Healthy California for All Commission
Survey Report
September 2021

Survey background:

In late September 2021, HCFA Commissioners were surveyed regarding key concepts and ideas that have been discussed to date in our Healthy California for All Commission meetings. The goal of this survey was to gauge agreement on key concepts and principles for the design of a unified financing system. Many of these ideas are foundational. Others are intended to push our thinking forward and are likely to merit further discussion and debate. Future surveys will build on initial responses and revisit many topics in more detail, particularly those slated for deeper dives as part of upcoming Commission meeting agendas.

Commissioners were invited to rate multiple statements using the scale below. In the box below each section, they could suggest additional ideas or edits to proposed language.

Rating scale:

3 = I agree
2 = I agree with slight modifications
1 = I disagree
0 = I don't know / no opinion

How to use the scale: If commissioners agreed with a statement and its framing, they entered the number 3. If they agreed with the statement but wanted to re-frame it or make minor changes, they entered in the number 2 and used the comment box to suggest their re-framing. If they disagreed, they entered the number 1 and used the comment box to explain why.

Survey Responses:

Goals and Values

Healthy California for All: A "Healthy California for All" envisions a California health care system that delivers safe, timely, efficient, equitable and person-centered care for all Californians through a system of unified financing.

Total Count:	
3 = I agree	**7**
2 = I agree with slight modifications	**4**
1 = I disagree	**0**
0 = I don't know / no opinion	**0**

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Carmen Comsti	3 = I agree	
Sandra Hernandez	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	Looking at the macro health system. Also considering the cost of the system and who pays for it and how.
Andy Schneider	3 = I agree	
Cara Dessert	3 = I agree	
Jennie Chin Hansen	2 = I agree with slight modifications	Affordable and accessible? Given the new report just out from the community voices
Sara Flocks	2 = I agree with slight modifications	I would add to the end "with the goal of improving mental and physical health and well-being for Californians." I also think we should add "sustainable" somewhere in the definition, maybe a "sustainable California health care system...."
Antonia Hernandez	2 = I agree with slight modifications	I agree with most of the statement, my reservation is on the method, (Through a system of Unified Financing.) we will get there but I am not sure we can get there as a first step.
Anthony Wright	2 = I agree with slight modifications	Agree with the statement as written. Suggestions to think about would add "quality," and potentially something about simpler, more understandable more culturally competent system (which might be implies by "person-centered" but that term has been used for lots of things). We also seek a system that is focused on public health, population health, prevention and wellness goals, rather than simply the profit motive that drive so much of our current system, that also leads to distrust of the system.

1. **Integration and Coordination:** California's health care system should deliver care that is integrated and coordinated across all types of diagnoses and the continuum of care.

Total Count:	
3 = I agree	**9**
2 = I agree with slight modifications	**1**
1 = I disagree	**1**
0 = I don't know / no opinion	**0**

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Jennie Chin Hansen	3 = I agree	just an addendum; I think the coordination is especially important if there are co morbidities; there are times "coordination and integration" may not be needed when health care is more basic
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	A holistic approach will yield better health outcomes and it will be less costly.
Anthony Wright	2 = I agree with slight modifications	Agree with the statement as an aspiration. That should be the goal. Realistically, a comprehensive health system that adapts to new benefits and practices may not be fully integrated on every type of care all the time. Any such system will be evolving. But not sure how this can be articulated in such a short statement.
Carmen Comsti	1 = I disagree	Rating : 1. I am concerned about including the goal of "integration" without defining the term. I do not believe that integration of payment or integration of health care corporation structures are appropriate goal or value, and I do not believe that integration for

Name:	Response:	Comment (if option 2 or 1 was selected):
		the purposes of reducing costs is an appropriate goal or value. Whether "integration" improves care depends on how care is integrated. Similarly, how care is coordinated is and who is coordinating care is crucial to improving health and health care. Only a licensed health care professional with the appropriate competencies and exercising professional judgment and who is treating an individual should integrate or coordinate care; we should not condone the unlicensed practice of medicine by corporations, health plans, or individuals who either incentivized to act on their own economic interest through risk-based payments. Additionally, research shows that patients have concerns about who is able to see their medical records, even within a health system, particularly regarding mental health and substance use issues. I have two suggestions as reframing: (1) delete references to "integration" altogether, (2) add that coordination should be done by each patient's treating licensed health care professionals, and (3) add to the end – "for the purposes of providing each patient necessary and appropriate care that meets their individual care needs." All together the goal/value would read (additions bracketed, deletions not shown): "Coordination: California's health care system should deliver care that is coordinated [by each individual patient's treating licensed health care professionals] across all types of diagnoses and the continuum of care [for the purposed of providing each patient necessary and appropriate care that meets their individual care needs]."

2. **Accountability:** Care quality and health outcomes for individuals and for populations should be monitored and systems of accountability should be established.

Total Count:	
3 = I agree	**8**
2 = I agree with slight modifications	**3**
1 = I disagree	**0**
0 = I don't know / no opinion	**0**

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	We need to know and measure results.
Carmen Comsti	2 = I agree with slight modifications	As I discuss in the more detailed goals/values below, the kind of system of accountability matter and I do not agree with certain systems of accountability that create risk-based incentives, that interfere with the doctor-patient relationship, or that substitute individual care needs with population metrics and population-based medicine.
Sara Flocks	2 = I agree with slight modifications	I would add to quality and health outcomes something that captures the goals of equity as well as cost containment....so "care quality, equity, cost efficiency and health outcomes"... Or add something about value? All those should be part of an accountability system.
Anthony Wright	2 = I agree with slight modifications	Agree with the statement, but it seems significantly insufficient. Such a statement could apply to our public and private health systems today--and I think we find those accountability

Name:	Response:	Comment (if option 2 or 1 was selected):
		systems lacking: whether for childhood immunizations to timely surgeries to the complex care needed for people with disabilities. A unified financing system requires a higher threshold of robust oversight and accountability.

