Healthy California for All Commission
Survey Report
November 2021

Survey background:

In September 2021, HCFA Commissioners were surveyed regarding key concepts and ideas that had been discussed in 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. Building on the first round of responses, HCFA Commissioners were surveyed again in November 2021. The November survey refined language for some previous statements and explored a number of topics in more detail.

Voting members of the Commission 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 the number 2 and used the comment box to suggest refined language. If they disagreed, they entered the number 1 and used the comment box to explain why. Ex officio members (and voting members who had no opinion) entered 0 for each statement.

Survey Responses:

Goals and Values

Healthy California for All: A "Healthy California for All" envisions a sustainable California unified financing system for health care through which safe, timely, efficient, equitable and person-centered health care advances the mental and physical health and well-being of all Californians. The system would assure that care is affordable, accessible and treats all people with respect.

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):
Andy Schneider	2 = I agree with slight modifications	Suggest substituting "ensure" for "assure"
Antonia Hernandez	2 = I agree with slight modifications	A unified system that includes employer coverage/Kaiser like enterprises.
Anthony Wright	3 = I agree	Agree, but given the previous discussion, a topline statement like this would also include "quality", and highlight that a system would be simpler/easier to navigate, where people feel valued and *empowered.*
Cara Dessert	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	The original language from the last survey ended the first sentence with “through a system of unified financing.” It is exceedingly important that this fundamental goal of the Commission is included here. Our enabling statute, Health and Safety Code Sec. 1001, requires us to develop a plan for “achieving a health care delivery system in California that provides coverage and access through a unified financing system, including but not limited to, a single-payer financing system.”
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	2 = I agree with slight modifications	At the very end add “And promotes racial equity.”
Sandra Hernandez	3 = I agree	
Sara Flocks	3 = I agree	
William Hsiao	3 = I agree	

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	**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):**
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	2 = I agree with slight modifications	Should it be integrated and/or coordinated to the greatest level possible? Just practically, some forms of care are specialized enough that they don't require going through a central gatekeeper, but you certainly want communication and coordination between all health providers and services. Integration is another level that is aspirational, but may involve trade-off with other goals.
Cara Dessert	3 = I agree	
Carmen Comsti	1 = I disagree	To repeat my comment from the first survey -- 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 an appropriate goal or value, and I do not believe that integration for 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 are incentivized to act on their own economic interest through risk-based payments. Additionally, research shows that

Name:	Response:	Comment (if option 2 or 1 was selected):
		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 proposition would read (additions in brackets, deletions not shown because of the Survey Monkey format): "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]."
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	2 = I agree with slight modifications	On the last survey, I put 3, but after our discussions, I would suggest that we define both integration & coordination and specify if this applies only to treatment, or to care delivery through integrated health systems. I would also suggest that we add that the goal of this type of care is to provide holistic physical and mental health care that improves outcomes and well-being. We may also want to look at how care coordination can increase access and equity (if implemented through the lens of health equity) by supporting

Name:	Response:	Comment (if option 2 or 1 was selected):
		individuals who have been marginalized because of institutional discrimination.
William Hsiao	3 = I agree	

2. Accountability: Care quality and health outcomes for individuals and for populations should be monitored. Robust systems of accountability to assure high-quality, equitable outcomes should be maintained, expanded or established.

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):
Andy Schneider	2 = I agree with slight modifications	Suggest substituting "ensure" for "assure."
Antonia Hernandez	3 = I agree	
Anthony Wright	2 = I agree with slight modifications	In particular, the system should insist on accountability to assure quality outcomes for those with complex conditions and high needs as well as chronic conditions amenable to care management.
Cara Dessert	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	Reiterating my comment from the first survey – It is difficult to rate this statement because the kind of system of accountability matters 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.
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Sara Flocks	2 = I agree with slight modifications	I don't think it's sufficient to just monitor quality & health outcomes. The system of accountability should be defined and have appropriate ability to address, remedy, or if needed, enforce standards for high-quality, equitable outcomes. The accountability system is critical to root out waste, fraud, abuse and discriminatory care as well as to ensure that the system is moving to address health disparities and inequity in care quality.
William Hsiao	3 = I agree	

3. **Payment and Funding:** Provider payments and funding, including methods of payment and levels of payment, should be used to address inequities and to improve access and quality.

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):
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Cara Dessert	2 = I agree with slight modifications	I'm not sure what robust variety of methods are best to ensure this occurs, but I am sure of the desire outcome: that in a state as geographically diverse as CA, its rural and low-income communities must be treated intentionally and equitably in this Commission's reimagination of our healthcare system, in a way that safe, affordable and competent care is available and accessible to those who have been left out - this must mean that incentives are provided to doctors and healthcare systems serving these

Name:	Response:	Comment (if option 2 or 1 was selected):
		communities, because without a financial plan to incentivize these providers, we will continue to have inadequate and inaccessible healthcare systems in rural and low-income areas.
Carmen Comsti	2 = I agree with slight modifications	This is an improvement from the statement in the original survey. But I think the word “used” is too vague here and “targeted” may be a better word choice. As I have previously said, I disagree with payment methodologies that incentivize care denial or interfere with the doctor-patient. I do not think we should make blanket statements implying that ANY use of payments and funds is appropriate to address inequities and improve access and quality are appropriate. As such, I think language needs to be added on reducing excess prices and ensuring reimbursements go towards care. The proposition would read (additions in brackets, deletions not shown because of the Survey Monkey format): “Provider payments and funding, including methods of payment and levels of payment, should be used to address inequities and to improve access and quality [to pay appropriate prices, and [to ensure health care expenditures are directed towards the provision of care].”
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	3 = I agree	The most effective way to create an effective system of accountability is through payment, since it puts our money where our mouth is, so to speak, and demonstrates that the system is serious about meeting equity, access & quality goals.

Name:	Response:	Comment (if option 2 or 1 was selected):
William Hsiao	2 = I agree with slight modifications	Payment method and level are the principal instruments that incentivize providers to improve the equity, efficiency, quality and availability and distribution of services/drugs. This statement left out efficiency and availability and distribution of services/drugs.

4. Equity: The health care system should proactively monitor, mitigate, and work to eliminate disparities in health care access and quality, including those resulting from structural discrimination related to race and ethnicity, those associated with income, immigration status, disability, sexual orientation and gender identity, and the intersectional effects among these characteristics. The health care system should also contribute to addressing social determinants of health that compromise health status.

