Healthy California for All Commission
Survey Report
March/April 2022

Survey background:

In September 2021 and again in November 2021, Healthy California for All Commissioners were surveyed regarding key concepts and principles for the design of a unified financing system. Complete survey findings from previous iterations are available at the Healthy California for All webpage under "Meeting Information" for September 28, 2021 and November 17, 2021.

In December 2021, Commissioners were surveyed again. The December 2021 version of the survey was intended to do three things: 1. Gauge agreement on high-level value statements; 2. Seek input on two topics – Financing and Benefit Design/Cost-Sharing; 3. Invite Commissioners to share their priorities about steps that would pave the way for a smooth transition to Unified Financing. The December 2021 survey report can be found here.

The most recent survey occurred in March/April 2022 and solicited the Commissioners' feedback regarding the draft report. Commissioners were asked to evaluate each section of the draft report from two main perspectives:

1. Whether the section accurately reflects the Commission's discussions;
2. Whether you agree, personally, with the conclusions in that section. *(this question was omitted for ex officio Commissioners)*

In the box below each section, Commissioners were encouraged to offer suggestions where applicable and explain their answers if they expressed disagreement.

Survey Responses:

Report Section 1: Introduction and Overview

1. The Introduction and Overview Section of the draft report provides an accurate description of the Commission process.

Total Count:	
4 = Agree	**6**
3 = Mostly Agree	**3**
2 = Somewhat Agree	**1**
1 = Disagree	**0**

Name:	**Response:**	**Comment (if not "Agree"):**
Anthony Wright	4 = Agree	The Introduction seems a good and fair description of the Commission process, and the report seems focused throughout on describing the process comprehensively. I will guess that those reading who wish to reform our health care system will be less interested in the particulars of

Name:	Response:	Comment (if not "Agree"):
		our specific process, and more interested in the substance of our conclusions and discussion of key issues, and as such, would suggest more emphasis on those conclusions. In these early sections, the report would benefit from a more detailed discussion of the benefits of a universal system of unified financing. The report rightly details the significant barriers and issues that would need to be worked through, so it is worth a page to detail why such changes, or even steps in that direction, are worth the effort. For example, it would be important to have a fuller discussion of the benefits of a universal system—not just to the uninsured, but for the public health and economic vitality of the state as a whole. Moreover, I think we discussed the benefits of a system of unified financing—one that is not just accessible and affordable and administratively simple, but in fact is automatic. The report details that California is taking important steps toward near-universality already, but unified financing would facilitate true universality. Our system of fragmented financing inevitably leaves many people with gaps of uninsurance that occur due to changes in life circumstances. There are other specific benefits of a unified financing system, particularly to address misaligned incentives, that could be further spotlighted as well. Finally, this introduction can be clearer to tease out the value of the report: • An endorsement of the concepts of the universal system with unified financing; • A fleshing out of key decision points in crafting such a system for California; and • Recommendations of current and next steps to get California closer to those benefits.
Carmen Comsti	2 = Somewhat Agree	See also my comments in Question 3. (1) The report should include a definition of a "single-payer financing system" given that it is part of our legislative charge. There is confusion and conflation throughout the report of what kind of

Name:	Response:	Comment (if not "Agree"):
		system is being discussion as a UF system. As we've discussed at length, a single-payer system is very different than a system that includes risk-based intermediaries (i.e., a system with health plans or health systems). While the draft report includes under the rubric of "unified financing" both a single-payer system and a system with health plan or health system intermediaries, I fundamentally disagree that a system that includes health plans can be properly defined as a UF system. (2) As I have said consistently throughout Commission meetings, we have not had a clear definition of what a system that includes risk-based intermediaries actually is. The consulting team tacitly assumed that a system with health plans is a kind of UF system. But the Commission was never given the opportunity to fully discuss the threshold question about including this intermediary model in our definition of UF. Indeed, while I generally understand the intermediary scenario to mean health plans, we as a Commission never came to a uniform definition of what is or is not an "intermediary" and what is or is not considered to be included in the "intermediary" scenario. (3) It is also important to include a definition of "single-payer" here given that not all readers may understand that the "direct payments" model in the report generally refers to a single-payer system. Indeed, if the link between a "direct payments" model and a single-payer system are not made explicitly in the report, some readers may rightly conclude that we did not fully consider a single-payer model in our work. (4) Moreover, we need a definition of single-payer upfront because, as I have said multiple times at Commission meeting, there is a continued false assumption that single-payer means fee-for-service and subsequently a false assumption that any criticism of fee-for-service is a criticism of single payer. As I have described at several meetings, there are several options for payments under a single-payer system that are not fee-for-service payments. (5) The lack of a definition of a single-payer system upfront in the report ultimately has resulted a conflation between UF

Name:	Response:	Comment (if not “Agree”):
		and single-payer. What I mean is that the report can be read to incorrectly attribute the benefits of single-payer to ANY AND ALL UF systems such as one that includes health plans. We must distinguish between the two, and we must, as I discuss further in my overall comments, actually discuss single-payer. By virtue of talking about UF as a generalized idea and by euphemistically calling single-payer the “direct payments” scenario, the report largely ignores our charge to create a plan for achieving single-payer. In the main text, the term “single-payer” only appears 7 times, inclusive of its use in the appendices.
Sara Flocks	4 = Agree	
Jennie Chin Hansen	4 = Agree	
Richard Scheffler	3 = Mostly Agree	The Introduction and Overview need to be rewritten after the report is revised to adequately reflect its content.
Robert Ross	3 = Mostly Agree	so...the intro and document are impressive on analysis. The prose is good but it needs poetry. The strategic and moral demands of needed health system transformation (and post pandemic, why now?!) are glossed over and need to be unapologetically elevated. And that health system transformation is an important car on California's "For All" train. Racial equity needs to be prominently mentioned in this overview. Health For All needs to be the headline; UF is a MEANS in service of that end.
Andy Schneider	4 = Agree	
Antonia Hernandez	4 = Agree	
William Hsiao	3 = Mostly Agree	It described the process OK, but not summarizes the all the points make adequately such as the challenges made on low estimates of savings from UF and criticisms of fee-for-service payment method as inflationary and outdated method that so many empirical studies have shown. Most advanced nations trying to move away from using fee-for-service method of payment.
Cara Dessert	4 = Agree	

2. Regarding the Synthesis of Findings included in Section 1, do you:

Total Count:	
Agree as drafted	**2**
Agree with modest suggestions for improvement or clarification	**7**
Disagree	**1**

Name:	**Response:**	**Comment (if not "Agree as drafted"):**
Anthony Wright	Agree with suggestions	As stated above, I think the Synthesis of Findings seems to miss the detailing of at least some of the key benefits of a truly universal system of providing comprehensive coverage to all Californians. I am glad the synthesis mentions other benefits, including affordability and simplicity. The document says it would remove complexity that prevents practitioners to "focus on what matters most." Yet the goal is not just getting rid of administrative burdens, it's the opportunity to replace misaligned incentives now in place with positive incentives that reward quality, affordability, and equity. In discussion delivery system reform and more, this is hinted to, but can be much more explicit. The bullets correctly point out that the "changes in health care financing are necessary but not sufficient." Our Commission deliberations indicated that this "needed but not sufficient" formulation can apply not just to delivery reform, but to many details of unified financing, from the decision points detailed in the report, to implementation. Finally, the community engagement work really emphasized the patient experience, and talked about the problem that our health system can be disempowering and disrespectful. That is a significant enough finding to be included in the summary in this front section: the need to build the trust, cultural competence, and respect is another "threshold issue" to achieve the system transformation, and as a goal and value for the reformed system.
Carmen Comsti	Agree with suggestions	(1) Please also see my comments in Question 2 also about adding a definition of single-payer.

Name:	Response:	Comment (if not "Agree as drafted"):
		(2) Page 7: The following sentence needs to be clarified: "Changes in health care financing are necessary but not sufficient." I'm not sure to what end this sentence is getting at. (3) Page 8: My organization should be listed as California Nurses Association/National Nurses United, Lead Regulatory Policy Specialist. (4) Page 14: In the section about "Prior Work", the point about quality of care should also mention individual health care needs that are not being met under the status quo fragmented system of health care financing. As drafted, the paragraph on quality of care only mentions population health. Analyzing a health care system for quality should not rely solely on population metrics. Population-based metrics can hide disparities and inequity within the population. Just as or even more importantly than population health, quality of care also means ensuring that each individual gets the care they need.
Sara Flocks	Agree with suggestions	I suggest additional findings: * Data collection and analysis are critical to a UF system and that requires a statewide infrastructure and standardized data collection. * There are also cost containment efforts underway in health care that will also lay the foundation for a UF system in California. * Corporate profit-taking do not belong in a UF health care system.
Jennie Chin Hansen	Agree with suggestions	When the effort to get direct community input was implemented there was a good description of race/ethnic breakdown; what I didn't pick up was the proportion of Medicare beneficiaries as well (asking since Medicare benefits are planned as part of the unified financing blend.
Richard Scheffler	Disagree	Here are my major high level concerns about the draft report. Page 6: Bullet point 1 talks about a standard package but I do not recall the Commission deciding on what would be in it. Seems to assume the status quo, which has different benefit packages for different populations. Page 15—the 7 principles: Number 1 calls for an integrated delivery system, which is strongly supported by the Commission, but gets little discussion in the report though it is clearly the hallmark of a CA delivery system. Number 3 notes that methods and level of payments should