3. **Payment:** Provider payments, including methods of payment and levels of payment, can exert leverage to address inequities and to improve access, cost efficiency, quality, and outcomes.

Total Count:	
3 = I agree	**6**
2 = I agree with slight modifications	**4**
1 = I disagree	**1**
0 = I don't know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Sara Flocks	3 = I agree	
Antonia Hernandez	3 = I agree	Payment for services is the primary method for insuring equitable results.
Jennie Chin Hansen	2 = I agree with slight modifications	Would like to understand how the leverage comment would be operationalized for my better understanding. It may be fine as written but not just clear to me yet.
Sandra Hernandez	2 = I agree with slight modifications	
Cara Dessert	2 = I agree with slight modifications	I'm concerns about regional gaps in CA, and how we build equity in healthcare deserts in CA will require an increase in providers in these region with deeply inadequate number of healthcare providers and systems; I don't want

Name:	Response:	Comment (if option 2 or 1 was selected):
		provider payments to be a barrier for these regions (e.g. Imperial Valley, Central Valley)
Anthony Wright	2 = I agree with slight modifications	Provider payments not only can but should be used to advance quality and equity. Certainly better than the system where provider payments vary largely on market share/power.
Carmen Comsti	1 = I disagree	We have not yet discussed payments in earnest and it is inappropriate to include this goal here now. I strongly disagree with the express goal of using payment to "exert leverage" and the goal should be about funding care and not just payment. Financial incentives tied to reimbursement and care interfere with the doctor-patient relationship. Payments, and funding generally, can and should be targeted to address health inequities where there are healthcare deserts or where parity in payment is lacking (e.g., in behavioral health and primary and preventive care). I disagree with the inclusion of this goal/value if the term "exert leverage" remains. To that end, I suggest changing "exert leverage" to "be targeted" and adding "funding" as a parallel goal with payment. Additionally, I am not sure what "cost efficiency" means here and am concerned that that inclusion of this term in reference to payments ultimately supports care denial. I suggest deleting "cost efficiency" and adding language that references reducing excess prices or ensuring reimbursements go towards care. The goal would read (additions bracketed, deletions not shown): "[Funding and] Payment: Provider payments [and funding], including methods of payment and levels of payment, can [be targeted] to address

Name:	Response:	Comment (if option 2 or 1 was selected):
		inequities, to improve access, quality, and outcomes, [to pay appropriate prices, and to ensure health care expenditures are directed towards the provision of care].”

4. **Equity:** The health care system should proactively monitor, mitigate, and eliminate racial and ethnic disparities in health care access and quality.

Total Count:	
3 = I agree	**9**
2 = I agree with slight modifications	**2**
1 = I disagree	**0**
0 = I don’t know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	A must
Sara Flocks	2 = I agree with slight modifications	Add "and improve individual and population health."
Anthony Wright	2 = I agree with slight modifications	While racial and ethnic disparities need to be prioritized given the historical and ongoing structural barriers associated with race and racism, a drive toward equity should at least include "other" disparities as well, to acknowledge the intersectional impact of other factors, including income, immigration status, disability, sexual orientation and gender identity, and more.

5. **Public Health, Prevention and Population Health:** The health care system should address not just the acute, short-term needs of individuals but should focus on prevention and the social and structural factors that affect long-term health outcomes for individuals and populations.

Total Count:	
3 = I agree	**7**
2 = I agree with slight modifications	**3**
1 = I disagree	**1**
0 = I don't know / no opinion	**0**

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Sandra Hernandez	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	Prevention should be the top priority.
Jennie Chin Hansen	3 = I agree	I think this is really important and involves significant re-calibration so that outcomes are more clearly delineated and are integrated to well being functionality.
Carmen Comsti	2 = I agree with slight modifications	I would like to add the term "should address" before "social and structural factors…" While our health care system can address social determinants of health where possible, any measure taken by our health care system will necessarily be piecemeal. We must recognize that to address social determinants of health we need robust social safety nets and other social programs outside of our health care system. While our health care system and other social programs should coordinate with one another, it is important that health care be the focus of our health care system.
Sara Flocks	2 = I agree with slight modifications	I agree but they desire to address social and structural factors has to be balanced with the financing and sustainability of the system. The system

Name:	Response:	Comment (if option 2 or 1 was selected):
		should acknowledge and address the social determinants of health as best they can, but there will be limits on what a health care system can do. At some point, the government has to step in to provide those supports and programs.
Anthony Wright	2 = I agree with slight modifications	The only caveat is that the health system should focus on keeping people healthy, and that the health system should be a leader with other sectors in addressing the social determinants of health. This includes at least connecting to the social safety net of human services, housing and more.
William C. Hsiao	1 = I disagree	The socioeconomic determinants of health and health care involve income and redistribution, housing, nutrition/food, education, social equality, racial justice, etc. Seriously considering the socioeconomic determinants would take the focus away what we can do about Unified Financing for healthcare. They involve most social and economic programs, much, much beyond the boundary and expertise the Commission. It would just dilute the Commission's efforts and what we can do.

6. **Sustainability:** A new universal, unified health care system implies a long-term commitment by the State of California and will require sustainable financing.

Total Count:	
3 = I agree	**10**
2 = I agree with slight modifications	**1**
1 = I disagree	**0**
0 = I don't know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	We need to be mindful of cost.
Anthony Wright	2 = I agree with slight modifications	Absolutely the goal--a health system needs to be a long-term commitment and sustainable. But like the financing for Medicare, we should expect that there needs to be adjustments over time.

Propositions

1. Healthy California for All

Definition: To advance a "Healthy California for All," Unified Financing would eliminate distinctions among Medicare, Medi-Cal, employer-sponsored insurance, and individual market coverage. All Californians would receive a comprehensive package of health care services and coverage would not vary by age, employment, disability status, income or other characteristics.

a. To effectively advance a Healthy California for All, Unified Financing is required.

Total Count:	
3 = I agree	**6**
2 = I agree with slight modifications	**4**
1 = I disagree	**1**
0 = I don't know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	Need to eliminate distinction as to form of payment. focus on the health needs.