Total Count:	
3 = I agree	**6**
2 = I agree with slight modifications	**5**
1 = I disagree	**0**
0 = I don't know / no opinion	**0**

Name:	Response:	Comment (if option 2 or 1 was selected):
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Cara Dessert	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	I appreciate that the first sentence was fleshed out but I think the second sentence is too vague. I do not know what "contribute to addressing" means. I'm also unsure of how this sentence is different than what is in the next goal/value. I think this second sentence should be deleted because of the next recommendation. As we discussed at our Commission meeting, addressing social determinants of health should not come at the expense of reducing health care funds. Moreover, there are simply

Name:	Response:	Comment (if option 2 or 1 was selected):
		some social determinants of health that the health care system cannot address and we shouldn't expect it to. We need fully funded and robust public social programs that address social determinants of health in addition to a universal guaranteed health care system for all Californians.
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	2 = I agree with slight modifications	It will be very difficult if not impossible for the health system to address many of the social determinants of health such as the distribution of income, employment differences, education levels. Suggest we focus on things that would make the health system more equitable and the causes of health disparities in the Heath system.
Robert Ross	3 = I agree	
Sandra Hernandez	2 = I agree with slight modifications	the health care system should in coordination with other sectors, and where feasible, address social determinants of health that compromise health status.
Sara Flocks	2 = I agree with slight modifications	I agree with the sentiment & the attempt to modify the previous question, but a sustainable, effective health care system has to focus on providing HEALTH CARE first & foremost. Addressing the social determinants of health (even just contributing) is a huge undertaking, given that housing, transportation, jobs, etc all impact health. If we want an effective health care system, we have to accept that it cannot address all social determinants of health & the government has to step in with additional programs. That argues for a cost-efficient health care system, so there's more funding available for robust social programs provided by other agencies.

Name:	Response:	Comment (if option 2 or 1 was selected):
William Hsiao	2 = I agree with slight modifications	The health care system does NOT directly deal with the social determinants of health such as occupation, social status, and family composition. I recommend the statement revised to state "the health care system should advise and coordinate with social policies that would improve the social determinants of health."

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. In coordination with other sectors, the health care system should work to address the social and structural factors that affect well-being, functional status and long-term health outcomes for individuals and populations.

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):
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Cara Dessert	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	I appreciate the language here on needing a focus on prevention. With respect to the second sentence, I want to reiterate my concerns from the previous recommendation, social determinants of health should not come at the expense of reducing health care funds. Moreover, there are simply some social determinants of health that the health care system cannot address and we shouldn't expect it to. We need fully funded and robust public social programs that address social determinants of health in addition to a

Name:	Response:	Comment (if option 2 or 1 was selected):
		universal guaranteed health care system for all Californians. I would add to the end of the second sentence "while making robust public investment in both our health care system and social programs outside the health care system."
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	2 = I agree with slight modifications	See my comments in the previous question.
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	2 = I agree with slight modifications	I agree with the first part on prevention, but need more details on what the 2nd part on addressing social & structural factors means. Again, we can only ask the health care system to do so much. We can advocate for more social programs but the health care system cannot cure all structural & institutional ills itself if it is going to be sustainable and effective at health care.
William Hsiao	2 = I agree with slight modifications	Our current health care policy and resource allocation give very low priority prevention. I recommend we put in much stronger language that we must shift priority from acute care to prevention, primary and secondary.

6. Sustainability: A new universal, unified health care system requires policy alignment and action at the federal level and a long-term commitment by the State of California and will require sustainable financing.

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):
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	Yes, we need alignment and action at the federal level to realize our full vision of a universal system of unified financing. Yet we should also recognize there's much we can do to get closer to these goals and to this vision without the need for federal approvals.
Cara Dessert	2 = I agree with slight modifications	This Commission does not have authority or partnership with our federal government; therefore I'm wary of the first part of this statement regarding "action at the federal level". To present the best menu of options to our Governor, I believe our approach should present an outline of all the possible ways to reimagine our CA healthcare system to be equitable, accessible, and affordable healthcare for all; this menu of options should certainly include scenarios with and without federal partnership. I am 100% agreed on the second part of the statement: our goals require CA's long term commitment and sustainable financing.
Carmen Comsti	2 = I agree with slight modifications	The new language about “policy alignment and action” at the federal level is vague and with such non-specificity can be misleading. The “action” required is by HHS not by Congress. We need to make that clear. The federal government does not need to “align” – whatever that even means – its policy with California’s. As we discussed at the Commission meetings, the federal government can allow states to experiment with approaches to federal health programs, which is not “policy alignment”. We really need to avoid such vague language, which can become meaningless or apt for

Name:	Response:	Comment (if option 2 or 1 was selected):
		misinterpretation. Addressing my comments above, my edits are (additions in brackets, deletions not shown because of the Survey Monkey format): "A new universal, unified health care system requires [agency] action at the federal level and a long-term commitment by the State of California and will require sustainable financing."
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	3 = I agree	
William Hsiao	2 = I agree with slight modifications	Sustainability is extremely important. Our political system encourages the government actions to focus on the short-run success. But an unified financing program is a long-term commitment. The statement on sustainability should explain that an unified financing system such as universal health insurance requires the legislature to put in a long-term financing plan to sustain it. A good example is the actuarial principles established in the US Medicare program which requires the Congress to set the financing for Medicare on a sound basis for the next 25 years.

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, immigration status, income or other characteristics.

a. In order to advance a Healthy California for All, the state should move to a system of unified financing.

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):**
Andy Schneider	2 = I agree with slight modifications	Add this sentence: "Achieving a system of unified financing will require changes in federal legislation."
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	The state should move to unified financing, along with other elements of a Healthy California for All.
Cara Dessert	3 = I agree	
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	2 = I agree with slight modifications	I agree with the principle but the actual implementation will take extraordinary understanding of complexity as well as significant statutory and regulatory change from a policy perspective and an impact evaluation to current beneficiaries re what "it means to them" re changes.
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	3 = I agree	
William Hsiao	2 = I agree with slight modifications	We need a stronger and vigorous statement such as "the state should take concrete significant policy actions and move to UF."

b. To effectively advance a Healthy California for All through a system of unified financing, integrated delivery systems should play a continued or increased role in care coordination and population health management.

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):**
Andy Schneider	2 = I agree with slight modifications	Delete "continued or increased"
Antonia Hernandez	3 = I agree	
Anthony Wright	2 = I agree with slight modifications	Support the concept, but probably want a better definition of integrated delivery systems before endorsing their increased role. Some providers describe themselves that way, with mixed definition and mixed outcomes and results. However we define them, the goal is integration not for its own sake but better coordination, quality, and outcomes and consumer experience.
Cara Dessert	3 = I agree	
Carmen Comsti	1 = I disagree	I strongly disagree with the inclusion of this proposition, particularly without defining "integrated delivery system." That term typically means or at least always includes HMOs and other health plans. I strongly disagree that health places should play a role in our health care system or that health plans should be used to provide care coordination or population health management. Many integrated health systems by their very nature, whether it is because of they are insurance plans or because they operate through risk-based capitation, are in the business of denying and limiting care and are anathema to the goals of universal health for all.
Jennie Chin Hansen	2 = I agree with slight modifications	The sizing of care coordination should be based on logic (how much and when) and need (e.g. complexity of care)
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Sara Flocks	2 = I agree with slight modifications	I would like a definition of integrated delivery system including whether they would assume financial risk.
William Hsiao	3 = I agree	

c. To effectively advance a Healthy California for All, if health plans are retained they should be subject to greater regulation with respect to cost, profit and administrative burden.