Name:	Response:	Comment (if not "Agree as drafted"):
		address equity and quality but the report gives little details on how this might be done. Analytic finding starting on page 17: Often uses the phrase that the estimates are based on plausible assumptions but it never says what they are. These are perhaps technical assumptions to make the estimates but they are not key assumptions. The report assumes lower administrative costs and lower prescription drugs costs which are far from certain. It also assumes lower fees of physicians, hospitals, and other providers, which would make a substantial impact on the delivery system. This is not recognized or assessed. Most importantly, the estimates make a key assumption that the method of payment will be fee-for/service. This was never agreed to by the Commission. In fact, the vast majority of the Commissioners support a capitation system. Moreover, more than 70 percent of the population is enrolled in a plan that uses capitation. Page 22: The health plans section points out the increase in utilization and spending of moving away from capitation, which is the dominant payment system in CA. Data on it is easily available on the Department of Managed Care's web page. A move in this direction was never discussed by the Commission and is not in the realm of being a plausible assumption. It ignores what Commissioner Lee clearly pointed out at our last meeting: the more than forty years of policy research that clearly demonstrates that capitation payments are lower in cost and higher in quality than fee-for-service. I am asking that these issues be aired, and that the staff produce a savings estimate based on the same set of assumptions but increasing the population covered under capitation to 90 percent phased in over five years. All these estimates are based on a one-time saving and do not fundamentally deal with the rate of growth of per capita spending. The rate of growth can be altered by policy that emphasizes prevention and improves the efficiency and productivity of the system such as workforce substitution and new healthcare technology. These need to be addressed. Page 23: The list on page 23 is useful but no estimates

Name:	Response:	Comment (if not "Agree as drafted"):
		of the impact of these policies are provided. Page 24: The if statements on the growth of spending and growth of the California economy are based on hypothetical assumptions only. I do not take the work in Appendix C seriously because it ignores 40+ years of research that shows that the fee-for-service is wasteful, lacks coordination and integration, and is more costly and lower quality than capitated systems. The support for capitation is noted on page 52: it says some support but in reality, it is supported by the vast majority. This needs to be corrected. Page 27: Again, the report states that it wants to unwind managed care which is based on capitation. My objection to this policy goal is already stated from the above and to my knowledge was never discussed by the Commission. The taxes suggested to raise revenue are varied and suggestive. However, a more formal estimate of their impact is needed. Many are simply unrealistic and very unlikely to be implemented. The financing plan lacks rigor and does not adequately examine its full impact. I suggest that a clear plan to finance the system be included to move the unified health care financing system forward. Page 37: There are conceptual mis-statements that say that non-profit hospitals focus on "revenue maximization." Theory and research as well as common sense tells us they focus on profits that are often measured by hospital margins. You can have all the revenue you want but if costs exceed it, the hospital cannot survive. Setting global budgets for hospitals has been tried and failed many times. The experience in Maryland, which is the only state to have used global budgets has been mixed and is a work in progress. Maryland receives higher Medicare payments due to a once-only agreement that everyone admits is unlikely to be given to other states. Basing policy on this kind of evidence is unacceptable. See page 48. Page 52: Says that those paid on FFS would not have the incentive to stint on needed care. There are two points worth making. It is well-known that FFS promotes excessive and wasteful care that is lower in quality

Name:	Response:	Comment (if not "Agree as drafted"):
		to care paid by capitation. The IHA has a huge amount of data supporting this universal finding in California. And there is not credible evidence presented that capitation leads to stinting. The outcome of this debate is key. The report takes the position that FFS is better though it says that debate was not resolved. The discussion is unbalanced and does not point out the well-known evidence that a fee-for-service produces excessive utilization and cost, uncoordinated care, and low-value care. This is a biased view of evidence and is not supported by a significant amount of the Commission members. Page 56—Outpatient Payment: The report assumes that fees would be negotiated or set by the state. I do not recall any agreement by the Commission to take this approach. A better and more realistic approach would be to have prices set by the market. The U.S. and California's health care system is market-based. Policies to improve how the market functions and the growth of monopoly power in the market were discussed in the environmental report, but not in this draft. This needs to be included. Finally, a minor point, the report title needs to include the word "healthcare."
Robert Ross	Agree with suggestions	as mentioned above, let's not bury the headline: California getting to For All, 100%, nobody left-behind coverage and in an health equity frame. UF as a means to this end.
Andy Schneider	Agree with suggestions	The 2nd to last paragraph should be revised and converted into a bulleted finding that follows the 3 above: -- Transitioning California to a system of unified financing will be a highly complex undertaking that will require buy-in from the people of California and from the federal government in the form of adequate and sustainable funding. This phrasing--"It will also be important to overcome inertia and hesitation from Californians and health care providers who may prefer "the devil they know" to an entirely different approach" -- does not give Californians enough credit. They SHOULD be wary of a change of this magnitude even though it would be a far better result for them.

Name:	Response:	Comment (if not "Agree as drafted"):
Antonia Hernandez	Agree as drafted	
William Hsiao	Agree with suggestions	UF offers unique benefits and requires reforms of financing AND delivery system. This means systemic change of the health care system. The finding does not clearly state the SYSTEMIC reform needed, including funding, payment methods and rates, organization of the delivery system, regulation of monopolistic insurers, and effective bargaining with monopolistic pharmaceutical suppliers. Otherwise, UF can't produce its expected benefits nor sustain itself.
Cara Dessert	Agree as drafted	

Report Section 2: Goals and Values

3. The Goals and Values section is an accurate representation of Commissioner discussion and input.

Total Count:	
4 = Agree	**6**
3 = Mostly Agree	**4**
2 = Somewhat Agree	**0**
1 = Disagree	**0**

Name:	Response:	Comment (if not "Agree"):
Anthony Wright	4 = Agree	I would repeat my earlier comments on emphasizing the urgency of address gaps in coverage, and misaligned incentives. The goals and values list is reflective of the discussion and heavily vetted survey results. The beginning paragraph is especially appropriate. The bullet points are fine individually, but don't have a lot of flow or connection between them: Perhaps a better order would be 6, 1, 2, 4, 3, 5--going from broad statements about the patient experience, to the systems of accountability on the backend, and 7 being on a distinct issue of financing and federal engagement.
Carmen Comsti	4 = Agree	

Name:	Response:	Comment (if not "Agree"):
Sara Flocks	3 = Mostly Agree	It is noted in a footnote that I disagreed with Value #5 that the health care system should address social determinants of health. I agree that our state MUST address social determinants but my concern is that requiring the health care system to take on that burden distracts from the core mission of providing high-quality, equitable, affordable care in a sustainable system. The system should coordinate with other entities on social determinants but to put that responsibility on a new, complex health care system is burdensome.
Jennie Chin Hansen	4 = Agree	
Richard Scheffler	4 = Agree	
Robert Ross	3 = Mostly Agree	Health and racial equity, and the matter of the health workforce, need more lift. But otherwise, a very fair representation of Commissioner input.
Andy Schneider	4 = Agree	
Antonia Hernandez	3 = Mostly Agree	
William Hsiao	3 = Mostly Agree	The report misses the desirability of the integration of health care delivery to achieve the noble goals of UF. Integrated delivery means more than coordination of care. It means organizational, managerial and incentive changes.
Cara Dessert	4 = Agree	

4. Regarding the discussion of Goals and Values presented in the draft report, do you:

Total Count:	
Agree as drafted	**4**
Agree with modest suggestions for improvement or clarification	**6**
Disagree	**0**

Name:	Response:	Comment (if not "Agree as drafted"):
Anthony Wright	Agree with suggestions	I think there are other "goals and values" on this subject that are shared and important among Commissioners, but I understand that this is what the HCFA Commission specifically surveyed on.
Carmen Comsti	Agree as drafted	
Sara Flocks	Agree as drafted	

Name:	Response:	Comment (if not "Agree as drafted"):
Jennie Chin Hansen	Agree as drafted	
Richard Scheffler	Agree with suggestions	The report should even more strongly address the equity and community issues.
Robert Ross	Agree with suggestions	Again, lifting health and racial equity, and the crisis of our state's health workforce, need some attention here.
Andy Schneider	Agree with suggestions	Principle 7 uses the term "sustainable" funding. The term under Synthesis of Findings is "adequate and sustainable." I prefer the latter, but whatever term you choose it should be the same throughout.
Antonia Hernandez	Agree with suggestions	more emphasis on covering the immigrant community
William Hsiao	Agree with suggestions	This section only stresses equity principles, not quality and efficiency of health care and sustainability of UF. The principles emphasize monitor and accountability, not HOW to achieve the goals of UF through payment and delivery system changes. The payment principle does not state payment methods and level are the key policy instrument to achieve quality and efficiency of health care, in addition to equity. The principle does not mention the shortcoming of the current payment methods and payment rates and they must be changed.
Cara Dessert	Agree as drafted	

Report Section 3: Analytic Findings

5. The Analytic Findings section is an accurate representation of the report on unified financing that the Commission received, and an accurate representation of the resulting discussion and input.