Name:	Response:	Comment (if option 2 or 1 was selected):
Anthony Wright	2 = I agree with slight modifications	Unified financing is a key goal to get to a Healthy California for All, and is the main focus of this commission. But there's many ways we can "advance" toward the goals of universal, quality, affordable, equitable coverage that do not require a pure version of unified financing. Those goals would be a lot easier if we had unified financing, but there are also steps we can take to get closer.
Andy Schneider	2 = I agree with slight modifications	I agree with this ideal in principle, but it is simply unrealistic to assume that distinctions between Medi-Cal, Medicare, ESI, and the Individual market can be eliminated in the foreseeable future.
Carmen Comsti	2 = I agree with slight modifications	In the lead in proposition above #9, I would also add “immigration status” to the list of characteristics.
Jennie Chin Hansen	2 = I agree with slight modifications	How this is defined will be important.
Sandra Hernandez	1 = I disagree	

b. To effectively advance a Healthy California for All, health plans should be retained but reimagined, encouraging their role in care coordination and population health management but imposing greater regulation on their contributions to cost and administrative burden.

Total Count:	
3 = I agree	**5**
2 = I agree with slight modifications	**2**
1 = I disagree	**4**
0 = I don’t know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Robert Ross	2 = I agree with slight modifications	I would say “could be” rather than “should be.”
Antonia Hernandez	2 = I agree with slight modifications	Everything needs to be reimagined.
Cara Dessert	1 = I disagree	
Sara Flocks	1 = I disagree	I don't think health plans that assume financial risk or that make any decisions regarding premiums or care access have a role in a UF/single payer system. There's a role for them in care coordination but not as risk-bearing entities.
Carmen Comsti	1 = I disagree	I strongly disagree with the inclusion of this goal/value. I do not believe health plans should be retained in any form. I do not believe health plans should be used to provide care coordination or population health management even with greater regulation. Health plans are in the business of denying and limiting care and are anathema to the goals of universal health for all.
Anthony Wright	1 = I disagree	Not opposed to intermediaries that provide care coordination, but not sure health plans as we know them today "should" be retained--it depends a lot on the system we are able to build, and what the alternative is. What the health plans do today: 1) market and aggregate lives, 2) bear risk and a social insurance function, 3) build networks and negotiate with providers on cost and quality, and 4) administer, organize and coordinate care. Presumably many of these functions would be taken by the new health system. The care coordination and maybe other roles could also be done by providers or health systems or other

Name:	Response:	Comment (if option 2 or 1 was selected):
		nonprofits. Just not sure this is the right way to frame the question.

c. To effectively advance a Healthy California for All, health plans and other risk bearing intermediaries should be eliminated.

Total Count:	
3 = I agree	**3**
2 = I agree with slight modifications	**0**
1 = I disagree	**6**
0 = I don't know / no opinion	**2**

Name:	Response:	Comment (if option 2 or 1 was selected):
Carmen Comsti	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Jennie Chin Hansen	1 = I disagree	There is merit in the infrastructure. I do understand that "excess profit" is unacceptable but how to address that needs some expertise.
Sandra Hernandez	1 = I disagree	
William C. Hsiao	1 = I disagree	Without incentive and risk bearing, how could an UF plan motive the health plans and intermediaries to improve quality and efficiency of healthcare and contain the health costs so the UF can be sustained?
Richard Scheffler	1 = I disagree	
Andy Schneider	1 = I disagree	
Anthony Wright	1 = I disagree	Not sure for the need for health plans as currently structured, but I can imagine integrated health systems, clinics and other providers, and maybe others serving as an intermediaries to coordinate care and help consumers navigate through the health system. Without a clearer sense of how the health system would function, would be loath to have a blanket statement

Name:	Response:	Comment (if option 2 or 1 was selected):
		against a core function to assist consumers.
Robert Ross	0 = I don't know / no opinion	
Antonia Hernandez	0 = I don't know / no opinion	

2. **Integration and Coordination:** California's health care system should deliver care that is integrated and coordinated across all types of diagnoses and the continuum of care. In particular, integration and coordination can be accomplished by:

   a. Individuals selecting or being assigned a primary care provider that coordinates their care.

Total Count:	
3 = I agree	**7**
2 = I agree with slight modifications	**4**
1 = I disagree	**0**
0 = I don't know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Anthony Wright	3 = I agree	
Cara Dessert	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	Allowing each person to have a regular primary care provider is important but we should not require that the primary care provider acts as a gatekeeper to care and there should be no referrals or prior authorizations or step therapy needed to access care. I would like to add to the end "in a manner that does not introduce gatekeeping barriers to care such as step therapy, prior authorization, or mandatory referrals."

Name:	Response:	Comment (if option 2 or 1 was selected):
Jennie Chin Hansen	2 = I agree with slight modifications	it would be ideal but since there are insufficient primary care physicians, it may take a "system" that would include other primary "providers' eg. advanced practice providers to to be the primary.
Sara Flocks	2 = I agree with slight modifications	I think it could be a primary care provider or integrated health system that designates a coordinator.
Antonia Hernandez	2 = I agree with slight modifications	need some degree of flexibility to select your provider

b. Integrating behavioral health and primary care services.

Total Count:	
3 = I agree	**9**
2 = I agree with slight modifications	**1**
1 = I disagree	**0**
0 = I don't know / no opinion	**1**

Name:	Response:	Comment (if option 2 or 1 was selected):
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	goal is to include all medical needs, including behavioral
Anthony Wright	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	Like many of the other goals/values in this survey. The language here is confusing as a result of vagueness and lack of clear definition. If we mean behavioral health and primary care services should be integrated into a unified health care system then I agree. However, primary care providers should not be asked or encouraged to provide

Name:	Response:	Comment (if option 2 or 1 was selected):
		behavioral health care services that they do not have the specialized training to provide such as psychiatry. I believe our discussion at the past commission meeting was reflective of the former interpretation of this goal/value. Additionally, it is important to emphasis the need to train and higher more licensed behavior health professionals with cultural, socioeconomic, and linguistic competencies that meet the needs of California's diverse residents. The goal/value should be modified to read (additions bracketed): "Integrating behavioral health and primary care services [into a single unified health care system, and adequately funding and retaining licensed behavioral health professionals in the unified health care system to ensure that care from unlicensed or those lacking appropriate behavioral health care education is not substituted for appropriately licensed behavioral health professionals]."
Sara Flocks	0 = I don't know / no opinion	I don't know enough about behavioral health to say.

c. Identifying and supporting dedicated entities that coordinate care for complex, high need populations.