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

Name:	Response:	Comment (if option 2 or 1 was selected):
Andy Schneider	2 = I agree with slight modifications	Insert "and transparency" after "greater regulation".
Antonia Hernandez	1 = I disagree	
Anthony Wright	1 = I disagree	It's a big "if." The statement is at best incomplete. If health plans are to be retained, it's not just regulation on cost/profit/administration, but that they deliver the care people need when they need it—and at a cost the system can afford. The care people need includes care for those with complex needs or high health needs as well as those with chronic conditions that can be managed. If retained--a big if--their role would be fairly different, especially since key functions would be taken by system itself.
Cara Dessert	2 = I agree with slight modifications	I seriously question whether health plans should be retained; the data we've seen shows that they are antithetical to our values of equity, affordability and accessibility. But if we are presenting a menu of options, then I agree that if the plans are retained, they should be subjected to great regulation

Name:	Response:	Comment (if option 2 or 1 was selected):
		by the state with respect to cost, profit and admin burden.
Carmen Comsti	1 = I disagree	I strongly disagree with the inclusion of this proposition. I do not believe health plans should be retained in any form, even if highly regulated. Health plans are in the business of denying and limiting care and are anathema to the goals of universal health for all.
Jennie Chin Hansen	2 = I agree with slight modifications	Being involved in a not for profit health plan, I see that there is such oversight while at the same time the need to assure the administrative oversight is not overly burdensome leading to "non value added costs". For example, with high performers with track records, giving the ability to perhaps need oversight review on a less frequent but still "regular" basis so the reward for high performance allows time and treasure for added innovation.
Richard Scheffler	2 = I agree with slight modifications	Not sure it is more regulations that we need . We need new and better regulations to achieve our objectives and at same time we need to eliminate needless and wasteful regulations.
Robert Ross	2 = I agree with slight modifications	“And/or incentivized...” in addition to the greater regulation phrase
Sandra Hernandez	2 = I agree with slight modifications	plans should be required to eliminate administrative barriers and work to simplify the accessibility of timely appropriate care and health services
Sara Flocks	1 = I disagree	I don't think health plans should be retained.
William Hsiao	2 = I agree with slight modifications	Unclear health plans includes what? We should be more specific and state: "if private health insurance plans are retained and they along with integrated delivery systems should be subject to greater regulation with respect to ....."

d. To effectively advance a Healthy California for All through a system of unified financing, health plans and all 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):**
Andy Schneider	1 = I disagree	Health plans and other risk bearing intermediaries are not per se bad.
Antonia Hernandez	0 = I don't know / no opinion	
Anthony Wright	1 = I disagree	Hard to endorse a blanket statement, when one can imagine types of risk-bearing intermediaries that would be useful in managing care within a state of the scale and complexity and diversity of California. However, with any risk should come responsibility--and regulation.
Cara Dessert	3 = I agree	
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	1 = I disagree	Due to my personal experience with professionally and personally (as a health plan member for over 35 years, I can see what value there can be if a system is designed well and is accountable.
Richard Scheffler	1 = I disagree	
Robert Ross	0 = I don't know / no opinion	It depends. If we envision an evolved or new version of intermediary customized for our strategic needs, then I'm fine with it
Sandra Hernandez	1 = I disagree	
Sara Flocks	3 = I agree	
William Hsiao	1 = I disagree	Ideally, we want to eliminate the existing public and private health insurance plans. Is that political viable? Is HCFA Commission going to address this issue? Are we going to offer a second-best plan to move forward UF

Name:	Response:	Comment (if option 2 or 1 was selected):
		for the governor and legislature to consider? As for removing risk bearing intermediaries, are you asking the Commissioners to vote against integrated delivery system such as Kaiser? Kaiser is a risk bearing intermediary delivering health care.

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 should be encouraged by:

   a. Individuals selecting a primary care provider that coordinates their care.

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):
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	Having a real medical home, with care coordination, is much more than the selection of a primary care provider. It's a start, but we can be more ambitious than this standard, especially in promoting primary care.
Cara Dessert	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	As I mentioned in the first survey, we should ensure that primary care providers do not act as a gatekeeper to care and there should be no referrals or prior authorizations or step therapy needed to access care. The following should be added 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	Primary providers yes, but there are also complementary ways to enhance/achieve coordination since there are not enough primary care providers even now.
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	2 = I agree with slight modifications	I think that there should be care coordination but I would like to have a discussion on who/what is the best entity to coordinate that care.
William Hsiao	3 = I agree	

b. Delivering behavioral health care and primary care services within a single system of care so that providers in each domain – behavioral health and primary care – communicate and work together in models that integrate and/or coordinate care in the patient's interest.

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):
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Cara Dessert	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	I appreciate that much of my comments and concerns from the first survey were taken into consideration here. However, I still have a number of concerns. I cannot fully support a statement that makes blanket recommends for all integration and coordination models. As I have stated previously, "integrated" and "coordinated" care has many different meanings and some models that are promoted or described as

Name:	Response:	Comment (if option 2 or 1 was selected):
		"integrated" or "coordinate" problematically create provider incentives to limit care. With respect to behavioral health specifically, primary care doctors have been asked or financially incentivized in some integrated care models to provide behavioral health care services that they do not have the specialized training, licensing, or knowledge to provide such as psychiatry. And as I mentioned in the first survey comments, it is important to emphasize the need to train and hire more licensed behavior health professionals with cultural, socioeconomic, and linguistic competencies that meet the needs of California's diverse residents. Addressing my comments above, the proposition should be modified to read (additions in brackets, deletions not shown because of the Survey Monkey format): "Delivering behavioral health care and primary care services within a single system of care so that providers in each domain – behavioral health and primary care – communicate and work together in models that integrate and/or coordinate care in the patient's interest [and while ensuring each patient receives appropriate behavioral health services from culturally competent and appropriately licensed behavioral health professionals and that licensed behavioral health professionals are adequately funding and retained]".
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	3 = I agree	
William Hsiao	3 = I agree	

c. Supporting dedicated entities (e.g., medical groups, behavioral health providers, clinics, hospitals, and/or community based organizations) that coordinate care for people with multiple chronic conditions and other complex, high need populations.

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

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Cara Dessert	3 = I agree	
Carmen Comsti	1 = I disagree	To make a similar comment to my response to the original survey, "entities" could include insurers or other non-health care professionals. The list here is not clearly a limited list of care coordination entities and so I cannot support it. Moreover, individual's treating health care professionals, not corporate health care entities, should coordinate care. 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. Again, as with some of my other comments, it still remains unclear what "coordinate care" actually means here. The recommendation should be edited as follows (additions in brackets, deletions not shown because of the Survey Monkey format): "Supporting [treating health care professionals who treat patients] with multiple chronic conditions and other complex, high need populations."
Jennie Chin Hansen	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	FQHC Community health centers are critical
Sandra Hernandez	3 = I agree	
Sara Flocks	3 = I agree	
William Hsiao	1 = I disagree	Question is unclear. What do you mean "dedicated entities?" Does it mean dedicated to a particular disease or type of illness? Question 14 just asked about integrated delivery of all diseases, primary and behavioral. I support that all categories of providers should coordinate their health services across all illnesses.

d. Expanding and building upon models, such as Kaiser and PACE, with demonstrated success in integrating and coordinating care across the continuum for a defined patient population.

