Diana Dooley on Two Years of Budget Cuts, Controversy and Reform

Diana Dooley reflects on her first two years as California's Health and Human Services secretary -- a tumultuous period of deep budget cuts, county and state realignment and the beginning of historic reforms.

by David Gorn, California Healthline Sacramento Bureau

It's hard to believe Diana Dooley has been on the job only two years, given the number of large and historic health care changes under way in California.

Appointed secretary of California's Health and Human Services Agency by newly elected former Gov. Jerry Brown (D), Dooley has overseen billions of dollars in budget cuts, realignment of county and state responsibilities and the building of a foundation for comprehensive reform that includes creating a statewide insurance exchange and launching multiple conversions from fee-for-service to managed care in Medi-Cal, California's Medicaid program.

It has been a packed two years.

Dooley reflected on her first two years as secretary -- challenges, successes and lessons learned from the sometimes-bumpy road to reform.

***California Healthline*:** Pearl Harbor Day, December 7th, two years ago. That's when you took this job.

Diana Dooley: Really? That was the day? That's pretty fitting.

California Healthline: How would you characterize how it's gone over the last two years?

Dooley: Well, they often say, it's like drinking from a fire hose. It has just come gushing out at us over these two years.

***California Healthline*:** And how have you handled that?

Dooley: Clearly, the foundation of what we're trying to do in this agency … is based on the governor's commitment to a strong foundation and the deficit, addressing the structural issues with the financing of state government more broadly.

We're all in this together, and we can't build a strong health care future or reform the health care system or address some of these other issues if we don't have a firm foundation. So everything has been through the lens of dealing with the deficit and the structure of government.

The work that we did in these first two years around what we called the public safety realignment, it had a lot of health and human services-related issues in it, of course, with mental health and substance use disorders. Behavioral health is a part of public safety, and we married those in ways that local government has understood for a very long time. Their police departments were working with their hospitals, with the [emergency departments] and with their mental health and substance abuse disorder populations, recognizing that they were dealing with the same people. And so what we did with the realignment in 2011 -- and we've implemented that this year -- created a process for better coordination for these populations between the state and local governments, but again at a foundational level, it was steeped in the governor's commitment to changing the nature of the relationship between state and local governments.

***California Healthline*:** That's interesting that's what you pick out, because if I had to sum up the past two years, I would say creation of the Health Benefit Exchange, the five conversions to Medi-Cal managed care, launching the task force. You picked something that actually isn't even on my list here.

Dooley: Those are things that I have on my list, as well. But those things sit on top of the basic program of working to restore public confidence. A fundamental tenet of democracy is you have to have consent of the governed. You have to have people recognizing the value. With Prop. 32, you're trying to get the vote of the people.

***California Healthline*:** So you're trying to get everyone on board for the Affordable Care Act implementation, for the Medi-Cal managed care conversions, for all of these things that take a lot of public confidence and provider confidence. Yet at the same time, there are huge budget cuts and service cuts. How do you frame that for people?

Dooley: That is the challenge. If we had enough money, we would continue to let health care escalate in its cost.

Shortly after Medicare and Medicaid were enacted 40-plus years ago, by the early 70s, by the time the governor was governor the first time, within 10 years after that enactment we were trying to control costs. When we had the certificate of need. And then we were at 5% or 6% of GDP and health care was unsustainable at 5% or 6% of GDP. And every generation, every political generation, which I define to be every six to eight years, now it's 10% it's unsustainable, now it's 12% it's unsustainable, now it's 17%, that's unsustainable. You know, we could go to 25% -- it's a priority setting that we make about how we spend our money.

I don't know what's unsustainable, we've blown through every other one, but the crisis that represents in government -- and government is such a big player in the health care arena -- is that, if we can't fund education and we can't fund environmental protection, and we can't build roads, if we can't do

the other things that government is expected to do because of the amount that's being taken to deliver health care, we then have to address that. I think that's where we are. I think that's where we are in California, and that's where we are in Washington.