Total Count:	
3 = I agree	**8**
2 = I agree with slight modifications	**2**
1 = I disagree	**1**
0 = I don't know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Anthony Wright	3 = I agree	
Jennie Chin Hansen	2 = I agree with slight modifications	There can be dedicated entities or programs (e.g. PACE)/health plans who can continue to do what they do or build on what they have.
Antonia Hernandez	2 = I agree with slight modifications	We already have some systems that work
Carmen Comsti	1 = I disagree	I don't know what this means or what is meant by "entities" and cannot support it because "entities" could, because it is undefined, could include insurers or other non-health care professionals. Coordination of care should be done only by an individual's treating health care professionals using their professional judgment after assessing the patient and in a manner that is in the best interest of the patient and is consistent with the patient's wishes. It is also incredibly unclear what "coordinate care" actually means here.

d. Expanding and building upon models, such as integrated delivery systems, with demonstrated success in integrating and coordinating care for a patient population.

Total Count:	
3 = I agree	**8**
2 = I agree with slight modifications	**2**
1 = I disagree	**1**
0 = I don't know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
William C. Hsiao	2 = I agree with slight modifications	I do not know what are these models. The Commissioners questioned the existing IDS models such as managed care and even Kaiser Plan. This question has to be more specific about what type of IDS.
Sara Flocks	2 = I agree with slight modifications	It depends on whether they assume the role of health plans or are built into a single payer system.
Carmen Comsti	1 = I disagree	I disagree that “integrated delivery systems” should coordinate care. Existing integrated delivery systems are largely HMOs, ACOs, and risk-bearing managed care models. I strongly disagree with the goal of maintaining such models in a unified financing system. Integration of business interests of providers in risk bearing integrated delivery systems is not necessary to achieve integrated care. We can pay for collaborative care under unified financing without using financing incentives and risk-bearing payment models and it’s important to recognize the real costs to our current approach. The managed care model rewards corporate consolidation leading to regional monopolies, price hikes, and facility closures. The Kaiser Foundation Health Plan is held up as the model for integrated care yet they have repeatedly been called out for their bad behavior, which has resulted in denied and delayed care as well as gaming reimbursement systems.

3. Accountability: Care quality and health outcomes for individuals and for populations should be monitored and systems of accountability should be established.

a. Standard measures of care quality, health outcomes and other outcomes of interest (e.g., timely access, consumer experience, social risk) for individuals and populations should be measured and publicly reported.

Total Count:	
3 = I agree	**7**
2 = I agree with slight modifications	**4**
1 = I disagree	**0**
0 = I don't know / no opinion	**0**

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Carmen Comsti	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Cara Dessert	3 = I agree	
Andy Schneider	3 = I agree	
Jennie Chin Hansen	2 = I agree with slight modifications	there need to be standardized and adapted measures such as points being elevated in the very recent consumer engagement report coming out on Sept 21, 2021-new ones related to respect and dignified care.
Sara Flocks	2 = I agree with slight modifications	Along with granular demographic information.
Antonia Hernandez	2 = I agree with slight modifications	but not create burdensome procedures
Anthony Wright	2 = I agree with slight modifications	Measures must take into account high need populations---whether it is Black maternal health, persons with disabilities or seniors with complex needs, compounded by lack of access to the social safety net.

b. Accountability for population health outcomes should be established so that when outcomes do not meet expectations, corrective action can be taken.

Total Count:	
3 = I agree	**9**
2 = I agree with slight modifications	**1**
1 = I disagree	**1**
0 = I don't know / no opinion	**0**

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	Must be able to change according to need
Anthony Wright	2 = I agree with slight modifications	This language should be stronger: Accountability must includes actually fixing problems, and a system should have the capacity to monitor, but also to enforce, and to ensure needed will and funding.
Carmen Comsti	1 = I disagree	I disagree with this goal/value without additional language again because the language as written is vague and unclear, and because of the overuse of the passive voice. The term "corrective action" could mean anything. It's not clear who is taking "corrective action" or if "corrective action" is being taken against a particular person/entity. I would disagree with this goal/value, for instance, if "corrective action" meant through the use of risk-based payment schemes. I believe that type of corrective action unjustly punishes providers that treat sicker and vulnerable patient populations, encourages gaming, punishes small

Name:	Response:	Comment (if option 2 or 1 was selected):
		practitioners who cannot afford expensive reimbursement gaming software, and has led to corporate consolidation in health industry. Importantly, risk-based payment schemes do not actually attempt to solve the underlying issues that resulted in poor population outcome metrics. Rather, the system should positively analyze the cause of the poor population outcome and directly target funds to address those structural gaps and inequities (e.g., staffing medically underserved areas, building more facilities where there are health care deserts, funding facilities to have longer operating hours, ensuring that patients are receiving primary and preventive care, etc.). I would like to add to end "to target funding and programs to address any care delivery inequities or gaps that contribute to poor health outcomes."

c. Unified data systems and health information technology that allow analysis of patient data (by characteristics such as race/ethnicity, gender, sexual orientation and gender identity, disability, age, and income), cost, quality, and health outcomes are necessary tools for accountability.