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

Name:	Response:	Comment (if option 2 or 1 was selected):
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	2 = I agree with slight modifications	There's a benefit to building on existing models, both to use existing capacity, to provide some comfort and continuity to consumers as other aspects of the health system changes, and yes, to build on *the elements of these models* that have shown success. Yet while some of these models are popular and praised by many, they may not be for everyone, and for some there are real areas for improvement.
Cara Dessert	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Carmen Comsti	1 = I disagree	It is highly problematic to universally declare that Kaiser and all PACE programs have been a success. Moreover, 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. The term “Kaiser” is also meaningless because Kaiser Permanente has three parts – Kaiser Health Plans (the HMO), Kaiser Foundation Hospitals, and the Permanente Medical Group. With respect to PACE, while it is a good program that could continue with global budgets in a single-payer system, it is not a model that would be appropriate or desirable for most patients. PACE – and not all PACE programs that are currently approved under Medicare are the same – can work well for a very specific opt-in group of patients who are elderly or disabled and eligible for nursing home care but able to stay in the community with intensive services, but. So, PACE is not a program that could be replicated beyond the patient population that may be treated through nursing home care. Integration of business interests of providers in risk bearing integrated delivery systems is not necessary to achieve integrated care. We can pay for coordinated 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

Name:	Response:	Comment (if option 2 or 1 was selected):
		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.
Jennie Chin Hansen	3 = I agree	full disclosure: I have been a Kaiser enrollee for over 35 years; I have spent nearly 25 years working/leading the original PACE program in San Francisco.
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	0 = I don't know / no opinion	I would like more information on both examples and what parts would be considered the model before taking a position. I'd prefer that we look at best practices and expand on those rather than saying we'll take the Kaiser model wholesale.
William Hsiao	3 = I agree	

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, quality of consumer experience, social risk) for individuals and populations should be measured and publicly reported. Detailed demographic data should be collected and used to analyze disparities and identify ways in which more equitable outcomes can be advanced.

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):
Andy Schneider	2 = I agree with slight modifications	Add at the end: "To the extent services are furnished through health plans, these measures and data should be publicly reported on a plan-specific basis."
Antonia Hernandez	3 = I agree	
Anthony Wright	2 = I agree with slight modifications	Proposed addition: Standard measures should also be analyzed to determine access, quality and outcomes for high needs populations.
Cara Dessert	3 = I agree	
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	2 = I agree with slight modifications	I agree with standard measures to ensure accountability, but we have to be very careful in crafting those measures to prevent adopting ones that perpetuate systemic racism and other systems of oppression. We also need to be very careful with consumer experiences especially if it reflects the racism or other biases of the consumer that could penalize providers for their identity, not performance.
William Hsiao	3 = I agree	

b. Accountability for population health outcomes should be established so that when outcomes do not meet expectations, the Unified Financing Authority can take corrective action, including imposition of penalties or other enforcement actions.

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

Name:	Response:	Comment (if option 2 or 1 was selected):
Andy Schneider	1 = I disagree	I agree with the proposition that "Accountability for population health outcomes should be established." I don't agree that the focus of accountability should be on penalties and other enforcement actions, as this implies; in my view, withholds tied to outcome benchmarks are likely to be more effective at achieving improved population health.
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	The goal of prevention and population health is much more achievable with a focus on the system as a whole, rather than any specific provider.
Cara Dessert	3 = I agree	
Carmen Comsti	1 = I disagree	I appreciate that some of my concerns were addressed. However, I still disagree with this statement because “corrective action” could still include penalties through risk-based payment schemes, which unjustly punish providers that treat sicker and vulnerable patient populations encourages gaming, punishes small 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

Name:	Response:	Comment (if option 2 or 1 was selected):
		care, etc.). I would support this recommendation if everything following "Unified Financing Authority" were deleted and it read (additions in brackets, deletions not shown because of the Survey Monkey format): "Accountability for population health outcomes should be established so that when outcomes do not meet expectations, the Unified Financing Authority can [target funding and programs to address any care delivery inequities or gaps that contribute to poor health outcomes]."
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	2 = I agree with slight modifications	Hoping that incentives, partnership, and a clear shared vision can reduce the need for heavy handed enforcement.
Sandra Hernandez	3 = I agree	
Sara Flocks	3 = I agree	
William Hsiao	3 = I agree	

c. Unified data systems that assure patient privacy but 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	**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):
Andy Schneider	2 = I agree with slight modifications	Suggest substituting "ensure" for "assure".
Antonia Hernandez	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Anthony Wright	2 = I agree with slight modifications	Add "high health needs" to the list.
Cara Dessert	3 = I agree	
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	2 = I agree with slight modifications	I agree but also appreciate the balance with appropriate privacy needs.
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	3 = I agree	
William Hsiao	2 = I agree with slight modifications	Recommend wording change. California needs an "UNIFORM clinical and claim data system," not just an unified data 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	**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):
Andy Schneider	1 = I disagree	Care delivery should be centered on patient needs. Period. If the care is centered on patient needs, the motive of the individual or entity delivering that patient-centered care (for-profit, not-for-profit, public) is not important.
Antonia Hernandez	3 = I agree	
Anthony Wright	2 = I agree with slight modifications	Yes, patients over profits! I would add "patient needs and public health" to reflect that the goal is both individual, family, *and* community health.
Cara Dessert	3 = I agree	
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	YES!

Name:	Response:	Comment (if option 2 or 1 was selected):
Richard Scheffler	2 = I agree with slight modifications	I agree with this but do not what is mean by Excessive Profit motive. Clearly patients come first. All physicians and others in private practice are set to make profits .The profits are their income.Non profit hospitals make profits they call net revenue or margins.Non profit hospitals decide how to spend them on employees compensation, investments, building new facilities are the main ways .These are just a few examples of how profits are used in our healthcare system.
Robert Ross	3 = I agree	Would be pleased to see us catapult “profit” out of the Cali health system equation
Sandra Hernandez	3 = I agree	
Sara Flocks	3 = I agree	
William Hsiao	2 = I agree with slight modifications	All healthcare providers and integrated delivery systems should not be motivated by profit. I'd like the Commissioners vote on that. This statement state "excess profit" leaves ambiguous about profit motive of providers and seems to endorse the profit motive is OK. How do you define "excess profit?"

e. Encouraging individuals to enroll into models with demonstrated success in integrating and coordinating care for a patient population would facilitate accountability for cost, quality and outcomes. Patients should have a periodic opportunity (e.g., annually) to select a different care arrangement.