Total Count:	
4 = Agree	**3**
3 = Mostly Agree	**4**
2 = Somewhat Agree	**1**
1 = Disagree	**2**

Name:	Response:	Comment (if not "Agree"):
Anthony Wright	3 = Mostly Agree	For someone reading this report, they get into a fairly weedy discussion of financing quickly, as soon as page 17. I wonder whether this makes more sense later in the report, especially given how the financial modeling directly interfaces with decision points and discussions later in the report, whether on cost sharing, intermediaries, etc. There are some blockbuster findings that are glossed over, and could be key takeaways from this report. • One key item is the projection that health care spending is expected to grow by $158 billion is current dollar (not including inflation!) in the next decade if nothing is done. That is a clarion call for urgent action, for unified financing and anything else that can address health costs in the meantime. • The savings is also eye popping, and would benefit from some social math, explaining what this would be equivalent to, in terms of existing spending (how the savings compares to what California spends on higher education, for example). This type of highlighting could also be done with regard to the lives saved under a fully universal system, which elsewhere is clocked at 4,000, or a Californian every two hours. • Understanding the space constraints, the report could explain just a bit more about the actual savings that unified financing could achieve. For example, how exactly would unified financing get substantially more prescription drug savings than Medi-Cal, buying coverage for 13 million, gets today? What is the mechanism for the bullet point that says "reducing the rate of growth in prices"? I suspect opponents will challenge the assertion that these savings can be achieved, so it would be helpful to bolster this and be able to answer inevitable questions. On the discussion on financial options, it might be more useful to have a more "checklist" of these lists, of both the options for financing, and the considerations: progressivity, disruption, stability, and interaction with the federal tax system, for example. That said, I think it would be useful to have more distinctions within these categories. As

Name:	Response:	Comment (if not "Agree"):
		the report suggests, it would be hard to have a system more regressive than the current status quo of employer-based benefits, but while most of the options are more progressive, some are more progressive than others. I also appreciated and wanted more about the transitional steps that would be needed for some financing options. Finally, the notion of requiring employers who now provide health benefits to pass through savings of a unified financing system to workers deserves more than one line—any policymaker advancing this issue would want and need to detail that issue out.
Carmen Comsti	2 = Somewhat Agree	I have general comments on this section as well as specific suggestions on modifications and clarifications. (1) We need to publicly post underlying data and calculations. Much of the underlying calculations in the analytic findings were not included. While it's noted in a footnote that some data is available upon request, we must publish the underlying calculations (the excel sheet that Commissioners were able to see previously) to the final report or ensure that these calculations and underlying data are posted publicly on the Commission webpage. It is important that the calculations in the analytic findings are replicable and transparent. The public should be free to see the underlying assumptions at work in the analytical calculations. For example, the report should clearly explain the underlying calculations for the savings and added costs associated with the Direct Payment Scenario (Figure 1), including both the baseline expenditures for each category listed and the calculated expenditures for Year 1 (2022) of the Direct Payment Scenario, rather than just showing the estimated percentage change for each expenditure category. (2) The analytic findings inaccurately equate the "direct payments" scenario and the "health plan" scenario. At several points in the analytic findings, the report makes the inaccurate statement that spending under the "health plan" scenario and "direct payments" scenario is "similar" (Pages 22, 24). From all the

Name:	Response:	Comment (if not “Agree”):
		calculations presented and from the calculations previously present to the Commission, the “health plan” scenario expenditures (when not considering LTSS) are consistently higher than the “direct payments” scenario. By saying broadly that expenditures under both programs are similar, the report glosses over both that (1) under the direct payments scenario patients would be provided more care with reduced administrative costs and lower overall expenditures, and (2) under the health plan scenario, patients would be receiving less care with increased administrative costs. (3) The explanation of expenditures under the “health plan” scenario is misleading and fails to recognize that reduction in care is what makes utilization expenditures low for a health plans model. On Page 22, the report draft misleadingly states that under the health plan scenario, “These increases in spending are largely balanced by an estimated increase in utilization in the direct payment scenario due to the elimination of risk-based capitation and the elimination of health plan efforts at reducing low-value care, which is accompanied by an increase in spending for services.” This sentence inaccurately implies that health plans reduce spending just by eliminating “low-value care” instead of acknowledging that health plans reduce care whenever possible to make money. There is nothing inherent about a health plan or health system that says so-called “low-value care” would be targeted to reduce costs. The risk-based motive of health plans and capitation to reduce as much costly care as possible is precisely one the fundamental issues I have with the health plan/intermediary scenario. Moreover, as I described elsewhere in my feedback on the report draft, “low-value care” is a meaningless and potentially dangerous term to clinical practice, which can exacerbate racial and other biases as well as inappropriately label care as “unnecessary” before patient and doctor can make a reasoned deliberation about the care. As I have said previously, the report should not be using jargon like “low-value care” because what a health plan deems to be low-value care may be necessary

Name:	Response:	Comment (if not "Agree"):
		care for a particular patient. Similarly, what may be considered "low-value" care for a population may actually be necessary care for a particular patient. (4) Edits need to be made to ensure that the analytic findings of the various scenarios are easily comparable to the status quo baseline. Currently, not all the calculations are easily comparable to baseline. The report does not clearly present Year 10 (2031) expenditures for each of the scenarios or for the baseline. Without this information about 2031 baseline expenditures and expenditures for each of the scenarios, it is hard to fully analyze and comprehend the cumulative 10 year savings In Table 3. For example, Table 3 should have baseline comparison with the status quo baseline (as a percentage). And Figure 5 should have a comparison to the baseline total health expenditures in 2031. (5) Add additional information to show results from Year 2 to Year 10. There should be additional tables presenting information from Year 2 to Year 10 on the various scenarios. Again, this work needs to be verifiable and replicable. Currently, without seeing the underlying calculations that were available to Commissioners, I doubt that such review of the findings could be done properly. Moreover, to be consistent with principles of transparency and public participation, more information about the consultant's underlying calculations and assumptions (for all parts of the report) must be disclosed publicly and be made easily accessible either in the report itself or on the Commission's webpage. (6) The report needs to describe the underlying assumptions and calculations for each revenue generation option mentioned (Page 31 & Table 4). In the description and calculation of potential state revenue sources, there needs to be a clear explanation on how estimated revenue was calculated and what assumptions were made in these estimates (e.g., exemptions, progressivity, etc.). To be helpful to lawmakers and the public, these estimates on revenue generation need to be replicable. At the moment, the estimated revenue is not very helpful because there is no description

Name:	Response:	Comment (if not “Agree”):
		of how these estimates were made and what the underlying assumptions were. Namely, I am concerned about ensuring that there is progressivity and appropriate exemptions of tax credits to ensure that low- and middle-income families are not paying more under various options presented. And I would like to see what the estimated revenues would be if there were significant progressivity in each of the options that we discussed and are listed in Table 4. - Additionally, I want to repeat my request that we include a calculator in our report on potential new revenue sources and how such sources may impact different families and business. Ideally, we would have one that the public and lawmakers could use on our website. (8) Much of the discussion on the potential impact of state revenue generation (i.e., the tax options) is speculative and lacks justification. While it is useful to discuss some available tax options and estimate the amount of revenue that is possible to be raised from them, the draft on a few occasions drifts into open speculation without providing underlying data or references when discussing the potential drawbacks of certain tax schemes. While general statements about potential impacts are necessary, it is unhelpful and improper for the Commission (and the consultants) to go into detail about potential taxation impacts based on pure conjecture. - Page 30: For example, in the discussion of “winners and losers” in the payroll tax scenario, the drafters made no attempt to back up any of the claims with data. There appears to be no justification to make the claims about the impacts of a payroll tax on firms. While some of these concerns may be warranted, the report should limit conclusory speculation of this nature; and, instead, the report can broadly describe concerns or questions about the impact of any tax plan. - Page 32: Another example of potentially harmful speculation is the concern that if wages increase because of unified financing, a portion of them will be captured by the federal government through income taxes, resulting in a net loss for Californians overall. As we discussed at the

Name:	Response:	Comment (if not “Agree”):
		Commission meeting on state financing options, it is problematic to couch more wages in workers pockets as a negative because of the potential for federal taxation. Additionally, the discussion in these paragraphs is devoid of any references to underlying data or economic theory. The discussion takes relatively complicated questions about currency circulation, taxes, and macroeconomics and boils them down to an overly simple equation, without any real justification. - For the reasons described above, much of this discussion about the potential impact of tax options on firms and individuals needs to be deleted from the report because no basis for these assertions and no underlying data are presented. As I have said before, the consultant teaming has not shown their work. But without any data or justification for their conclusions, it behooves me as a good steward of this Commission and to the Commission’s charge of presenting a reliable and actionable plan on unified financing, including single payer, to call these conclusions out as potentially inaccurate. (9) Clearer presentation of savings needed. Some of the tables on savings and changes in total health expenditures are not the most approachable in terms of public understanding of the potential savings and changes in expenditures (i.e., additional services and universal coverage) under a UF system. - The presentation of the saving in Figure 1 and Table 2 should be presented in a more approachable fashion that includes dollar figures, again in comparison to the baseline. - As mentioned above, savings for each of the 10 years between 2022 and 2031 should be clearly presented in a table to show the rate in which additional savings in comparison to the status quo baseline would accrue.
Sara Flocks	3 = Mostly Agree	I think the economic modeling of the looming burden of the existing health care system and the potential savings under UF should be part of the introduction and woven into every part of the report. The cost of our current system is unsustainable and should set the context for the rest of the report. The report finds that health

Name:	Response:	Comment (if not "Agree"):
		spending will increase by $158 BILLION by 2031 under status quo. That number demonstrates the urgency of acting now on UF and the cost to every single California of doing nothing. In addition, the potential savings under UF are a huge benefit that should be highlighted. UF potentially could save $32 to $535 BILLION compared to the status quo. That savings could be invested in addressing social determinants of health, addressing the root causes of health disparities.
Jennie Chin Hansen	4 = Agree	
Richard Scheffler	1 = Disagree	Analytic finding starting on page 17: Often uses the phrase that the estimates are based on plausible assumptions but it never says what they are. These are perhaps technical assumptions to make the estimates but they are not key assumptions. The report assumes lower administrative costs and lower prescription drugs costs which are far from certain. It also assumes lower fees of physicians, hospitals, and other providers, which would make a substantial impact on the delivery system. This is not recognized or assessed. Most importantly, the estimates make a key assumption that the method of payment will be fee-for/service. This was never agreed to by the Commission. In fact, the vast majority of the Commissioners support a capitation system. Moreover, more than 70 percent of the population is enrolled in a plan that uses capitation. Page 22: The health plans section points out the increase in utilization and spending of moving away from capitation, which is the dominant payment system in CA. Data on it is easily available on the Department of Managed Care's web page. A move in this direction was never discussed by the Commission and is not in the realm of being a plausible assumption. It ignores what Commissioner Lee clearly pointed out at our last meeting: the more than forty years of policy research that clearly demonstrates that capitation payments are lower in cost and higher in quality than fee-for-service. I am asking that these issues be aired, and that the staff produce a savings estimate based on the same set of assumptions