***California Healthline*:** Basically the budget cuts have forced us to be more efficient.

Dooley: Exactly. It has forced us to address the issues. For example, one of the fundamental principles of the ACA, although it isn't squarely stated, is that one of the biggest challenges to implementing the Affordable Care Act is changing the way people think about managed care. Because that is hard, coming to the recognition that we can't stay in the fee-for-service environment. We call it value over volume, we call it a lot of things, but fundamentally it is that we have to coordinate and integrate the care people receive, in order to avoid duplication and inefficiency and manage the utilization to some degree.

When we tried that in the 90s, I mean the words 'health maintenance organization,' those are really good words. Maintain your health. That's what all the prevention advocates, all of the public health advocates, they all want to maintain health instead of spending money on curing disease. But we have a health disease system. We don't have a health care system. So having a way to manage your health is a good idea. But HMO became the evil of health care.

We have to rethink what care integration and care management is, that's at the heart of it. That's what we're doing with our Coordinated Care Initiative, it's what we're doing with our Seniors and Persons with Disabilities program. The dustup over Healthy Families is a little bit curious, because all of those kids are in managed care anyway, in the Healthy Families program, and almost every state in the country put their CHIP program into their Medicaid programs at the outset.

***California Healthline*:** It seems many people may be comfortable with the idea of moving kids from Healthy Families into Medi-Cal managed care, I think the question people have is whether the state is ready to do it. You're talking about getting people behind it, getting the trust, and the SPD conversion and the ADHC/CBAS conversion have had so many troubles. We're also looking ahead to the bigger ACA and CCI conversions, and Healthy Families is right in the middle of that. I think most people want to know that the state has concrete lessons-learned from the SPD conversion, from the CBAS program, moving into Healthy Families.

Dooley: We're doing a lot of things at the same time. We're making a lot of changes. And there are going to be speed bumps. There are going to be places where you have to slow down, and get over. But we have to move in that fundamental direction of the ACA, away from fee-for-service, and into

care coordination and care management. And we're doing that. I share your observation that there's broad recognition that that's where we have to go. The devil's in the details.

When you are changing the way people get paid, you're going to have resistance. So we have a lot of people who don't want to make those changes. Don Berwick is an academic, and Mark Smith and Bob Ross, they're great thinkers and they say we have 30% that is wasteful and possibly harmful, that we have 30% that we don't need to spend, and they all say that. And every dime of that is in somebody's pocket. Nobody reaches into their own pocket.

Everybody comes to meet with me, I can't tell how many people sit around this table and everyone says, 'The system is inefficient and we can save money.' What we've tried to do in the Let's Get Healthy California task force is to say, 'What would you do -- not what do you think someone else can do -- but what are you willing to do to make the triple aim of health care a reality?' Better health, better outcomes and lower cost.

California Healthline: Back to the controversy. Just in terms of specifics. A lot of providers have told their patients who have had ADHC and should be going over to Medi-Cal managed care so they can get CBAS, don't do it. And there's no reason for them to say that, there's no benefit for them or their patients to say that. But there's this sense of distrust. Some physicians have said it's because of how the SPD conversion has gone, or the ADHC conversion has gone so far. They all really want to trust, but how do you get them to trust? More specifically, what can you tell providers about the lessons learned, and what direction they should go?

Dooley: These are separate issues. In the Community Based Adult Services, that's about 5,000 out of about 35,000, that population of people who have Medicare doctors, who are not affected but still have told their Medi-Cal not to go into managed care.

California Healthline: Despite what the centers tell them to do.

Dooley: Exactly, and we're doing everything we can to put in place an easy way back in, once they realize they need [those services]. But at the heart of it, they are deciding they don't need that service as much as they thought they did. It's the physicians that are telling them, but they're also seeing whether they can get along without these services. One of the things about the Adult Day Health Care centers as an optional benefit is, it built up very randomly around the centers themselves. And so, you have two-thirds of them in L.A. County, and you have whole parts of California that have no adult day health care at all. ... Now, do they get a benefit at these centers? Absolutely. Without question, I think there is a benefit. And now they're making a choice.

California Healthline: I guess I'm referring more to perception, to provider perception.

Dooley: At the heart of what you're saying is sort of like the T-shirt, 'If mama ain't happy, ain't nobody happy.' If the providers aren't happy, the system doesn't work. What this illustrates is a lot of the policy is driven by the providers.