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

Name:	Response:	Comment (if option 2 or 1 was selected):
Andy Schneider	2 = I agree with slight modifications	Suggest substituting "arrangements" for "models".
Antonia Hernandez	3 = I agree	
Anthony Wright	2 = I agree with slight modifications	The system should help patients with choices that they do have, and encourage enrollment with providers/systems/models with the best results. We want to facilitate continuity and ultimately accountability, but a form of that accountability is the patient's ability to change providers, in those limited circumstances where patients have agency when sick and needing care. There may need to be exceptions for leaving a care arrangement beyond an annual opportunity--such as, if the existing provider is not living up to its end of its obligations and contract, such as with regard to lack of timely access to care, or issues of cultural competence, or other reasons.
Cara Dessert	3 = I agree	
Carmen Comsti	1 = I disagree	Again, because we don't define it, it's unclear what is meant by "models with demonstrated success". Having a choice to enroll in a care coordination model is different than being "encouraged" to enroll in one. Moreover, if we limit eligibility in an integrated or coordinated care system based on their patient population, this could lead dangerously to stereotyping people by their race, gender, geographic, or other profile or for other populations (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

Name:	Response:	Comment (if option 2 or 1 was selected):
		population some undescribed algorithm, metric, or profiling places them in.
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	0 = I don't know / no opinion	I don't quite understand the way this question is framed. I agree with encouraging (not requiring or auto-enrolling) individuals in models with proven records of success for cost, quality, equity, outcomes, but why is it phrased as "would facilitate accountability"? I'm not sure I agree with that addition.
William Hsiao	3 = I agree	

4. **Payment and Funding:** Provider payments, including methods of payment and levels of payment, should be used to address inequities and to improve access and quality. In particular, provider funding streams and 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 alternative payment models in which providers are held accountable for cost, quality, and outcomes across the populations they serve.

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):
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Cara Dessert	3 = I agree	
Carmen Comsti	1 = I disagree	As I said in the original survey, this statement inappropriately perpetuates the false dichotomy between FFS and

Name:	Response:	Comment (if option 2 or 1 was selected):
		value-based payments (although it's been changed to "alternative payment models"). Often such "alternative payment models" are actually overlaid onto a FFS reimbursement system. It's also inappropriate to include this because we actually have not discussed so-called "alternative payment models" which are being referred to here. As I have said previously, I do not agree with a move towards risk-based payments because risk-based payments incentivize 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 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. And we must consider a diversity of reimbursement systems in addition to FFS, including institutional global budgets and provider salaries. In a single-payer model that does use fee-for-service or other payment models, a single-payer system will be in a position to better track and address any incentive to over-order care without creating incentives for doctors to limit care or avoid a high-risk patient

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

b. Ensure providers caring for populations with greater social risk factors succeed in alternative payment models by adjusting payment, including upfront supplemental payments or incentive payments that provide higher reimbursement.

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

Name:	Response:	Comment (if option 2 or 1 was selected):
Andy Schneider	3 = I agree	
Antonia Hernandez	0 = I don't know / no opinion	
Anthony Wright	2 = I agree with slight modifications	Proposed addition: "greater social risk factors or higher health needs"
Cara Dessert	3 = I agree	
Carmen Comsti	1 = I disagree	As I voiced at the Commission meeting on payments, I have tremendous concerns about "social risk" adjustment. My recommendation is to delete the reference to "incentive payments" and "alternative payment models by adjusting payments" and, rather, to

Name:	Response:	Comment (if option 2 or 1 was selected):
		simply have this recommendation talk about targeting funding towards addressing health inequities. The statement would read (additions in brackets, deletions not shown because of the Survey Monkey format): “Ensure providers caring for populations with greater health inequities can receive supplemental payments or targeted funds to address such inequities.” Social factors—like income inequality, structural racism, and other socioeconomic factors—are not medical factors. So, attempts to risk adjustment that consider these non-medical indicators like race or other proxies for underserved groups can end up baking in racial bias, racial stereotypes, and inequities in the provision of care. Not all people in one social group or social population have the same health care needs – Frankly, increased payment should be based on a patient’s actual health care conditions not their inclusion (or not) in a socially constructed category. While individualized assessment of health is harder than social risk adjustment, social risk adjustment can lead to very dangerous unintended consequences. For example, risk-adjustment tools that explicitly “race correct” can result in bias against marginalized groups – for example, the eGFR kidney function indexes, the vaginal birth after C-section tool, and claims correction tools used by insurance adjusters like the NFL football payers’ concussion claims tool. At worst, these race-based risk adjustment tools functionally engage in a kind of racist biological essentialism. Importantly, this bias as a result of risk adjustment can happen even if it is

Name:	Response:	Comment (if option 2 or 1 was selected):
		unintentional. As I mentioned, in Obermeyer study on a widely used hospital risk prediction/adjustment algorithms resulted in racially biased care. This algorithm used cost as a proxy for risk but because of how much people traditionally spend on health care is reflective of systemic racial bias how much people traditionally spend on care is reflective of systemic racial health inequities and racism in our society – using cost as a proxy for risk ended up baking in racial health inequities into the algorithm and resulted in black patients receiving less care than their white counterparts. And again, the reference to “alternative payment models” here lacks specificity and, like the previous recommendation, impliedly creates a false dichotomy between FFS and “alternative” models. I recommend changing this to refer generally to targeting provider funds to address health inequity.
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	2 = I agree with slight modifications	I think i agree with the spirit of this statement but I would like more definition of the terms "social risk factors" and "alternative payment models"
William Hsiao	3 = I agree	

c. Provide increased support for primary care and improve access to primary care services.

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):
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Cara Dessert	3 = I agree	
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	1 = I disagree	I agree with the focus on primary care, but part of the problem is with the distribution of primary, or any health care, in the state. Payment to improve access to ALL care, primary and specialty, should be focused on medically underserved areas and on reducing health disparities.
William Hsiao	3 = I agree	

d. Provide hospitals, medical groups and health plans the flexibility to use resources to maximize the health of the populations they serve, rather than being tied to fee-for-service payment methods. One example of such flexibility would be to establish global budgets for hospitals, linked to community health and health equity measures. Another example might deploy risk-adjusted capitation payments to assign accountability for access, cost, quality and health outcomes while taking into consideration population size and provider financial solvency.

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

Name:	Response:	Comment (if option 2 or 1 was selected):
Andy Schneider	1 = I disagree	The term "flexibility" implies that global budgets and capitation are voluntary. The examples, however, imply that they would be mandatory. This needs clarification, perhaps by fashioning

Name:	Response:	Comment (if option 2 or 1 was selected):
		separate statements for global budgets and for capitation.
Antonia Hernandez	3 = I agree	
Anthony Wright	2 = I agree with slight modifications	While I support moving away from fee-for-service, it's not enough to provide flexibility or shift risk, but we need to put in place the right incentives to use that flexibility to improve quality, equity, and value--rather than the current incentives which reward volume, upcoding, and consolidation.
Cara Dessert	3 = I agree	
Carmen Comsti	1 = I disagree	Again, the language creating the false dichotomy between FFS and other payments needs to be deleted. While I agree with the use of global budgeting, I think the description of the benefits of hospital global budgeting that I envision is misleading here. It is not the "flexibility" of resource use that is beneficial in hospital global budgeting but rather the transparency, accountability, and ability of the system to pay for all the needs of a patient population. Moreover, I disagree with presenting risk-adjusted capitation as and payment methodology for reasons.
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	Hospital budget are a very complicated and difficult approach. I do see how we can successfully do it. It is also to capture by the hospitals and would need to deal with the unique care model and understanding the how the market operates. Budgeting eliminates market competition and many incentives to improve quality and lower cost. It is not perfect but still useful.
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	0 = I don't know / no opinion	This is a very important area to explore but it's hard to rate it based on two examples that need additional

Name:	Response:	Comment (if option 2 or 1 was selected):
		explanation. I do like the idea of global budgets, but there are still many details to discuss on how to implement especially in a state the size of California.
William Hsiao	3 = I agree	

e. 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):
Andy Schneider	2 = I agree with slight modifications	Suggest substituting "ensure" for "assure".
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Cara Dessert	3 = I agree	
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	3 = I agree	
William Hsiao	3 = I agree	

f. Encourage the use of the non-physician health care workforce (e.g., nurses, other health care professionals, navigators, community health care workers) in situations where these roles have been demonstrated to improve access to care, address social determinants of health, reduce health disparities, and/or support effective patient engagement.