Name:	Response:	Comment (if not "Agree"):
		but increasing the population covered under capitation to 90 percent phased in over five years. All these estimates are based on a one-time saving and do not fundamentally deal with the rate of growth of per capita spending. The rate of growth can be altered by policy that emphasizes prevention and improves the efficiency and productivity of the system such as workforce substitution and new healthcare technology. These need to be addressed.
Robert Ross	4 = Agree	
Andy Schneider	4 = Agree	
Antonia Hernandez	3 = Mostly Agree	
William Hsiao	1 = Disagree	This draft report gives the findings of the analytic studies done by consultants BUT does not give the criticisms that the Commissioners gave about the findings. For examples, the cost estimation under-stated the potential savings of UF by giving a very low estimate of potential reduction of administration expenses of providers. It excluded the potential savings from reducing fraud and abuse in claims. The analytic study assumed the unwinding managed care would increase the aggregate health expenditure by 3.9%. Why is this policy being taken as given? Commissioners raised questioned about the rational, soundness and desirability of this assumption. We never had an adequate chance to discuss and debate this important policy measure and assumption.
Cara Dessert	3 = Mostly Agree	

Report Section 4: Community Engagement

6. The Community Engagement section represents an accurate representation of the Community Engagement that was conducted, and an accurate representation of the resulting Commissioner discussion and input.

Total Count:	
4 = Agree	**6**
3 = Mostly Agree	**4**
2 = Somewhat Agree	**0**
1 = Disagree	**0**

Name:	Response:	Comment (if not "Agree"):
Anthony Wright	4 = Agree	These conclusions were vetted and discussed and are a worthy and important contribution to the report.
Carmen Comsti	3 = Mostly Agree	I think the report would benefit to include some of the visualization of the findings from the Community Engagement report that we received. The report should include the following graphic visualizations of the findings from the Community Voices Report: (1) Page 29 of the Community Voices Report (and Page 18 from the Community Voices presentation), Figure 6 on "Support for a Single, Statewide Government-Run Health Care System." This is important to show that there is majority support among low-income California's for a state single-payer system. (2) Page 33 of the Community Voices Report, Figure 8 on "Support for a Proposed Financing Mechanism for a Statewide Government-Run Health Care System." This importantly shows that there is majority support among low-income California's for a system that replaces cost-sharing with progressive taxation. (3) Page 47 of the Community Voices Report, FM3 Research graphic on Californian's dissatisfaction with their current health insurance coverage. This graphic demonstrates that among people dissatisfied with their current coverage cost is the biggest concern, followed by not covering all services/treatments. (4) Page 60 of the Community Voices Report, FM3 Research graphic on showing that the top two concerns people have even after seeing a health care professional are (1) not being able to afford the cost of a follow up or treatment, and (2) insurance not approving the treatment or test the doctor ordered.
Sara Flocks	4 = Agree	
Jennie Chin Hansen	3 = Mostly Agree	As mentioned in a earlier question, I would like to have the participation of members more robustly describe in addition to race/ethnicity-.i.e. uninsured, under insured, Medicare, MediCal participants.
Richard Scheffler	4 = Agree	
Robert Ross	4 = Agree	I really appreciated this section, thank you.
Andy Schneider	4 = Agree	

Name:	Response:	Comment (if not "Agree"):
Antonia Hernandez	3 = Mostly Agree	
William Hsiao	4 = Agree	
Cara Dessert	3 = Mostly Agree	Just one thing: I believe it was noteworthy and therefore should be noted, that the LGBTQ had overwhelming support for a single, statewide, government-run health care program that covers all people who live in California.

Report Section 5: Decisions and Actions Needed to Achieve Unified Financing

7. The section on Decisions and Actions Needed to Achieve Unified Financing is an accurate representation of Commissioner discussion and input.

Total Count:	
4 = Agree	**3**
3 = Mostly Agree	**4**
2 = Somewhat Agree	**3**
1 = Disagree	**0**

Name:	Response:	Comment (if not "Agree"):
Anthony Wright	4 = Agree	
Carmen Comsti	2 = Somewhat Agree	DESIGN: (1) Pages 48-52: While I appreciate the description of global budgets for institutional providers and the options of fee-for-service or salaries for physicians as payment options under a direct payments (i.e., single-payer) scenario, the report should include explicitly state that fee-for-service payments are not required under a single payer system. As I have said ad nauseum in Commission meetings, we should not contribute to the continued false assertion that single payer equals fee-for-service, especially given that the next section starts with "One of the major decisions to be made in designing a UF system is whether payments will be made directly from the UF authority to hospitals, physicians, and other health care providers, or whether capitated payments will be made to health plans or health systems, which in turn make payments to providers." For example, we also discussed time-based payments for things like care coordination for primary and preventive care providers. (2) Page 52: There could be much more said here

Name:	Response:	Comment (if not “Agree”):
		about the potential problems with risk-based capitation, which we discussed at Commission meetings, particularly because so much space is spent on the contrasting viewpoint on the use of risk-based intermediaries. Specifically, the mention that issues with risk-based capitation include “unproductive efforts to attract enrollees who are in relatively good health and avoid patients most in need of care” should be expanded upon. These kinds of provider behaviors of lemon dropping and cherry picking, which are incentivized by risk-based capitation, are in conflict with the goals of equity and access in a UF system. (3) Page 56: While I appreciate the description of my concerns about risk adjustment, particularly for providers who serve vulnerable populations, the description of my concern is incomplete. Risk adjustment also encourages provider gaming, particularly through the proliferation of health care algorithms, as well as fraud and abuse. Moreover, the heavy reliance on risk adjustment and health care metrics also contributes to high administrative burdens for solo and small practices and incentivizes consolidation of providers. While there is not enough space here to describe the attendant issues related to risk-adjustment and metrics-based and risk-based payment incentives, articles I cited throughout these comments and in my previous comments on the environmental report, the draft analytic findings, and in various surveys also provides additional information on problems in these kinds of metrics-based systems of accountability and risk-based payment schemes. As I have said at previous Commission meetings and previous surveys, the metrics used in risk-adjusted managed care payment schemes are easily gamed and ineffective guarantees of quality. We know from Medicare Advantage, which introduced intermediaries into Medicare, that risk-bearing intermediaries with closed networks are rife with fraudulent upcoding as they compete for the healthiest and avoid the sickest and most costly. Intermediaries game risk-adjusted capitation payments by diagnosing patients with severe

Name:	Response:	Comment (if not “Agree”):
		illnesses and then providing as little treatment as possible. I repeat some of my concerns again here which I believe should be mentioned in the report. • Risk-adjusted, capitation-based managed care systems incentivize providers to diagnose patients with severe illnesses and then provide as little treatment as possible. • As we have previously discussed and as the analytic findings bear out, risk-adjusted managed care and capitation have limited savings relative to the direct payments under a single-payer because of the high administrative costs. Additionally, it is difficult and possible impossible to effectively address the known problems of care denial in risk-based capitated systems. • For example, health care professionals serving patients under Medicare Advantage plans, including in California, have reported being pushed by management to go back through their care notes and retroactively diagnose patients with serious conditions to increase payments from Medicare, whether or not any services are provided to treat the condition. This increases the cost to the system and may have ramifications for the care patients actually receive. • Again, an article co-authored by our own consultant Rick Kronick demonstrates this kind of gaming within a risk-adjusted managed care system. The article examined what Medicare Advantage plans do with increased revenues for higher intensity coding of patient diagnoses – and the plans directed increased revenue towards medical-loss ratio at twice the magnitude as passing the money back towards patients. In other words, the economic motivation of increased payments for coding intensity doesn’t go back to patients or care but goes toward net revenue of the plan. • The California Health Care Foundation found that quality of care in Medi-Cal managed care was “stagnant at best” between 2009 and 2018. https://www.chcf.org/publication/close-look-medi-cal-managed-care-quality-trends/ (4) Page 56: It would be worthwhile here to note my repeated point that corporate integration and economic integration of provider interest is NOT required for care coordination and integration of

Name:	Response:	Comment (if not "Agree"):
		care. For example, researchers Brady Post et al. described vertical integration of hospitals and physician practices, concluding: "In light of this evidence [of vertical integration of hospital-physician practices raising concerns about anticompetitive behavior, spending increases, and uncertain effects on quality of care], it is worth questioning whether economic integration with hospitals is required for sharing clinical best practices." Post et al. "Vertical Integration of Hospitals and Physicians: Economic Theory and Empirical Evidence on Spending and Quality." Med. Care Res. Rev. 75(4): 399-433 (2018). FINANCING: (1) Page 59-60: The summary of the legal memo in the report is much more pessimistic on the prospects of redirecting Medicare funding into a UF system than the memo in Appendix D itself. Brown & Peisch, in their legal memo, state that CMS probably has the power—if it chooses to use it—to redirect Medicare funding into a UF system and proceeds to describe several possible forms for a Medicare demonstration waiver program (Pages 101-104). (2) Page 59: The discussion of federal waiver authorities in this section fails to mention, as we discussed in our meeting on federal waivers, that the federal health program waiver authority in Section 1332 of the PPACA would permit a state to apply for several federal health care waiver authorities in one single process.
Sara Flocks	2 = Somewhat Agree	I will submit written comments given the length of this section.
Jennie Chin Hansen	3 = Mostly Agree	There was broad discussion vs more specific; more time and detail n this area could highlight where we are in the continuum and activity towards UF.
Richard Scheffler	3 = Mostly Agree	It would be strengthened with more detail about the exact actions that are to be taken, by whom, and when.
Robert Ross	4 = Agree	A nice, fair and balanced job of summarizing Commissioner views
Andy Schneider	3 = Mostly Agree	On page 54 is the following statement: "Uniform benefit packages, a uniform data system, and the expectation of large and relatively stable membership will make much more transparent the