Total Count:	
3 = I agree	**10**
2 = I agree with slight modifications	**1**
1 = I disagree	**0**
0 = I don't know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Andy Schneider	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	We need to consider the ethnic/gender needs of certain populations.
Anthony Wright	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	Delete “health information technology”. We do not need unified HIT or complex health data exchange systems to track this data we just need a single public entity to collect and track this data. We should not give the impression that complex health data exchange systems are a necessary prerequisite to achieving unified financing. The opposite is true – a unified financing health care system would make it easier to establish unified HIT. The faster CA implements single payer or unified financing, the better it can make sure the new networks being built are designed optimally for our new health system.

d. The health care system should ensure that care delivery is centered on patient needs rather than excessive profit motives.

Total Count:	
3 = I agree	**10**
2 = I agree with slight modifications	**0**
1 = I disagree	**1**
0 = I don’t know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
William C. Hsiao	1 = I disagree	Patient's need is hard to define and administer. Health risk selection by health plans or IDS are serious. They can select patients' with particularly kind of health condition and treatment preference. Thus satisfy the patients, but make huge profits.

e. Enrolling or assigning individuals into models with demonstrated success in integrating and coordinating care for a patient population would facilitate accountability for cost, quality and outcomes.

Total Count:	
3 = I agree	**7**
2 = I agree with slight modifications	**2**
1 = I disagree	**2**
0 = I don't know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Anthony Wright	3 = I agree	
Cara Dessert	3 = I agree	
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	2 = I agree with slight modifications	Enrollment in closed systems, even if they are demonstrated models of care, should be voluntary and disenrollment at least once a year should always be an option. It is essential that patients be able to vote with their feet if they are dissatisfied with access or quality.
Antonia Hernandez	2 = I agree with slight modifications	

Name:	Response:	Comment (if option 2 or 1 was selected):
Carmen Comsti	1 = I disagree	This goal is very suspect again because of, like many of the other propositions in this survey, the lack of definition, vagueness, and passive voice. I'm not sure if it is asking that the system place individuals in integrated health systems without their choice or agency in the matter. I strongly disagree with any system that enrolls or assigns individuals into integrated care models without their choice, knowledge, or consultation with their treating health care professional. Any enrollment in an integrated or coordinated care programs must be voluntary, particularly given that these programs result in narrow choice of provider and narrow networks. Moreover, there is no indication in this goal/value what is meant by "model." Not all models are desirable. Additionally, assigning people to providers or systems based on patient population could lead dangerously to stereotyping people by their race, gender, geographic, or other profile. Limiting eligibility in an integrated or coordinated care system based on their patient population (e.g., elderly, substance use, mental health, or housing insecurity) can lead to the integrated health system or care coordinator's cherry picking or lemon dropping. An individual's care or their ability to enroll in a care program should be based on their individual need not whatever population some undescribed algorithm, metric, or profiling places them in.
William C. Hsiao	1 = I disagree	Individuals should make the choice, not assign or mandatory. The UF can educate and "persuade" the individuals, not mandatory assignment.

4. Payment: Provider payments, including methods of payment and levels of payment, can exert leverage to address inequities and to improve access, cost efficiency, quality and outcomes. In particular, provider payments should be used to:

a. Continue the shift from fee-for-service (FFS) payments, which pay providers for the volume of services delivered, to value-based payments, which hold providers accountable for cost, quality, and outcomes.

Total Count:	
3 = I agree	**9**
2 = I agree with slight modifications	**0**
1 = I disagree	**1**
0 = I don't know / no opinion	**1**

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Jennie Chin Hansen	3 = I agree	I strongly agree for the need to shift from FFS.
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Anthony Wright	3 = I agree	
Carmen Comsti	1 = I disagree	This statement inappropriately perpetuates the false dichotomy between FFS and value-based payments. Again, it is inappropriate to include this goal/value in our survey when we have yet to discuss payments in earnest. I do not agree with a move towards so called "value-based" payments, which are better described as risk-based payments. Risk-based payments, incentive care denial, lemon-dropping, and gaming of quality metrics-based reimbursement systems by well-resourced corporate providers. Risk-based payments also hurt providers who have higher levels of vulnerable patient populations and safety-net providers, but risk-based payments do

Name:	Response:	Comment (if option 2 or 1 was selected):
		not actually solve the underlying systemic problems that cause poorer health outcomes that are not a result of provider behavior. Risk-based payments merely use market-incentives in the hopes that it will change provider behavior. As we have discussed at commission meetings, numerous studies have shown that high healthcare costs in the U.S. are because we pay higher prices, not that we use more services. As I have said multiple times and hope to discuss at our payments meeting, current single-payer models contemplate a diversity of reimbursement systems in addition to FFS, including institutional global budgets and provider salaries. In single-payer models that does use fee-for-service or other payment models, having a single payer allows the system to track doctors and investigate bad actors. Thus, it is possible to combat any incentive to over-order care without creating incentives for doctors to limit care or avoid a high-risk patient population. The state can also set the fee schedule for each service, controlling the prices that make care so expensive in the current model. Another option would be to pay doctors a salary instead of being subject to payment systems that try to influence how much care they provide to their patients.
Antonia Hernandez	0 = I don't know / no opinion	

b. Adequately support primary care and encourage greater use of primary care vs specialty services.

Total Count:	
3 = I agree	**7**
2 = I agree with slight modifications	**2**
1 = I disagree	**2**
0 = I don't know / no opinion	**0**

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Anthony Wright	3 = I agree	
Sara Flocks	2 = I agree with slight modifications	I agree as long as it does not deprive patients access to necessary specialty care.
Antonia Hernandez	2 = I agree with slight modifications	Without burdensome barriers to specialty care.
Cara Dessert	1 = I disagree	This feels more complex than either/or or "vs" framing of the question: YEs we should expand primary and preventative healthcare, but for those who need specialized care, that should also be available - its both/and not either or. Both should be adequate systems
Carmen Comsti	1 = I disagree	I disagree with this goal/value because it is written in a manner that fundamentally misunderstands the role of specialists in the provision of health care. While, of course, I agree that we should support primary care, it's dangerous to make a blanket statement that we need people to use primary care over specialty care. Specialty care is necessary for an individual in many circumstances. And the need for specialty care results from an individual's lack of access to primary

Name:	Response:	Comment (if option 2 or 1 was selected):
		and preventive care. The problem isn't that people are clamoring to see specialists, the problem is the lack of access to primary and specialty care which results in the needs for specialty care. Moreover, primary care providers should not be asked or encouraged to provide care they are not trained to provide (e.g., psychiatry, neurology, etc.). I agree that many specialists, but not all as we discussed with behavioral health, may have inflated reimbursement rates. But the solution is not to discourage people from using primary care; rather the solution is to ensure valuation of services between primary and specialty care (where primary care rates go up and specialty care, where appropriate, go down). I would agree with this statement if the second half of the sentence – "encourage greater use of primary care vs specialty services" – were deleted.

c. Employ risk-based capitation payments to assign accountability for cost, quality and outcomes.