Total Count:	
3 = I agree	**7**
2 = I agree with slight modifications	**2**
1 = I disagree	**1**

0 = I don't know / no opinion	**1**

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	0 = I don't know / no opinion	The case is compelling in several circumstances, like with the current roles of navigators and community health workers in general, but hard to endorse a blanket statement without knowing further specifics.
Cara Dessert	2 = I agree with slight modifications	Yes, but these systems, like nonprofit medical case managers and promoters should be inside and not outside the system; they need to be paid as professionals doing critical healthcare work, compensated as such and included in the healthcare system
Carmen Comsti	1 = I disagree	This statement inappropriately conflates health care professionals that provide patient care with unlicensed personnel who contribute to the health care system and who provide important system navigation roles but who do not provide patient care. 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. Doctors have a different scope of practice than nurses and nurses are different than respiratory therapists. Trying to push direct patient care to lower-licensed or unlicensed individuals is merely a stop-gap measure. What should be our proposition 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

Name:	Response:	Comment (if option 2 or 1 was selected):
		jobs for our health care workers to retain such professionals in our health care system. I would like a total rewrite of this proposition 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."
Jennie Chin Hansen	3 = I agree	Strongly agree
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	2 = I agree with slight modifications	There has to be protections against de-skilling the health care workforce and protections against reducing the quality of care, especially in a way that perpetuates health disparities. Employers should also not be allowed to use changes in workforce as a way to cut costs rather than improve quality and coordination. In addition, we need protections that prevent artificial intelligence from overriding professional judgement of providers.
William Hsiao	3 = I agree	

g. 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):
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	A really important model that needs to be included in any health system.
Cara Dessert	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	CHCs are an important kind care delivery system but I disagree with the use of capitated payments to fund CHCs. Language here could be added to say that CHCs should be better funded. The propositions should be modified to read (additions in brackets, deletions not shown because of the Survey Monkey format): "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]."
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	Thank you
Sandra Hernandez	3 = I agree	
Sara Flocks	0 = I don't know / no opinion	
William Hsiao	3 = I agree	

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

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):
Andy Schneider	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	Could probably make this sharper, to be clear there needs to be more investment in certain areas and with certain populations in order to build infrastructure where it isn't now and meet unmet needs.
Cara Dessert	3 = I agree	
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	The challenge will be defining equitable distribution.
Robert Ross	3 = I agree	Rural needs our attention
Sandra Hernandez	3 = I agree	
Sara Flocks	2 = I agree with slight modifications	I'd modify to ensure the equitable distribution of health care providers that are culturally & linguistically appropriate for the communities they serve.
William Hsiao	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):
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	Could be even sharper in terms of examples used.
Cara Dessert	3 = I agree	
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Richard Scheffler	3 = I agree	It is Len's which we should financing and delivery system changes.
Robert Ross	3 = I agree	Thank you
Sandra Hernandez	3 = I agree	
Sara Flocks	3 = I agree	
William Hsiao	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	**7**
2 = I agree with slight modifications	**3**
1 = I disagree	**0**
0 = I don't know / no opinion	**1**

Name:	Response:	Comment (if option 2 or 1 was selected):
Andy Schneider	3 = I agree	
Antonia Hernandez	0 = I don't know / no opinion	
Anthony Wright	3 = I agree	Shouldn't we be clear that underserved communities need not just the same but greater resources than affluent communities?
Cara Dessert	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	This recommendation misses the mark. The most fundamental thing we can do to address socioeconomic health care disparities, particularly disparities related to "differences in financial resources" is to create a unified financing health care system where health care is guaranteed as a right without premiums, copayments and deductibles. In the list of examples, the following should be added: "guaranteeing health care as a right without premiums, copayments,

Name:	Response:	Comment (if option 2 or 1 was selected):
		deductibles, or other cost-sharing." We can also highlight the need for ensuring access to the full continuum of care for rural and underserved hospitals. Together these edits read as follows (additions in brackets, deletions not shown because of the Survey Monkey format): "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, by providing targeted resources and supports that are not dependent on provider reimbursements [to ensure access to the full continuum of care including rural and underserved hospitals, and by guaranteeing health care as a right without premiums, copayments, deductibles, or other cost-sharing]."
Jennie Chin Hansen	2 = I agree with slight modifications	needs a very thoughtful, deliberate process and includes enhancement of telehealth and tech bandwidth.
Richard Scheffler	3 = I agree	I support this but really need clarification on what not dependent on provider reimbursement means.
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	2 = I agree with slight modifications	I think I agree but it's hard to understand the way it's written. For the first part, I suggest modifying it to say that provider payments would be increased to providers in underserved or low-income/high poverty regions (or safety net providers). The 2nd part needs more clarification. What is meant by "targeted resources & supports"? Supports of providers or of communities? Resources like social services or technology? This part needs to be fleshed out a lot more.

Name:	Response:	Comment (if option 2 or 1 was selected):
William Hsiao	3 = I agree	

c. To achieve equitable care, the needs of populations that have been marginalized – e.g., racial and ethnic minorities, immigrants, the aged, people with disabilities, LGBTQ+, and people with limited English proficiency – should be addressed with the goal of eliminating disparities in access and outcomes.

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):
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Cara Dessert	3 = I agree	
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	It is much easier to do this on access . Outcomes depend on many factors outside the health system as we know.
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	3 = I agree	
William Hsiao	3 = I agree	

d. The health care system should invest in a workforce that is diverse, that can meet the cultural, socioeconomic, and linguistic diversity of California's residents and that is responsive to consumer and patient needs. The Unified Financing Authority should work in partnership with others in the public and private sector to address gaps in access to physicians and other allied health care workers and to ensure California's future workforce needs.

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):
Andy Schneider	2 = I agree with slight modifications	Suggest substituting "A system of unified financing" for "The health care system." Also suggest deleting the second sentence for lack of clarity: what is it exactly that the UFA would do?
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Cara Dessert	3 = I agree	
Carmen Comsti	1 = I disagree	I'm reiterating my edits from the first survey. But I specifically rated this as a 1 because of the new language on "partnership with others in public and private sector" is too unspecific. Who are these "others"? As written, "others" could mean anything from big tech to insurers to health professional educational institutions and labor. If this is meant to say that we should engage in public-private partnerships for the sake of public-private partnership's sake without more, that is would be a highly problematic policy goal. The who is important in this equation. Thus, I recommend deleting that first half of the second sentence and recommend my original edits (additions in brackets, deletions not shown because of the Survey Monkey format): "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."
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	Workforce needs to be a core element of the system, not an afterthought. This is super critical

Name:	Response:	Comment (if option 2 or 1 was selected):
Sandra Hernandez	3 = I agree	
Sara Flocks	2 = I agree with slight modifications	The workforce should also be equitably and appropriately distributed (culturally & linguistically appropriate providers). Health care jobs should also be good jobs with direct employment, living wages, benefits, appropriate staffing and safe workplaces. We can't sacrifice job quality and worker safety in pursuit of cost containment or meeting staffing goals.
William Hsiao	3 = I agree	

e. A system of governance and accountability that is responsive to the priorities of Californians and incorporates consumer voices, including voices of marginalized populations in priority-setting, should be established. This includes regularly soliciting meaningful, authentic community input regarding planned changes and establishing mechanisms to report back to communities.