Name:	Response:	Comment (if not "Agree"):
		performance of plans or systems in assuring access to care, reducing disparities, and improving population health outcomes." Uniform benefits packages and data systems are critical and necessary to transparency, but they are not sufficient. Performance metrics on access to services, racial disparities, and population health have to be reported and publicly posted on a plan-specific basis. In my world, this is a child health dashboard, but obviously there should be dashboards for other populations as well. The paragraph at the top of p. 59 relating to the risk of the federal government reneging on an agreement to finance UF in California correctly makes the point that the risk is greater in the case of a waiver from the Executive Branch than in the case of legislation. But I don't think it gives enough weight to the risk that California's UF system would face as an expenditure item in the federal budget, where the pressure to reduce cap or reduce health care spending will only increase going forward (CBO projects that federal debt held by the public will increase from 102% of GDP at the end of last year to 107% in 2031). Capping California's UF funding and then dialing it down, or subjecting it to sequestration, will be a constant, growing risk, and while California might be able to protect its UF funding in the House if the entire delegation is on the same page, it will not be able to defend itself in the Senate.
Antonia Hernandez	3 = Mostly Agree	
William Hsiao	2 = Somewhat Agree	Some actions the Commission reviewed and discussed were downplayed and inadequately presented.
Cara Dessert	4 = Agree	

8. Regarding the Decisions and Actions Needed to Achieve Unified Financing presented in the draft report, do you:

Total Count:	
Agree as drafted	**2**
Agree with modest suggestions for improvement or clarification	**7**
Disagree	**1**

Name:	Response:	Comment (if not “Agree as drafted”):
Anthony Wright	Agree with suggestions	Beyond the detailing of the benefits of unified financing, this section is the heart of the report, detailing the various decision points that would need to be made. I think the report can serve to crystallize these decision points, and even where there wasn’t consensus, to detail and narrow options. Some of these decision points are not either/or. On cost sharing, I think the evidence suggests it is a tax on poorer and sicker people. It's not just the regressive nature, that a flat amount of cost-sharing falls harder on those with more limited means, but that those with conditions just rack up significantly more costs over a year. • While I can make a case for no cost-sharing, I recognize there was some discussion in the Commission about the potential use of nominal co-payments as a tool (albeit a blunt one) for utilization control. • That said, all cost-sharing is not equal--I don’t think anyone on the Commission argued for co-insurance, which is inherently deceptive to consumers (nobody knows that 10% of a hospital bill is still a really big bill), or even deductibles, which is mainly a mechanism to shift costs from the premiums. • The Commission should clearly come out against those forms of cost-sharing at a minimum, even if there isn’t complete consensus on prohibiting co-pays entirely. • Just to be clear, on the statement about “Copayments or coinsurance, if any, should reflect individuals and households ability to pay,” I was a commissioner that generally agreed with the sentiment about “ability to pay,” but I am opposed to the inclusion of “coinsurance” being included as a "consensus" item, and would ask than that bullet be edited. • I would also point out that the issue is not just “ability to pay” but also the disproportionate impact of cost-sharing on those who are sick. People rallied around the ACA concept that we shouldn’t have to pay more based on our medical conditions--and that should have been a "goal and value" that we tested on. Yet those with “pre-existing conditions” still pay more, not through

Name:	Response:	Comment (if not "Agree as drafted"):
		premiums, but through cost-sharing. • Finally, I note that the modelling for cost sharing suggested a 94% AV for populations above 138% of the poverty level, but since an actuarial value is an average across an entire population, it is still regressive as impacting sicker groups much more, and that average may be meaningless to an individual consumer. 94% AV is not scaled to income, and would increase cost burdens automatically as health costs rose. Our experience with Covered California showed how we can provide scaled cost-sharing based on income. Again, even if the system includes cost-sharing, we could and should envision something better than what was modeled. On other forms of utilization management, like networks and formularies (which are the current, and less-than-effective means to negotiate with providers on cost and quality now), the report says "the tradeoffs were not fully examined," and "any future design…will need to consider mechanisms to ensure appropriate care and management of costs." We would benefit from fleshing this out more but recognize it may not be in this report due to time constraints. The discussion of intermediaries seems to have conflicting conclusions, some of which did not seem to be the majority of the Commission. Some paragraphs suggest the goal is to "unwind managed care" and go back to fee-for-service; others suggest a system could maintain for-profit health plans mostly as they are today. My sense was that there was some skepticism in both directions. • I appreciated the chart on page 57 on "care coordinating entities." To the extent there are intermediaries, or "systems," or coordinators of care, it was useful to indicate what functions were still with the unified system, vs what would be done by this care coordinator. • In this model, one might look at existing health systems, and to readjust the role of the local initiatives in Medi-Cal. Further clarification could indicate that these would not be the for-profit insurance companies of

Name:	Response:	Comment (if not "Agree as drafted"):
		today. • The question of how to pay providers is key, to incentivize the right behaviors, focus on equity to get key providers in key areas, etc., could use more discussion. On financing and getting federal waivers, we appreciated the legal memo—to augment the significant expertise of our appointed Commissioners, which should be detailed in the report for appropriate context. The detailing of the changes needed to the California Constitution was also helpful in being clear-eyed about the work ahead.
Carmen Comsti	Agree with suggestions	Agree with modest suggestions for improvement or clarification. Please see my comments and recommendations in Question 8 and my comments below. (1) Page 53: Refrain from using industry sources, particularly to justify claims about risk-based integrated health systems. I saw some problematic use of industry sources to justify claims in the report, and I strongly urge these industry sources to be deleted in their entirety from the report and that non-industry produced sources are used. • For example, the Integrated Healthcare Association, which is a non-profit business league that represents the interests of its member corporations and has an interest in maintaining the status quo health plan intermediary system, should not be used to support claims related to utilization and quality of care under capitation (Footnote 45). It is inappropriate and misleading to cite to industry reports on these types of claims, particularly when there is disagreement among Commissioners as to the veracity of the purported claims of various health system design choices. In the case of the Integrated Healthcare Association report, I strongly disagree that there is sufficient evidence to make the claim that capitation improves quality of care. • For a contrasting research-based perspective on capitation that should be cited in the report: - Researchers Brady Post et al. described vertical integration of hospitals and physician practices, finding that

Name:	Response:	Comment (if not "Agree as drafted"):
		"While increased efficiencies may be possible, emerging research raises concerns about anticompetitive behavior, spending increases, and uncertain effects on quality." Post et al. "Vertical Integration of Hospitals and Physicians: Economic Theory and Empirical Evidence on Spending and Quality." Med. Care Res. Rev. 75(4): 399-433 (2018). - In a 2021 working paper from the National Bureau of Economic Research, Cutler et al. describe some existing research on issue of "self-referrals" in vertically integrated health care providers: "In the context of vertical mergers among health service providers, one specific concern is the risk of inefficient "self-referrals" to co-owned providers. These referrals may be for care that is unnecessary (and potentially harmful, beyond being costly), as shown in Afendulis and Kessler (2007). Providers might also refer patients to co-owned providers who are higher-cost or lower-quality than alternative providers, as found in Baker et al. (2016)." Cutler et al. "Vertical Integration of Healthcare Providers increases Self-Referrals and Can Reduce Downstream Competition: The Case of Hospital-Owned Skilled Nursing facilities." National Bureau of Economic Research, Working Paper 28305 (2021). (2) Add more detail on my concerns about risk-based payments and risk-adjusted managed care. I repeat my earlier comments on the topic here, which should be incorporated into the report to provide a more balanced discussion of these issues. As I have said at Commission meetings and in previous surveys, the metrics used in risk-adjusted managed care payment schemes are easily gamed and ineffective guarantees of quality. We know from Medicare Advantage, which introduced intermediaries into Medicare, that risk-bearing intermediaries with closed networks are rife with fraudulent upcoding as they compete for the healthiest and avoid the sickest and most costly. • Risk-adjusted, capitation-based managed care systems incentivize providers to diagnose patients with severe illnesses and then provide as little treatment as possible. • As we have previously discussed and

Name:	Response:	Comment (if not "Agree as drafted"):
		as the analytic findings bear out, risk-adjusted managed care and capitation has limited savings because of the high administrative costs. Yet, the known problems of care denial in risk-based capitated systems show that they remain ineffective. • For example, health care professionals serving patients under Medicare Advantage plans, including in California, have reported being pushed by management to go back through their care notes and retroactively diagnose patients with serious conditions to increase payments from Medicare, whether or not any services are provided to treat the condition. This increases the cost to the system and may have ramifications for the care patients actually receive. • Again, an article co-authored by our own consultant Rick Kronick demonstrates this kind of gaming within a risk-adjusted managed care system. The article examined what Medicare Advantage plans do with increased revenues for higher intensity coding of patient diagnoses – and the plans directed increased revenue towards medical-loss ratio at twice the magnitude as passing the money back towards patients. In other words. the economic motivation of increased payments for coding intensity doesn't go back to patients or care but goes toward net revenue of the plan. • The California Health Care Foundation found that quality of care in Medi-Cal managed care was "stagnant at best" between 2009 and 2018. https://www.chcf.org/publication/close-look-medi-cal-managed-care-quality-trends/. (3) Page 53: Delete the use of the term "low-value care". Generally, implying that a benefit of risk-based capitation is the reduction of "low-value care" is misleading and inappropriate. Whether or not care is of "high" or "low" value largely cannot be ascertained until after care is provided. The goal of reducing low-value care results in assumptions being made about what kinds of care should or should not be provided for a patient, which can result replication of provider and health plan racial and other biases about a patient's health. Additionally, patients – particularly a patient who is