Total Count:	
3 = I agree	**6**
2 = I agree with slight modifications	**2**
1 = I disagree	**1**
0 = I don't know / no opinion	**2**

Name:	Response:	Comment (if option 2 or 1 was selected):
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Cara Dessert	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Andy Schneider	2 = I agree with slight modifications	Risk-based capitation should not be the exclusive payment method. When deployed, it should only apply to provider groups and/or plans that are financially capable of bearing the financial risk involved and are totally transparent about their utilization management policies and practices as well as the outcomes for their patients.
Anthony Wright	2 = I agree with slight modifications	There should be recognition that different payment models may evolve, and that paying either per patient, per procedure, or per population has their own incentives built in and that adjustments may be needed as we get more evidence of what produces the best value. Also, risk-based capitation requires appropriate oversight, including reserves on the part of providers. If providers do not have two weeks of reserves, how do they handle downside risk?
Carmen Comsti	1 = I disagree	Again, it is inappropriate to include this goal/value in our survey when we have yet to discuss payments in earnest. I do not agree that risk-based capitation should be a goal/value. This payment model creates financial risk for providers so they have “skin in the game” and to economically motivate providers to limit care. Doctors’ financial interests are placed in direct opposition to their patient’s interest. This is a backwards solution. If the problem is the financial motivations of doctors (which results in physician driven overutilization), then asking them to bear financial risk makes the problem worse not better. Risk-based capitation incentivizes care denial, lemon-dropping, and gaming of quality metrics-based reimbursement systems by well-resourced corporate providers.

Name:	Response:	Comment (if option 2 or 1 was selected):
		Risk-based payments also hurt providers who have higher levels of vulnerable patient populations and safety-net providers, but risk-based payments do not actually solve the underlying systemic problems that cause poorer health outcomes that are not a result of provider behavior. Risk-based payments merely use market-incentives in the hopes that it will change provider behavior. First, like the modeling analysis showed, managed care does not save on health care costs overall, and with risk-based capitation we would be spending health care dollars on increased administrative complexity rather than on care. Second, managed care does not improve quality. There's a California Health Care Foundation report from 2019 reporting on quality trends from Medi-Cal's managed care plans and their numbers reveal that under managed care quality trends stagnated, increased competition between plans did not help, and COHs – that are entities not motivated by profit and that are directly paying for and providing care in a single risk pool with no competition – did the best on quality, had lower administrative costs. Also managed care organizations in CA have a history of unlawfully denying and limiting care, which I discussed at length in my comments on the analytic findings.
Antonia Hernandez	0 = I don't know / no opinion	
Sara Flocks	0 = I don't know / no opinion	

d. Assure care is well-coordinated, particularly for people with complex chronic conditions and/or behavioral health care needs.

Total Count:	
3 = I agree	**10**
2 = I agree with slight modifications	**1**
1 = I disagree	**0**
0 = I don't know / no opinion	**0**

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Anthony Wright	3 = I agree	
Antonia Hernandez	2 = I agree with slight modifications	

e. Encourage involvement of diverse levels and types of professionals and caregivers (e.g., nurses, other health care professionals, community health care workers).

Total Count:	
3 = I agree	**9**
2 = I agree with slight modifications	**0**
1 = I disagree	**1**
0 = I don't know / no opinion	**1**

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Carmen Comsti	1 = I disagree	I disagree that increasing diversity in types of caregivers is appropriate. The scope of practice of health care professionals should not be changed. To push care to lower licensed or unlicensed individuals is dangerous and fundamentally misunderstands the nature of direct patient care. Additionally, this goal/value is not clear what “involvement” means. Doctors have a different scope of practice than nurses and nurses are different than respiratory therapists. Trying to push care to lower-licensed or unlicensed individuals is merely a stop-gap measure. What should be our goal/value is investing in the pipeline of health care professionals from diverse socioeconomic backgrounds who are culturally competent and have language skills to meet the needs of California’s diverse residents. We should also be encouraging good, safe and healthy jobs for our health care workers to retain such professionals in our health care system. I would like a total rewrite of this goal/value to say: Encourage investment in increasing the numbers of health care professionals from culturally, socioeconomically, and linguistically diverse communities so that our professional health care workforce can meet the cultural and linguistic needs of California’s diverse residents as well as encourage workplace protections and good jobs to retain and value our health care workforce.

Name:	Response:	Comment (if option 2 or 1 was selected):
Andy Schneider	0 = I don't know / no opinion	Involvement in what?

f. Encourage the use of community health centers with expertise in delivering care to diverse and underserved populations.

Total Count:	
3 = I agree	**9**
2 = I agree with slight modifications	**1**
1 = I disagree	**0**
0 = I don't know / no opinion	**1**

Name:	Response:	Comment (if option 2 or 1 was selected):
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	I believe that CHCs are an important kind care delivery system but I disagree with the use of capitated payments to fund CHCs. I believe language here could be added to say that CHCs should be better funded. I would modify this to read (additions bracketed): "Encourage [full funding] of community health centers with expertise in delivering care to diverse and underserved populations [as well as expanding funding to ensure a workforce of licensed health care professionals who can meet the cultural, socioeconomic, and linguistic needs of California's diverse residents and to address hospital closures in rural and other underserved areas]."