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):
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	Strongly support.
Cara Dessert	2 = I agree with slight modifications	Yes, but I'd like to better define "regularly" - how about we commit to an annual feedback loop process that 1) gets feedback from marginalized communities from surveys, focus groups and town halls 2) incorporated that feedback and 3) reports back to the community
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Robert Ross	3 = I agree	Regional access points to accountability needed
Sandra Hernandez	3 = I agree	
Sara Flocks	2 = I agree with slight modifications	I find it hard to answer governance questions in the absence of a larger conversation of how such a huge, complex system would be governed. I agree that there should be accountable, responsive governance, but I don't know how priority-setting should be done, so can't agree with that part.
William Hsiao	3 = I agree	

f. Independent regional councils comprised of and governed by multiple sector and community stakeholders who work together to address the root causes of inequities should be established.

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

Name:	Response:	Comment (if option 2 or 1 was selected):
Andy Schneider	0 = I don’t know / no opinion	What would these councils do in a system of unified financing? How would they relate to a Unified Financing Authority?
Antonia Hernandez	0 = I don’t know / no opinion	
Anthony Wright	2 = I agree with slight modifications	Appreciate the concept, but would want to look at the structure and details to ensure community voice and power that is independent from the health care industry. Would also want to know how are regions defined and what powers, if any, these councils would actually have.
Cara Dessert	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	I want to raise caution here, which I mentioned in our health equity meeting. Regional councils for health care and

Name:	Response:	Comment (if option 2 or 1 was selected):
		for other social issues have been attempted as a means of community engagement, but regional councils run the risk of becoming forms of performative accountability. We cannot have regional councils where community member and community-based organizations are invited but have no real power in engaging with the health care system. How these councils are structured, so as not to dilute community members' ability to influence recommendations, and how these councils engage with the governing bodies of the health care system are of utmost importance. If councils reflect the makeup of our sociopolitical power structures as the exist today, we are setting the councils up to fail as they will merely replicate the power imbalances and inequities that presently exist in our health care system and society. Particularly if councils are geographically based, groups who are minorities in a region will likely be marginalized in councils. To this end, the recommendation should be edited as follows (additions in brackets, deletions not shown because of the Survey Monkey format): "Independent councils [of socioeconomically marginalized and medically underserved communities] comprised of and governed by multiple sector and community stakeholders who work together to address the root causes of inequities should be established [in a manner that does not replicate existing power imbalances in our sociopolitical systems and that provides a mechanism for such marginalized and medically underserved communities to meaningfully engage with the governing

Name:	Response:	Comment (if option 2 or 1 was selected):
		bodies of the unified financing system and have power in decision-making processes for establishing, monitoring, and funding health equity programs].”
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	0 = I don’t know / no opinion	
Sara Flocks	0 = I don’t know / no opinion	I find it hard to take a position on granular questions of regional governance in the absence of a discussion or establishment of an overall governance structure.
William Hsiao	3 = I agree	

g. The governance of existing health organizations should be strengthened by including more members of the community in positions that have power.

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

Name:	Response:	Comment (if option 2 or 1 was selected):
Carmen Comsti	0 = I don’t know / no opinion	This is much too vague. What are "existing health organizations"? Who are "members of the community"? What are "positions that have power"?
Andy Schneider	0 = I don’t know / no opinion	
Antonia Hernandez	2 = I agree with slight modifications	Appreciate the direction, but again would want to ensure how to make such positions--some of which exist today--as meaningful as possible. In particular, would be interested in the specific authority delegated to these positions.
Anthony Wright	2 = I agree with slight modifications	Sure, but this feels like a rather weak statement and not entirely specific? "Members of the community" could be

Name:	Response:	Comment (if option 2 or 1 was selected):
		10 white, straight, cis gender and wealthy locals - I think we should specify that we mean a diverse group of local community members that include people of color, immigrants, and the LGBTQ community. I also believe that healthcare system should have greater accountability to the state.
Cara Dessert	1 = I disagree	I cannot support this recommendation because it is entirely unclear what is meant by “existing health organizations”. The term “health organizations” could mean anything from a hospital to and insurer to public health agencies and health professional associations. Moreover, what does it mean to put community members in positions of power? Does this mean diversity in corporate governance? Frankly, I think it is naïve to think that making the board of a health insurer or large health care corporation more diverse would make meaningful impact on health inequity. Board members of health care corporations, particularly for-profit corporations but also non-profits, have a fiduciary duty to the corporate financial interests that takes precedence over and can conflict with patient needs and ending health inequity.
Carmen Comsti	2 = I agree with slight modifications	with supportive preparation both of the current "powers that be" as well as those who join the table as novices to the process of governance.
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	1 = I disagree	I don't think governance of large, complex and often powerful institutions like health organizations/providers are improved by putting community members on boards. That can help

Name:	Response:	Comment (if option 2 or 1 was selected):
		improve responsiveness, but to actually get health organizations to meet the goals HCFA is laying out we need robust transparency, accountability, regulation, and enforcement by government over those organizations.
Sara Flocks	0 = I don't know / no opinion	

6. 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 in health screening, early diagnosis and disease prevention.

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):
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	Appreciate this more focused approach. But it would be OK to acknowledge some support to addressing social determinants, we just don't want to pretend that the health system can actually solve for them overall.
Cara Dessert	3 = I agree	
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	This is tough trade off. We should do both. But excessive treatment and waste should be eliminated and redirected into prevention.
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	

Name:	Response:	Comment (if option 2 or 1 was selected):
Sara Flocks	1 = I disagree	I agree with increasing investment in prevention; however I disagree with the statement overall. The imbalance between high spending & underinvestment is fundamentally driven by overcharging, over-treatment, and overuse of expensive & often unnecessary or inappropriate treatment. The system can increase investment in prevention, yet high health care spending could ostensibly continue, it would just drive up the taxes/co-pays/overall cost of the system. To address the imbalance, we need to regulate health care service prices, address volume of services and root out waste, fraud and abuse of the system. In addition, we need to invest in primary care physicians so there are enough providers for preventative care.
William Hsiao	3 = I agree	

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. The health care system should also connect to the social safety net to address issues such as food insecurity and housing instability.