Name:	Response:	Comment (if not "Agree as drafted"):
		not a medical professional – should not be expected to whether care is necessary or not. For example, a patient should not be expected to know that a doctor's visit for migraines were not necessary until it is ruled out that they don't have some other issue. Or a patient may seek a second opinion from a doctor that provides more culturally competent care but a risk-based capitation system may deem that second doctor's visits for a second opinion as "low-value." The point being here is that the use of the term "low-value care" is problematic both because it is undefined in the report and because it implies a value assessment of different kinds of care which may not be universally applicable to every patient. As I have said previously, the report should not be using jargon like "low-value care" because what a health plan deems to be low-value care may be necessary care for a particular patient. Similarly, what may be considered "low-value" care for a population may actually be necessary care for a particular patient. (4) Page 54: In this section, there are assumptions incorrectly presented as a statement of fact about how health plans or systems would be incorporated under a UF system. • Specifically, one part of this section states: "Under UF, all health plans or systems would be required to offer the same set of benefits and – if copayments are used at all – the same copayment structure. Each plan or system will have a single contract with contracted health care providers." These sentences about what health plans would look like under UF are not a given. While some Commissioners may have suggested that standardization among health plans and systems should occur, it is wrong to imply that a UF system with health plan would necessarily have standardization among plan benefits, copayments, etc. • These paragraphs should change the word "would" to "could" because the enacting framework for the system would have to include these requirements. It is dangerous to assert that health plans would be subject to contracting and benefits standards, because we should reasonably expect that health plan will

Name:	Response:	Comment (if not "Agree as drafted"):
		lobby against this kind of standardization in that it could reduce revenue generation and net revenue for the plan. Importantly, the Commission should not incorrectly convey to the public that any UF system with health plans would include robust plan standards and regulatory oversight of health plans. • Moreover, as I have said previously, I do not think any system with health plans can be considered a unified financing system, as payment would be coming from a system that is separate and apart from the UF system and health plans would continue to bear financial risk. (5) Page 56 – This section should note that corporate integration and economic integration of provider interest is NOT required for care coordination. As Post et al. (2018), concludes: "In light of this evidence [of vertical integration of hospital-physician practices raising concerns about anticompetitive behavior, spending increases, and uncertain effects on quality of care], it is worth questioning whether economic integration with hospitals is required for sharing clinical best practices." FINANCING: (6) Page 59-60: The summary of the legal memo in the report is much more pessimistic on the prospects of redirecting Medicare funding into a UF system than the memo in Appendix D itself. Brown & Peisch, in their legal memo, state that CMS probably has the power—if it chooses to use it—to redirect Medicare funding into a UF system and proceeds to describe several possible forms for a Medicare demonstration waiver program (Pages 101-104). This section should be edited to align more accurately with the Brown & Peisch legal memo. SYSTEMS AND INFRASTRUCTURE: (7) Page 65: I think it should be noted that a "secure and seamless" electronic HIE is ideal but not a necessary prerequisite for a UF system.
Sara Flocks	Agree with suggestions	I will submit written comments
Jennie Chin Hansen	Agree with suggestions	As above, a more robust linking of the dots of where we started two years ago vs a vs now with CalAIM and other efforts to security quality, accountability and infrastructure (e.g. data design

Name:	Response:	Comment (if not “Agree as drafted”):
		and tech alignment for data exchange and access).
Richard Scheffler	Disagree	The plan to move to universal financing is still incomplete and not well spelled out, nor is there a timeframe or step-by-step approach discussed.
Robert Ross	Agree with suggestions	I think the UC decision/action section is excellent on analysis and tradeoffs, and the attention to waiver needs is clear and undeniable. But we need to put some boldness into needed actions. We have to land as a Commission on the tradeoffs, but this section needs to read more boldly and decisively before its ready to be shipped to the Governor.
Andy Schneider	Agree with suggestions	On p. 44 is the statement: "This section highlights the range of decisions and actions that will be required to establish UF." The implication is that this is the full range of issues that will need to be addressed. Of course, it's not. Both in this section of the report, and at the beginning, it should be emphasized that we were only able to discuss some of the design issues, that we did not reach resolution on many of the ones we did discuss (nor were we expected to), and that the purpose of this section is to give readers a sense of the complexity of transitioning to UF and the range of views among reasonable experts who support UF. It would be unfortunate for the report to leave readers with the impression that this transition will be a walk in the park with a magic wand. For example, also on p. 44 is a brief discussion of residency criteria. Because we want all residents covered regardless of immigration status, who is a resident is a very big deal. It affects the cost estimates -- if citizens and non-citizens alike learn that health care is "free" in California, many who need health care will come to California, or be encouraged to come by other states (think of the 12 non-expansion states). Of course, it's not the Commission's job to resolve this. But the report shouldn't leave the impression that it is a minor issue or that it has been resolved. On p. 57 is one paragraph on cost containment. If I were looking for an easy target to attack the credibility of this report, it would be the fact that in a 112-page report there is only one paragraph on cost

Name:	Response:	Comment (if not "Agree as drafted"):
		containment. There are several cross-references in the paragraph that build out the substance, but optically it is very low-hanging fruit for UF opponents.
Antonia Hernandez	Agree as drafted	
William Hsiao	Agree with suggestions	The Commission agree with the critical importance of obtaining federal government's agreement of federal financing support. However, meantime, CA can take several concrete measures to advance UF.
Cara Dessert	Agree as drafted	

Report Section 6: Priority Actions and Next Steps

9. The Priority Actions and Next Steps section is an accurate representation of Commissioner discussion and input on that topic.

Total Count:	
4 = Agree	**2**
3 = Mostly Agree	**5**
2 = Somewhat Agree	**2**
1 = Disagree	**1**

Name:	Response:	Comment (if not "Agree"):
Anthony Wright	3 = Mostly Agree	I agree that the question of federal partnership is a threshold issue, alongside other threshold issues, including getting the state financing, and the need to go to the voters and get the public's trust to make such a transition. On the list of actions, the list is useful and long on what the state of California and the Newsom Administration is already doing (for which we are deeply involved and proud of our state's leadership). The list is shorter on what else the state can could be doing that we aren't already. I would appreciate more detailing on specific, sequential steps that California can take that can help with our transition to a universal system with unified financing—the work to move forward even as we get legislative consensus and federal permissions. • We need to address the disparities

Name:	Response:	Comment (if not “Agree”):
		in rates and payments. In a current system world where hospitals get paid anywhere from the Medicare rates to over four times the Medicare rate for key services, we will need mechanisms to narrow those extreme differentials over time. • Similarly, can we start to further align benefits and contracting between public and private payers, and even start to set up a system of enrollment, especially as California moves to a place where everyone is eligible for something. We could even have a common benefit card & database for all Californians, even as we work on unifying the financing elements? • Given the extremely high bar for getting Medicare waivers, is there a way to structure a proposal where we start with unified financing for the under 65 population first, while we wait and explore the ways we could get a permission on Medicare? Again, I very much appreciated the list of the good work California is already doing and putting all these efforts into a frame about how these steps get us closer to universal coverage and unified financing. I would just hope there are further suggestions, and that the report takes advantage of our brainstorming.
Carmen Comsti	1 = Disagree	I strongly disagree that this section of the report as drafted represents the Commission’s discussion on the issue. I also strongly disagree with the section on “Steps on the Path to Unified Financing under State Authority.” (I am addressing the "Steps on the Path..." section here because there is no separate question for that section.) We simply did not discuss the vast majority of the actions described in this section, primarily the Administration’s current actions on health care (Pages 67-73) nor did we discuss at any length the concept paper by CHHS or timeline presented on page 84. This section should be deleted and actions listed in this section should not be presented as being discussed or endorsed by the Commission. (1) The ongoing CHHS planning and design role in UF was not discussed at the Commission. There is a recommendation that CHHS secure dedicated staff to develop a concept

Name:	Response:	Comment (if not "Agree"):
		paper and engage with federal partners, but we did not discuss this at the Commission meeting on transition and sequencing. There is also a lack of detail in this CHHS plan aside from a lengthy timeframe for completion. But of course, the devil is in the details about who is a stakeholder and how the legislature will be engaged, which must be engaged in certain elements of UF design. The 2-3 year timeline for issuing a CHHS concept paper was never discussed at the Commission. Not only is it procedurally improper to include this recommendation in the report given that the Commission did not discuss this CHHS concept paper and a 3-year timeline, but this recommendation substantively means that the Commission has failed at our charge to deliver a plan for UF, including single-payer, to the Governor and legislature. It is the Commission's charge, not CHHS, to establish a plan for UF, including single-payer. This recommendation kicks the goal post to 2 to 3 years down the road and hands our responsibility to create a plan for our state to a closed process within CHHS. As we've mentioned in our work on the Commission constantly, the need for unified financing is immediate – Californians will suffer and die because of delays. I frankly question the purpose of this Commission if the result is that we hand our work over to CHHS staff to chew on for another number of years and further delaying action. As I discuss more in the next question, the process of the proposed CHHS concept paper is also problematic and undermines the principle of community engagement and transparency that the Commission was striving to meet. (2) The Administration's current plan on health care reform, which includes proposed actions that are not accurately characterized as steps toward UF or single-payer, were not discussed in the Commission meetings (Pages 67-73). There is a lengthy discussion and description of the Administration's current plan on Medi-Cal, health care program budgets, and other health care related reforms, but the Commission did not discuss the Administration's plan in any detail.