Name:	Response:	Comment (if option 2 or 1 was selected):
Sara Flocks	0 = I don't know / no opinion	

g. Encourage the equitable distribution of health care providers across California's regions and diverse populations.

Total Count:	
3 = I agree	**11**
2 = I agree with slight modifications	**0**
1 = I disagree	**0**
0 = I don't know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	

5. Equity

a. Racial equity should be centered throughout every aspect of health care financing arrangements and the health care delivery system.

Total Count:	
3 = I agree	**11**
2 = I agree with slight modifications	**0**
1 = I disagree	**0**
0 = I don't know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	

b. To achieve equitable care, differences in financial resources and social supports among individuals and between California communities should be addressed, including adjusting provider payment by a region's status as an underserved area or by providing targeted resources and supports that are not dependent on provider reimbursements.

Total Count:	
3 = I agree	**10**
2 = I agree with slight modifications	**1**
1 = I disagree	**0**
0 = I don't know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Anthony Wright	3 = I agree	
Antonia Hernandez	2 = I agree with slight modifications	

c. To achieve equitable care, the needs of other populations that have been marginalized – e.g., racial and ethnic minorities, the aged, people with disabilities, LGBTQ+, and people with limited English proficiency – should be elevated.

Total Count:	
3 = I agree	**9**
2 = I agree with slight modifications	**2**
1 = I disagree	**0**
0 = I don't know / no opinion	**0**

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Andy Schneider	2 = I agree with slight modifications	I'm not clear what you mean by "elevated." Do you mean "addressed?" If so, I agree.
Carmen Comsti	2 = I agree with slight modifications	It's not clear what "elevated" means here. Historically marginalized communities deserve precision on what our recommendations should be otherwise this is but an empty recognition. I also think that the work "other" should be deleted before populations. Who are we comparing marginalized populations to and would this language resulting in further marginalization of such communities.

d. The health care system should invest in a workforce that is diverse and responsive to consumer and patient needs, including addressing the current gaps in access to physicians and other allied health care workers and ensuring California's future workforce needs.

Total Count:	
3 = I agree	**10**
2 = I agree with slight modifications	**1**
1 = I disagree	**0**
0 = I don't know / no opinion	**0**

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	This goal/value would benefit from more precise language on what we mean by a diverse workforce. As I mentioned previously, we should encourage investment in increasing the numbers of health care professionals from culturally, socioeconomically, and linguistically diverse communities so that our professional health care workforce can meet the cultural and linguistic needs of California's diverse residents as well as encourage workplace protections and good jobs to retain and value our health care workforce. However, I disagree that increasing diversity in types of caregivers is appropriate. The scope of practice of health care professionals should not be changed. To push care to lower licensed or unlicensed individuals is dangerous and fundamentally

Name:	Response:	Comment (if option 2 or 1 was selected):
		misunderstands the nature of direct patient care. To this end, I would add to this goal/value to clarify that diversity here means cultural and socioeconomic diversity. I suggest the following edits (additions bracketed): "The health care system should invest in a [licensed health care professional] workforce that [can meet the cultural, socioeconomic, and linguistic diversity of California's diverse residents] and [is] responsive to consumer and patient needs, including addressing the current gaps in access to physicians and other allied health care workers and ensuring California's future workforce needs."

e. A system of governance that is responsive to the priorities of Californians and incorporates consumer voices, including voice of marginalized populations in priority-setting, should be established.

Total Count:	
3 = I agree	**10**
2 = I agree with slight modifications	**1**
1 = I disagree	**0**
0 = I don't know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Andy Schneider	2 = I agree with slight modifications	A system of “governance and accountability “

7. Public Health, Prevention and Population Health

a. A fundamental imbalance between high spending on medical treatment versus underinvestment in prevention should be addressed through increased investment targeting the social determinants of health.

Total Count:	
3 = I agree	**7**
2 = I agree with slight modifications	**2**
1 = I disagree	**2**
0 = I don’t know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Sandra Hernandez	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Jennie Chin Hansen	2 = I agree with slight modifications	I agree in principle but realize this will take a process developed transparently on the values/outcomes for the redistribution.
Sara Flocks	2 = I agree with slight modifications	We can't expect a health care system to address the systemic racism, inequality and other issues in society especially if we expect it to be financially sustainable. It's one thing to shift resources to primary care and another to expect a UF system to address racism, homelessness and other social determinants.
William C. Hsiao	1 = I disagree	See my previous statement about addressing socioeconomic

Name:	Response:	Comment (if option 2 or 1 was selected):
		determinants of health. That's a huge, expensive, complex undertaking.
Carmen Comsti	1 = I disagree	I am rating this as a 1 because again, this goal/value is unclear. I do not understand what “prevention” is supposed to mean here. Additionally, this statement makes the problematic assumption that there is a false dichotomy between medical treatments and preventative care and/or spending on social programs. The actual mechanisms for targeting social determinants of health are incredibly important. Not all programs that claim to target social determinants of health are equal and some have vast array of problems such that I would not agree with their inclusion as a goal/value. For example, I oppose market-based incentives run by private corporations (even private health care corporations) in lieu of robust social safety net programs and protections enforced by other state agencies that have the necessary expertise. I also fundamentally disagree with the sentiment that there is a zero sum game between paying for health care and paying for social programs that address social determinants of health. We must recognize that having the health care system target social determinants of health will necessarily result in only piecemeal measures that can never adequately address major social problems. Moreover, health care corporations are poor choices for instituting such social programs. We need both universal guaranteed health care and robust public social safety net and other social programs.

b. Because population health outcomes are influenced by forces outside the four walls of medical care settings, the health care system should tightly align with state and local public health departments to support community based prevention activities.