And we have a very complex system of cost-shifting that has occurred, as we've had fewer resources to manage. I worked in the hospital industry for 10 years before I came here, I know how things are managed to get other rates. But moving those other rates down when we increase, it just seems to always go up. It never goes down.

California Healthline: What do you mean?

Dooley: You're not saving anything on the shift.

California Healthline: You're talking about the CBAS shift.

Dooley: Yeah, and we keep making these adjustments, and the system keeps accommodating those adjustments. In Healthy Families, a lot of the angst is around the recognition that the provider reimbursement rate for Medi-Cal is lower than the reimbursement rate has been for Healthy Families. A lot of people have had to make reductions in these hard times. State workers had to take a 5% pay cut after almost 10 years of no increases. I think a lot of these providers who are serving the public will end up taking a little less and serving this population. You can't expect them to be happy about it, no one wants to take a reduction, but until we get the state stabilized, until we get this economy turned, until we get revenues going up. Ten years ago, as you know, revenue in California was well over $100 billion, and now it's dropped down to $80 billion. You can't get blood from a turnip.

***California Healthline*:** So I guess what you're saying is because there's a limited amount of time, you just have to move forward, and hope the providers ...

Dooley: ... And slow down at the speed bumps, and make corrections where we have to make corrections. We will have access. Where we need to make course corrections, we will make course corrections, but we're not going to be able to wait 'til everything is perfectly aligned, 'til everybody agrees this can all go off without a hitch.

***California Healthline*:** Everybody talks about lessons learned, and how we've learned lessons from SPD and CBAS conversions. So what ARE the lessons learned, specifically? Healthy Families and the duals project, are those going to have problems and similar controversy? Specifically, can you pick out one lesson that you can learn from the other two transitions? And

say, with this next transition, with Healthy Families or CCI, we're going to do it THIS way, because we learned from the other ones.

Dooley: We're learning all the time. The process is pretty straightforward. We have communication with the beneficiaries, communication with the providers, we have dates, and when we get to that date we make the transition. There's phasing in the Healthy Families transition, so that it will start in January, and we'll phase as we need to. And there are going to be places where there will be problems we have to solve in the process, as we have in the SPDs, we're still dealing with those changes. But for the most part, most of the people we transitioned in the SPDs are satisfied. In our review of the actions, people are getting as good, and in some cases even better, care when it's coordinated with their plan.

It's going to take some time. We know how to do it. When we faced the resistance of providers and the participants, we have to deal with that. It takes us time to do the communication, and we're working on that.

California Healthline: With CCI, that timeline for implementation has been much longer, and in terms of outreach, the effort has been phenomenally different. There has been much more time invested in stakeholder input and making sure everyone understands what's happening. In terms of how it went in previous efforts and how it's going in the next one, is that one of the lessons you'd see?

Dooley: There's a transition in administration. When we come in, we have our teams in place.

But I think also, that in health care delivery and health care reform, more specifically, in California it hasn't been a partisan issue. Schwarzenegger was a real leader, and the elements of the '07 plan to establish health care reform in California are all the basic elements in the Affordable Care Act. We inherited everything about the ACA. The ACA was in place, the exchange was in place, the Bridge to Reform waiver was in place.

And so building on those principles in such a short amount of time, with such pressure, I'd say we can't talk about anything in this agency without the underlying pressure, because without that pressure, we may have taken more time to do these things. But we didn't have the time. We didn't have the resources. We had to move, to hit these budget targets.

***California Healthline*:** You strike me as a consensus person, and you've said that the hardest work is always in the middle. How has that approach helped get the health care effort moving over the past two years?

Dooley: I think there is considerable respect about the governor's motives. He wants what's best for California. He wants to bring people together -- with our county partners, with our stakeholders. I accepted this position with him

because I share that view. He leads from the middle, and I govern from the middle.

There's a certain process you go through when you're making a decision, gathering information, and there's a tipping point, where no amount of information is going to make you go a certain way, and when you get there you have to go. That's what we tried to do to meet our state budget demands, and moving us over this decade, away from paying for volume, and instead paying for value. And that's a very heavy lift.