Name:	Response:	Comment (if not "Agree"):
		This is the first time that the vast majority of the Administration's plan has been presented, let alone considered, by the Commission. As with other parts of this section, this discussion mischaracterizes all the actions within the Administration's current health care proposal as steps toward UF. I would characterize some of these steps as additional regulation of the status quo but not necessarily steps towards advancing us towards UF. I also have substantive concerns about several of the programs listed in the discussion of the Administration's plan. If we had had a discussion of the Administration's plan, I would have raised these concerns in more detail. I briefly touch on some of these substantive concerns at the end of my response to Question 10. (3) This section incorrectly presents a deterministic sequence of actions to achieve UF, representing all possible health care reforms as necessary steps to achieve UF. This section does not distinguish between actions that are or could be done and actions that are necessary to achieve UF. Problematically, this lack of clarity creates an implied logical fallacy that all the actions listed – both the current actions by the Administration and the actions listed in Table 7 – are necessary steps to UF. • This section does not distinguish between actions that are or could be done and actions that are necessary to achieve UF. Problematically, this lack of clarity creates an implied logical fallacy that all the actions listed – both the current actions by the Administration and the actions listed in Table 7 – are necessary steps to UF. • There is at least some disagreement among Commissioners about what is or is not necessary to achieve UF and what can be done on parallel tracks. The draft report's presentation of a strict sequencing of steps (ex. Table 7) may ultimately undermine any progress towards UF. It should be reflected somewhere that we can do multiple actions on parallel tracks AND that each of the actions listed may not be necessary steps. • Table 7, for example, implies that everything under "lay the foundation" is necessary to achieve UF, but that is inaccurate. • With respect to the

Name:	Response:	Comment (if not “Agree”):
		actions related to Medi-Cal listed in the Administration’s current health care reform plans, the report fails to recognize that Medi-Cal itself is a highly fragmented financing system with numerous health plans bearing risk. Thus, having California pay Medi-Cal providers directly rather than through managed care organizations would be a major step toward a UF system. (4) This section does not include important steps and actions that we’ve discussed throughout the Commission around legislation. There is no mention in Table 7 that legislation and enactment of a law to establish and implement UF is necessary, particularly with respect to applying for federal waiver authorities. As I discuss more below in response to Question 12, it is inaccurate to call “federal permissions”, which I assume to mean federal waiver authorities, to be a threshold issue. As I mentioned in our federal waivers discussion, state law enactment of the policy of single payer or UF is needed before the federal government can consider certain federal waiver applications complete. Without requisite state law being first enacted – specifically an application under federal waiver authorities in Section 1332 of the PPACA – the federal government cannot grant “federal permissions”. Therefore, it is inaccurate to call federal permissions and federal funding a “threshold” question.
Sara Flocks	2 = Somewhat Agree	I don't think this section captures the urgency of moving to a UF system. For one, it doesn't reiterate the massive amount of potential savings in the billions to the state of adopting UF. It's not just about being affordable to individuals, it's that the current system is unaffordable & unsustainable to the state and every Californian. I also think it should be more clear that UF is needed as a FOUNDATION for the other reforms in process. As is stated on page 76 the current fragmented system "impose admin burdens, dilute efforts to improve outcomes & provide opportunities to game the system" That is a key point that needs to be expanded. Without UF or single payer, all other reforms put bandaids on a hemorrhage. I also think that there was discussion about federal

Name:	Response:	Comment (if not “Agree”):
		waivers that is not captured in this section that I'll expand on in the next comment box. The section on Federal permissions also needs clarifications. I would recommend the following: The state could begin by informally engaging with CMS to determine what the federal government would consider and to start a negotiation with them outside of the formal waiver process. Then the legislature could authorize CHHS & the admin to negotiate over waivers based on the broad outlines of this report. That way we could start the federal waiver process immediately while simultaneously developing the policy for the UF system. That way the discussions could inform each other rather than developing a formal proposal to shop to the feds. This gives California flexibility to adapt to federal requirements or priorities and to develop a system that will get the approvals necessary to move forward. Make the path by walking!
Jennie Chin Hansen	3 = Mostly Agree	I would say broadly yes; the report has more good detail of policies, new policy/legislation. It would be good to visualize across a continuum line in planning and next steps.
Richard Scheffler	3 = Mostly Agree	This is a very important section and still needs to be rewritten as an action plan that specifies what is to be done, by whom, and most importantly, when.
Robert Ross	4 = Agree	I think the report does a nice job of asserting the criticality of getting the waiver right and supported as a prioritized action, and represents Commissioner views fairly.
Andy Schneider	3 = Mostly Agree	On p. 77: "If necessary, the state should work with federal partners to advance legislation to enact needed federal waiver authority." It will be necessary, of course, so it is EXTREMELY important that the following guidelines be added. First, any waiver authority must prohibit the Secretary from altering in any way the enforceable individual entitlement that Medicare and Medicaid beneficiaries now have to a defined set of benefits (e.g., the Secretary could not waive EPSDT benefits for children, as has happened since for the past 30 years in Oregon). Second, any UF waiver authority would have to apply to all three

Name:	Response:	Comment (if not “Agree”):
		funding streams: Medicare, Medicaid, and Marketplace subsidies. If the UF waiver legislation moves through the Congress, the pressure will be enormous to exempt Medicare, and let the Secretary block grant Medicaid (as Seema Verma illegally but effectively did for Tennessee even under current 1115 authority). As you note, Secretaries come and go. There's another risk, and it's not just to California. For opponents of UF, legislation creating a new waiver authority would be an ideal opportunity to enact a Medicaid block grant waiver authority, which many conservative Governors and their Congressional delegations would support. One can imagine a bargain: we'll support a UF waiver for California if you support a block grant waiver for us. It could get very tricky. On p. 78, this item is in both the "broad agreement" and "not so much agreement" lists: "Establish global budgets and all payer rate-setting and begin to address existing payment variation." I don't understand the distinction that Table 6 is trying to suggest. Why not combine the "among 3 most important" and "very important." Isn't the point that for most of the items, few commissioners thought they were not important? Figure 7 is mystifying. The red line collides with the blue line and disappears while encircling the threshold issue. What meaning is that visual trying to convey?
Antonia Hernandez	3 = Mostly Agree	
William Hsiao	2 = Somewhat Agree	The "North Star" gives the direction and benefits of UF. The threshold issue and the measures already taken or proposed by Governor Newsom are laid out clearly. However, the proposed actions are mostly the creation of new bureaucratic organizations and rely on them to do something, little clear concrete specific programmatic actions are laid out. From our presentations and discussion, the Commission could recommend several concrete actions. For one simple example, require hospitals to use standard cost accounting method to calculate the cost of specific hospital services. This information would be used to decide the "reasonable" level of

Name:	Response:	Comment (if not “Agree”):
		payment for these services as well as identify which hospitals are more efficient or less efficient.
Cara Dessert	4 = Agree	

10. Regarding the Priority Actions and Next Steps presented in the draft report, do you:

Total Count:	
Agree as drafted	**1**
Agree with modest suggestions for improvement or clarification	**7**
Disagree	**2**

Name:	Response:	Comment (if not “Agree as drafted”):
Anthony Wright	Agree with suggestions	See above...
Carmen Comsti	Disagree	I disagree with this section on Priority Actions and Next Steps as presented in the draft report both because of the issues I raise above in my response to Question 10 and for the following reasons. While I do believe there are areas that could be edited for clarification, the bulk of this section, including the discussion of the Administration’s current health care plan, the proposal that CHHS develop a concept paper on UF, and the proposed sequencing of actions, are deeply problematic and I cannot agree to them. Not only did we not discuss the vast majority of actions and proposals discussed in this section, but the proposal that CHHS take the next 2 to 3 years to develop a concept paper on UF fundamentally abdicates our responsibility as a Commission to providing the people of California, our state government, and our lawmakers with a viable path toward UF, including single-payer. The recommendations in this section, which were developed by the drafters of the report outside of the public Commission process, have not been discussed by or presented to the Commission and conflict with many of our efforts to ensure that the process of developing a UF program are transparent and allow for robust public engagement. I also want to reiterate and expound upon a few points I made in response to Question 10, and I have some suggestions around the discussion of Appendix E and ERISA that

Name:	Response:	Comment (if not "Agree as drafted"):
		should be incorporated into the Appendix or this section. (1) I disagree that each of the actions proposed under the Administration's plan (Pages 67-73) would advance California toward UF or single-payer. First, there are several pieces of the Administration's current plan that can be done in parallel to the adoption and implementation of a single-payer or other UF system or even after a single-payer or other UF system is adopted, but these actions do not necessarily advance us towards single-payer or UF. This section wrongly implies that all of these steps are necessary steps that must occur before we adopt and implement a single payer or other UF system. Importantly, many of these efforts would actually be easier to implement and more effective if we adopt a UF system first. This includes the following: - Building a workforce for a healthy California for all - Children and Youth Behavioral Health Initiative - Behavioral Health Continuum Infrastructure Programs - Implementing the "No Wrong Door" policy for behavioral health services - Care coordination through HIE - Office of Health Care Affordability - Health Care Payments Data Program - Reducing the cost of insulin through CalRx - Fortifying the public health system - Hospital equity reporting - DMHC Health Plan Quality and Equity Standards Second, there are several recommendations that, while they could be beneficial in expanding coverage under our current system, are not steps that advance California towards UF and should not be characterized as such. These actions of the Administration's plan are piecemeal efforts to reform our current multi-payer system of insurance and, unfortunately, will not end California's health care crisis. These actions may make the current system more tolerable for some Californians but ultimately they cannot be characterized as steps towards single-payer or UF. These actions include: - Expansion of Medi-Cal To All Income-Eligible Californians - Individual Mandate and Marketplace Premium Subsidies - Multi-Payer Alignment Efforts to Maximize Impact on Quality and Equity With

