparency. In the Medi-Cal program, from the standpoint of kids and managed care, there is a child health dashboard but it is not plan-specific. The agency knows and the plans know but the public doesn't. If the public did know, it is likely the actors would all up their game. This would be a good learning experience. Drug negotiations are hugely important to an effective communications campaign on behalf of single payer. We do not have to wait for the federal government negotiations on that. Commissioner Hsiao made an important point about the health equity agenda, that unifying the claims forms and having race and ethnicity identifiers on them is important to any basic analysis on racial disparities. Regarding federal waivers, HHS does not have the ability to turn over Medicaid and Medicare to California; you have to go to Congress to get that.

- Commissioner Marya replies to Commissioner Scheffler's comment about winners and losers in a health equity framework and also the historical context of ACA, noting this was not happening in the context of a transformational system. A system cobbled together that won't affect costs like a new single payer system. ACA was hampered by the admission of health care industry lobbyists in negotiations. This is why transparency of who is being funded by these health care organizations and insurers is important. The burnout doctors experience by private insurance is causing a crisis in hospitals, with not enough nurses and doctors, as people are leaving the health care industry. This is a critical moment of being able to advance something innovative that has not been done before. This is not the ACA. It is an opportunity to envision new rules for how we will move financing in the state of California directly to providers.
- Secretary Ghaly notes one of the immediate opportunities at the state level is to do a better job connecting silos within agencies. For example, CalHHS partners with EPA on connections around climate, or with CDFA around food, or OSHPD and Labor. There is opportunity in the transition period to strengthen these connections to deal with the social drivers of health that are directly connected to health equity.
- Commissioner Sandra Hernandez: Governance structure will be an issue to contemplate. Building on Commissioner Schneider's comments, transparency is a powerful tool. Under Commissioner Lee's leadership, transparency has been pretty good at Covered California. There is transparency and public accountability on a regular basis for finance, outcomes, reporting, and collection of data. In Covered California we have good models on the practice of transparency and accountability. Might Medi-Cal look different today if there were a public interface where enrollees had a chance once a month to get in front of the administration and call out things that worked well and that didn't? The Covered California governing board has had great consumer advocates to make it the best exchange in the country. We can't do anything without marketing and that this has been one of Commissioner Lee's hallmarks in every presentation. We can learn a lot from marketing, outreach, enthusiasm and branding a new program. The rules around what is done publicly and privately are important to call out. How do we negotiate and what are the terms? How and where do you do that? The rules in place around Covered California, along with good data, made negotiations more successful.
- Commissioner Comsti notes that HHS Secretary Becerra confirmed that existing waiver authority is sufficient, that no changes to federal law are necessary, and that they would consider a combined 1332 waiver. On the question of how to get public buy-in, if there is a program that will guarantee health care for all Californians, the single payer movement will rally. We should not confuse political will with public will, as these are two separate problems. The polling numbers are clear. Regarding transitioning patients from the current system, just because

someone is enrolled in a plan, or that a lot of people are in Kaiser plans, does not mean they like it. We should not confuse enrollment with satisfaction.

- Commissioner Ross highlights how with Covered California there was a strong commitment to a core set of values such as transparency, inclusion, and hearing the voices of impacted communities. He notes Covered California versus single payer seems like arithmetic compared to calculus in terms of scale and scope, but three things may help with buy-in from the public and legislature: 1) Everybody's in, 2) costs are under control, and 3) you can keep your provider.
- Secretary Ghaly summarizes the conversation and reiterates the need to be clear on the steps and sequencing, to be clear on whether or not health plans are included or reimagined, and how public engagement is included as a centerpiece. He notes the importance of early wins, fleshing out the workforce piece, and the six- and five-point plans by Commissioners Hsiao and Scheffler.
- 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 December 9 2021 meeting](#).

### **3. Adjournment**

- Secretary Ghaly thanks the public and commissioners for the rich discussion and that the report outline will be sent out and feedback taken in before the next meeting.
- Secretary Ghaly adjourns the meeting.