***California Healthline*:** So I assume you've had that consensus approach as chair of the Health Benefit Exchange. It's such a powerful entity making such big changes, and yet there's been almost no controversy about it. Is that because of the approach to it, or because of the united nature of the exchange board itself?

Dooley: I'm the only one from the current administration on the board. We were very fortunate to be able to recruit Peter Lee (executive director of the exchange). He and I share that sense of building to the middle. So we've been able to do that well, between my board leadership and his staff leadership. I credit him with a lot of that.

I think we have some rough spots ahead. There are the affordability questions, the plan design. This has been an inside-baseball conversation for two years, among people who speak the same language, and that will change when it's introduced in 2013 to the broader public, which has a far different language about what their needs are. I think we've positioned it really well, but it's not going to be without controversy.

The expectation that we're going to flip the switch in 2014 and suddenly everyone has health insurance is way wrong. It's the beginning of a decades-long effort to change the system.

***California Healthline*:** In our first interview two years ago, when you first took this job, you said this about California's health care system: 'I don't see it all radically redesigned. I see the gradual changes. I can't see the analytical construct for a big change.' Now, arguably, you've presided over the biggest changes in health care in California since the 1960s. Do you still feel it's not a radical change?

Dooley: I don't see a revolutionary change, like single payer would be. But there are still advocates for single payer, it's not happening right now. But there's a belief among some of those who think it should happen that we'll give this a little time and when it collapses, or doesn't produce the results people expect, we'll come back. And there's talk of a ballot initiative in 2014 for single payer.

What we're doing, it isn't immediate revolution. It is building over time. It is a revolution, yes. Clearly the basic tenet of moving from fee-for-service to managed care is revolutionary, but it's been a revolution that started 20 years ago.

But here's my point. Rube Goldberg himself could not have invented a machine like we have in health care. But we will tinker with it, use the wrenches and twist the knobs, as we have to, to get it moving in a different direction. We are an aircraft carrier. It's hard to turn, but we are turning it -- toward efficiency, quality measures, transparency. That is one of my priorities, having more transparency, both about the cost, that's what we're trying to do with the exchange where we really put out what it is you're going to buy.

In macro, we have done a lot in two years to move toward the goals of the triple aim of the Affordable Care Act. We are working on better health through our Let's Get Healthy California task force, though the task force is really about all three parts of the triple aim. The work that Ron Chapman is doing at CDPH, we had great success with pertussis and whooping cough and vaccinations, we have our health-in-all policies that grew out of the growth council.

We're improving health through our licensing and certification, through our Bridge to Reform waiver with the counties, through telehealth, we've reformed Cal eConnect and we're working with Ken Kizer to get more of that money out. So we're working on health information as well as telehealth. We're working on everything! And we're trying to keep all the balls in the air.

Getting to the central theme for me, that is getting people to sit down around a table and work together on a problem, no matter what the problem is, and figuring out what we're going to do to solve it.

The [consensus] around the Coordinated Care Initiative is probably the best example. Bringing people together, [various] services and the in-home support and bringing the Olmstead people in, bringing the delivery system people in, bringing the plans in, bringing the Medi-Cal departments in, everybody around, bringing the unions in, bringing the counties in.

And all of that to say, 'Your life conditions are a part of your health.' Integration isn't just integrating health providers, we don't mean coordinating care just by the care that's provided by an MD or a hospital, but really integrating the care with the community, with the faith-based organizations, with adult day health, with the systems that support people in [their] homes.

***California Healthline*:** One thing I've noticed over two years is the increasing shift in buy-in from stakeholders, mostly from the CCI project.

Dooley: Some of that is also a function of the deficit and the fiscal pressure. As long as people think there's enough money to be able to do things the way they've done them in the past, they'll want to keep doing them the way they've done it in the past. But when you've got to make changes ....

For example, the hospital community has made a huge shift in recognizing that because of low rates of reimbursement, they'd rather not have people in their hospitals. So the readmission rate work and the getting out and reducing hospital stays, has been driven in part by the recognition that they can't get paid for them, so they are looking outpatient, and they are looking for ways to do things differently.

For the banks, my debt is their asset. And for health care, my illness is their asset. So that is across the health care delivery system. And that is really hard to get at. How do we incentivize people so that they're paid for my health, rather than for my illness. That's very hard.