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):
Andy Schneider	3 = I agree	
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Cara Dessert	3 = I agree	
Carmen Comsti	1 = I disagree	As I said in the first survey response, I am rating this as a 1 because this proposition is unclear. I do not

Name:	Response:	Comment (if option 2 or 1 was selected):
		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 proposition. 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.
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	This is the secret sauce of addressing disparities and inequity
Sandra Hernandez	3 = I agree	
Sara Flocks	2 = I agree with slight modifications	I am wary of anything that overburdens the health care system and tasks it with patching together the social safety net. I would modify this statement to say that the health care system should provide referrals to safety net resources and

Name:	Response:	Comment (if option 2 or 1 was selected):
		should coordinate with public health departments, but it is unsustainable to expect it to take on the job of government in providing a social safety net or affordable housing.
William Hsiao	2 = I agree with slight modifications	We have to breakdown the medical mode of thinking only about illnesses and diseases. CA should pilot integrate social workers into primary care like the Medical Home model or England's GPs.

c. Complementary investments (likely from outside the health care delivery system) in the social determinants of health, including but not limited to safe and affordable housing, equitable, high-quality education, and affordable and accessible early child care would improve health outcomes.

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):
Andy Schneider	2 = I agree with slight modifications	Strike "likely".
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	
Cara Dessert	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	I fully agree that we need more public investment from outside the health care delivery system to address social determinants of health. We need robust social programs and public funding of these programs. It is key that we are clear that we mean public investment and not piecemeal private public relations gestures towards social issues. To this end, the language should be edited to say "Complementary public investment" and

Name:	Response:	Comment (if option 2 or 1 was selected):
		delete the word “likely” in the parenthetical.
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	Yep ditto
Sandra Hernandez	3 = I agree	
Sara Flocks	3 = I agree	The importance of investments in addressing the social determinants of health also argues for creating a sustainable, cost-effective health care system. Our taxes go to pay for much more than just health care. We need revenues to improve and increase social safety net supports, and having a self-sustaining health care system that doesn't create an excessive tax burden leaves money on the table for other social services and priorities that help improve health outcomes.
William Hsiao	3 = I agree	

7. **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 integrate federal funding for public insurance programs (Medicare, Medicaid and Affordable Care Act marketplace tax credits and subsidies) with state-based funding sources is critical in supporting a state-based unified financing system.

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):
Andy Schneider	2 = I agree with slight modifications	Add at the end: "Federal approval will require legislation."

Name:	Response:	Comment (if option 2 or 1 was selected):
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	While federal approval is critical to achieve the full vision of a unified financing system, we don't have to wait for federal approval to move forward on other specific elements of a universal and improved health system that get us closer to the vision.
Cara Dessert	2 = I agree with slight modifications	While it would obviously be best if had the partnership from the federal gov't to integrate systems for healthcare expansion and reform, I strongly believe this Commission should provide the Governor with a menu of options that includes parallel processes on how to both pursue federal integration AND plan for CA-only reform should that fail. This Commission should advocate for federal integration that AND create options that move our healthcare forward on equity, accessibility and affordability without it.
Carmen Comsti	2 = I agree with slight modifications	There is something substantively amiss with this statement even with the changes from the original survey. In practice, the federal funds do not need to be integrated into a single state account but, rather, the programs themselves become seamless on the user end. Indeed, there may need to be accounting of federal funds such that federal funds are directed into their own separate state account that the unified financing system can draw down on for certain services. I think this should be edited to read (additions in brackets, deletions not shown because of the Survey Monkey format): "Obtaining federal approval to integrate federal funding for public insurance programs (Medicare, Medicaid and Affordable Care Act marketplace tax credits and

Name:	Response:	Comment (if option 2 or 1 was selected):
		subsidies) with [the administration of] a state-based unified financing system.”
Jennie Chin Hansen	2 = I agree with slight modifications	agree in principle but know this needs to be stages in phases for actually implementation due to complexity given statutory issues among other factors.
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	3 = I agree	
William Hsiao	3 = I agree	

b. Sources of financing, including federal contributions, should be developed and managed in ways that assure California upholds its long-term commitments.

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

Name:	Response:	Comment (if option 2 or 1 was selected):
Andy Schneider	2 = I agree with slight modifications	Suggest substituting "ensure" for "assure".
Antonia Hernandez	3 = I agree	
Anthony Wright	3 = I agree	In particular, we should find sustainable revenues and funding structures to avoid the counter-cyclical nature of state health and human service programs, where revenues reduce during economic downturns when the need is greatest.
Cara Dessert	3 = I agree	
Carmen Comsti	1 = I disagree	I still don’t understand what this means and so cannot support it. I don’t know what “develop and managed” means or who is doing the development or management. If we are talking about financing, the role is for both the legislature and governor not the unified

Name:	Response:	Comment (if option 2 or 1 was selected):
		financing system. I also don't know what "long-term commitments" this language is referring to. At minimum, I suggest adding to the end "to ensuring that health care is provided to all California residents."
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	Waiver boldness
Sandra Hernandez	3 = I agree	
Sara Flocks	0 = I don't know / no opinion	I'd like a definition of what those long-term commitments are and why what would be actions the system would take that would not do that.
William Hsiao	3 = I agree	

c. Health care costs should be managed in line with a target annual rate of growth benchmarked to measures such as state gross domestic product in order to ensure that California can continue to afford its health care system.

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

Name:	Response:	Comment (if option 2 or 1 was selected):
Andy Schneider	0 = I don't know / no opinion	How will costs be "managed"? What is the consequence if the target annual rate of growth is not met?
Antonia Hernandez	0 = I don't know / no opinion	
Anthony Wright	3 = I agree	Strongly support such a target, with real accountability and enforcement--but it shouldn't be a hard cap without flexibility and consideration for real costs, from the specific needs of a region to an earthquake to an aging population.

Name:	Response:	Comment (if option 2 or 1 was selected):
Cara Dessert	3 = I agree	
Carmen Comsti	2 = I agree with slight modifications	Again, I am repeating parts of my comments on the first survey here. I appreciate that it includes of the example of state GDP for a growth rate benchmark but the language here, because it uses “such as”, can still be interpreted to support hard annual spending limit. I would disagree with a suggestion that we adopt hard spending limits for a unified financing system. Additionally, we should be in particular wary of creating spending limits that do not adjust for changes in inflation. I am reiterating the language that I suggested before “Health care costs should be managed in line with a target annual rate of growth benchmarked to measures such as state gross domestic product in order to ensure that California can continue to afford its health care system [and that appropriately reflects changes in economic growth in the state, growth in health care spending nationally, and inflation].”
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	2 = I agree with slight modifications	I would add at the end, or some other overall system that ensures that the health care system is affordable, sustainable, and that the cost does not crowd out funding for other public goods like schools, infrastructure, social programs, affordable housing, etc.
William Hsiao	3 = I agree	

d. Diverse sources of financing and reserves to ensure sustainability when costs exceed revenue, such as during economic downturns, should be established.

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

Name:	**Response:**	**Comment (if option 2 or 1 was selected):**
Andy Schneider	3 = I agree	
Antonia Hernandez	0 = I don't know / no opinion	
Anthony Wright	3 = I agree	There are other mechanisms as well toward this goal. For example, the federal government allows for deficit spending to help provide such sustainability against recession-driven cuts. Federal funding participating would help immensely.
Cara Dessert	3 = I agree	
Carmen Comsti	3 = I agree	
Jennie Chin Hansen	3 = I agree	
Richard Scheffler	3 = I agree	
Robert Ross	3 = I agree	
Sandra Hernandez	3 = I agree	
Sara Flocks	3 = I agree	
William Hsiao	3 = I agree	