Total Count:	
3 = I agree	**8**
2 = I agree with slight modifications	**2**
1 = I disagree	**1**
0 = I don't know / no opinion	**0**

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Anthony Wright	3 = I agree	If not somewhere else, I would add here to also "connect to the social safety net to address issues such as food insecurity and housing instability".
Jennie Chin Hansen	2 = I agree with slight modifications	Yes, but it make take more than public health departments.
Antonia Hernandez	2 = I agree with slight modifications	
Carmen Comsti	1 = I disagree	I have a similar answer as the previous goal/value. I am rating this as a 1 because again, this goal/value is unclear. I do not understand what "prevention" or "tightly align" is supposed to mean here. The actual mechanisms for targeting social determinants of health are incredibly important. Not all programs that claim to target social determinants of health are equal and some have vast array of problems such that I would not agree with their inclusion as a goal/value. For example, I oppose market-based

Name:	Response:	Comment (if option 2 or 1 was selected):
		incentives run by private corporations (even private health care corporations) in lieu of robust social safety net programs and protections enforced by other state agencies that have the necessary expertise. I also fundamentally disagree with the sentiment that there is a zero sum game between paying for health care and paying for social programs that address social determinants of health. We must recognize that having the health care system target social determinants of health will necessarily result in only piecemeal measures that can never adequately address major social problems. Moreover, health care corporations are poor choices for instituting such social programs. We need both universal guaranteed health care and robust public social safety net and other social programs.

8. **Sustainability:** A new universal, unified health care system implies a long-term commitment by the State of California and will require sustainable financing. In particular, sustainability should be advanced by:

   a. Obtaining federal approval to reinvest federal funding for public insurance programs (Medicare, Medicaid and Affordable Care Act marketplace tax credits and subsidies) is critical in supporting a state-based unified financing system.

Total Count:	
3 = I agree	**7**
2 = I agree with slight modifications	**3**
1 = I disagree	**1**
0 = I don't know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Richard Scheffler	3 = I agree	
Sara Flocks	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	Obtaining federal funding into a unified financing system is important but it's not clear what "reinvest" means here. It's incorrect to imply that we would need a blank check from the federal government in order to adequately capture and integrate federal funding into a unified financing program. The question is about integrating the programs in to the unified financing system not necessarily "reinvesting" federal funds. I suggest editing this goal/value to read (additions bracketed): "Obtaining federal approval to [integrate] public insurance programs (Medicare, Medicaid and Affordable Care Act marketplace tax credits and subsidies) [with and direct federal funds into a state-based unified financing system are] critical in supporting a state-based unified financing system."
Cara Dessert	2 = I agree with slight modifications	CA should pursue this, but our plan should not be dependent on it
Jennie Chin Hansen	2 = I agree with slight modifications	this is such a huge shift; important yes but may need to be staggered.
Andy Schneider	1 = I disagree	This will not happen in the foreseeable future. It is not a good use of time and energy. A better use would be making these programs work better.

b. Developing and managing sources of financing in ways that assure California upholds its long-term commitments.

Total Count:	
3 = I agree	**8**
2 = I agree with slight modifications	**0**
1 = I disagree	**1**
0 = I don't know / no opinion	**2**

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Jennie Chin Hansen	3 = I agree	Not just California commitments but federally as well.
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Cara Dessert	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Carmen Comsti	1 = I disagree	I don't know what this means really and so cannot agree with it. I am incredibly disappointed in the goals/values throughout this survey as written. Some of these suggested goals/values are written in a manner that is inscrutable because the language is vague and imprecise.
Sara Flocks	0 = I don't know / no opinion	
Sandra Hernandez	0 = I don't know / no opinion	

c. Managing health care costs in line with a target annual rate of growth to ensure that California can continue to afford its health care system.

Total Count:	
3 = I agree	**8**
2 = I agree with slight modifications	**2**
1 = I disagree	**1**
0 = I don't know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Anthony Wright	3 = I agree	Absolutely. Like the chicken and the egg, managing health care costs is both a prerequisite to get to single-payer/unified financing, which in turn is our best tool to manage such costs. Such management of costs is essential, and would also need to have some flexibility to take into account various issues, from an aging populations to a pandemic to the need to invest in key areas.
Carmen Comsti	2 = I agree with slight modifications	This statement should clarify what we mean by rate of growth. I agree with this statement if what it means is that target growth rate is tied to the economic growth rate in California or growth in health care spending (nationally and due to inflation in the health sector). But I would disagree with this statement if it is meant to suggest that there would be a set percentage increase annually for the system that serves as a hard spending limit. We should be wary of creating spending limits that do not adjust for changes in inflation or economic growth in the state. The statement should be modified as follows (additions bracketed): "Managing health care costs in line with a target annual rate of growth [that appropriately reflects changes in economic growth in the state, growth in health care spending nationally, and inflation]."
Antonia Hernandez	2 = I agree with slight modifications	

Name:	Response:	Comment (if option 2 or 1 was selected):
Andy Schneider	1 = I disagree	Spending caps are arbitrary, ultimately unenforceable, and will undercut progress toward health equity.

d. Establishing reserves to ensure sustainability when costs exceed revenue, such as during economic downturns.

Total Count:	
3 = I agree	**9**
2 = I agree with slight modifications	**2**
1 = I disagree	**0**
0 = I don't know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Jennie Chin Hansen	3 = I agree	
Sandra Hernandez	3 = I agree	
William C. Hsiao	3 = I agree	
Robert Ross	3 = I agree	
Richard Scheffler	3 = I agree	
Andy Schneider	3 = I agree	
Sara Flocks	3 = I agree	
Cara Dessert	3 = I agree	
Anthony Wright	3 = I agree	Agree. We don't want to be in the counter-cyclical situation that some HHS programs are in when there is pressure to cut at exactly the time the services are most needed. Reserves are important, although we note that the federal government has other means to handle downturns as well, including the ability to deficit spend.
Antonia Hernandez	2 = I agree with slight modifications	
Carmen Comsti	2 = I agree with slight modifications	I also think this goal/value should mention the need for obtaining diverse types of financing. I suggest the following modification (additions bracketed): "Establishing [diverse sources of financing and] reserves to ensure sustainability when costs

Name:	Response:	Comment (if option 2 or 1 was selected):
		exceed revenue, such as during economic downturns.”