Name:	Response:	Comment (if not "Agree as drafted"):
		respect to the actions related to Medi-Cal listed in the Administration's current health care reform plans, the report fails to recognize that Medi-Cal itself is a highly fragmented financing system with numerous health plans bearing risk. Thus, having California pay Medi-Cal providers directly rather than through managed care organizations would be a major step toward a UF system. Finally, and importantly, there are several parts of the Administration's plan that I have concerns about and I disagree with their inclusion in the Commission's report as recommended actions, namely the telehealth waivers and blanket endorsement of CalAIM, without having an adequate forum to discuss these concerns. This survey is an insufficient forum to express such concerns. (2) I disagree with several of the statements in the "Federal Permission and Federal Funding" section. - Page 76: The plan laid out here misses that the federal government, meaning the HHS Secretary, cannot commit to approving (or preapproving) a federal waiver before California applies for waivers. Moreover, California cannot apply for a consolidated federal waiver application (i.e., where a state can apply for several waiver authorities at one time) under Section 1332 of the PPACA until the state has enacted state law, through legislation, regarding the underlying program it is seeking waivers for. - Page 77: The description of ERISA preemption review is incorrect and misleading. The state does not need to provide "assurances" to the federal government or any entity on ERISA to implement a UF program. While politically it may be wise for California understand how a program may be subject to ERISA preemption litigation, there is no federal statutory or regulatory process that requires "assurances" be made by a state prior implementation of a state health care program. ERISA preemption analysis is not part of the federal waiver application review process and the bullet points on this page incorrectly imply that a state has to prove ERISA nonpreemption to some unnamed entity prior to implementation of a UF program. - Page 77: I have additional

Name:	Response:	Comment (if not "Agree as drafted"):
		recommendations below about improving Appendix E on ERISA. (3) Some modifications and clarifications are necessary in the "Commissioner Perspectives on Priority Actions. - Page 78: As I have mentioned before, several of the bullet points listed on this page are not steps on the path to UF. Namely, "[b]uilding on California's large integrated delivery systems, refine and expand efforts to align payments with value" are not steps on the path to UF. I strongly believe this bullet point should be deleted. Additionally, it should be made clear that none of these steps in these two bullet point lists are prerequisite steps on the path to UF. I discussed this issue above in response to Question 10 as well. As written, this section wrongly implies that "important" steps are somehow requisite steps. - Page 78: This page confusingly lists global budgets and all payer rate settings in both the "important" steps list and in the list where agreement on importance was not as strong. (4) There are several problems with actions described in the "Moving Forward" section. The actions described here are presented as necessary steps to UF, and this section incorrectly implies that there is a strict sequencing of actions that must take place on the path to UF. - Page 82: The following statement in the report is deceiving and may be setting California up for failure: "If there is a pathway to clear the threshold issue of federal permissions and federal funding, a community and stakeholder engagement process can be convened to describe implications of options and alternatives, hear concerns, and incorporate priorities." It is not clear what is meant by a "clear" pathway to federal permissions. As we discussed at Commission meetings, there cannot be 100% certainty that any given program will be approved for federal waivers. Even with the most willing federal partner, the HHS Secretary cannot provide preapprovals of waivers before an application is submitted. - Page 83: First, the "Stages to California's Path to Unified Financing" table (Table 7) incorrectly presents all of the actions in each of the columns as prerequisites to

Name:	Response:	Comment (if not "Agree as drafted"):
		UF. Second, the sequence of the three columns fails to recognize that some of these actions can be done in parallel sequencing. • For example, in the "Lay the Foundation" column several actions can be done after a UF system is adopted, including "Collect and use health care payments data", " Achieve health information exchange", "Standardize and align payments for care, including payments associated with cost, quality, and equity", "Demonstrate pharmaceutical cost savings", and "Enact Office of Health Care affordability to establish spending targets". Moreover, each of the bullet points I just listed will be ineffective or dramatically less effective without the administrative simplicity and ability to enact uniform standards under a UF system. • Table 7 also fails to clarify that passing state legislation is a step that must come before governance structures are established. The Administration cannot simply create a UF program without the necessary state legislation lawfully creating such a program. (5) I disagree with the recommendation on Page 84 regarding CHHS's ongoing unilateral role in planning and design UF. In addition to the problems with this recommendation that I describe in my response to Question 10, I want to highlight a number of other fundamental problems with this recommendation. • First, this proposal would delay even coming up with a basic design for a system to 2024, which would have disastrous results for the health and lives of Californian's who need health care today. I am not and the Commission should not be willing to acquiesce to self-imposed administrative delays on health care reform. Once the Commission's report is submitted to the legislature and Governor it should take days or weeks not years for the legislature and Governor to act. The Commission should urge the legislature and Administration to act with absolute urgency. We know that any delay will be paid through the health and lives of Californians. • Second, in addition to abdicating the Commission's responsibility to CHHS in creating a plan for UF and single-payer, this plan would fail to involve the legislature. This proposal

Name:	Response:	Comment (if not "Agree as drafted"):
		hands over the power and responsibility for determining the details of a single payer and UF system to a state agency when the legislature should and must be involved in making those decisions. • Third, the CHHS concept paper process is not subject to transparency, fundamentally rejecting the Commission's consistent calls for ensuring public engagement in the process of creating a UF program. Specifically, the plan merely plays lip service to transparency and public participation by slating community and stakeholder engagement to occur only AFTER a concept paper is developed and submitted to federal and state agencies by CHHS. • Fourth, the stakeholder engagement process wrongly puts industry interests on equal footing as the interests of patients and frontline health care workers. We cannot expect consensus between corporate interests and the interests of patients, nurses, and other health care workers. There should be a clear understanding that patients as stakeholders and health care professionals (doctors and nurses rather than administrators and health systems) should lead and be actively engaged in the design process. (6) Appendix E: The report overstates the risk that the three models discussed in Appendix E for avoiding ERISA preemption will be unsuccessful if judicially challenged (especially the second bullet point on Page 111). At the same time, Appendix E does not give adequate attention to the three major court decisions which have paved the way for the three approaches discussed. Specifically, two decisions demonstrate that the U.S. Supreme Court views cost and reimbursement regulations (even if they place substantial pressure on employee benefit plans) as outside of the scope of ERISA preemption: (1) the recent 2020 U.S. Supreme Court decision in Rutledge v. PCMA, 141 S. Ct. 474 (2020) which clarifies that states are free to regulate the reimbursement practices of prescription drug benefits plan administrators; and (2) N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995) which found that states can

Name:	Response:	Comment (if not "Agree as drafted"):
		require hospitals to add a 24% surcharge to any bills where Blue Cross & Blue Shield was not the insurer and a 13% surcharge to all bills paid by self-funded plans. Additionally, in Golden Gate Restaurant Association v. City and County of San Francisco, 546 F.3d 639 (9th Cir. 2009), the Ninth Circuit upheld the employer health care expenditure requirements in San Francisco's Healthy San Francisco program because it did not require employers to have their own health plans which would be the exact same outcome of the proposed payroll tax as a funding mechanism. Accordingly, the report should at the very least note that there is some helpful precedent that would support the legality of the three models discussed in Appendix E. (7) Question 12 on "federal permissions and federal fund": I also want to address Question 12 on federal permissions and federal funding here because that question does not have a comment box. I'm not sure what "threshold issue" means in this context. I think this language incorrectly implies that California must first obtain federal waivers and secure federal funding BEFORE taking action to establish a UF system. However, the opposite is true. California needs to have the necessary legal authority under state law to implement such a UF system before we can obtain necessary federal waivers. Even though the Administration or CHHS could certainly discuss and engage with the federal government on what UF system federal HHS potentially would and could consider under federal waiver authorities, we need to enact state law on UF before the federal government can act on and approve a federal waiver application. This means that the threshold issue is designing a UF system, passing legislation, and only then can California obtain "federal permissions and federal funding." Importantly, the report oddly does not mention the need for legislation in order to obtain "federal permissions and federal funding". As I said in my presentation on federal waivers, a requirement for obtaining a consolidated federal waiver under Section 1332 of the PPACA, which allows a state to apply under multiple waiver

Name:	Response:	Comment (if not "Agree as drafted"):
		authorities in one process, a state must have "enacted" state law. To put it plainly, if there is no state law establishing the legal infrastructure to implement the UF program and if there is no state law authorizing a state entity to apply for a federal waiver, then federal permissions and federal funding could not be obtained. California cannot apply for a federal waiver under Section 1332 without having an actual UF program established under state law through legislation. Additionally, a state government must have the authority to apply for a federal waiver for the purposes of such a UF program. Therefore, the threshold issue is establishing a UF policy through the legislative process. California cannot obtain "federal permissions and federal funding" without establishing the legal foundation for the UF program under state law. It also bears repeating here that California cannot expect the federal government to pre-approve a UF program. The federal waiver application process does not permit federal HHS to preapprove a program for a federal waiver. The federal government is required to be a good steward of federal health care dollars and must know that a program exists under state law before it approves waivers.
Sara Flocks	Agree with suggestions	I would refine the section on Priority Actions which is now a list of actions. The actions that Commissioners ranked in a survey could be grouped into different sections such as Data Infrastructure, Workforce, Federal Action, Payment & Cost Containment. In addition, Professor Hsiao gave the most compelling list of 6 priority actions in one of our sessions that I would urge is reflected in this report. I will include his points in separate written comments because they detail both the structural steps that need to be taken along with steps to address the political challenges of getting Californians to support and vote for necessary changes to move toward a UF system.
Jennie Chin Hansen	Agree with suggestions	Since Medicare is such a big integration along with employees, I think initiating a survey to see how beneficiaries understand what is being

Name:	Response:	Comment (if not "Agree as drafted"):
		proposed, implications and concerns and issues to mitigate and address.
Richard Scheffler	Agree with suggestions	Given that policy actions are based on what I consider unlikely changes in the healthcare payment system, which has CA returning to a fee-for-service system at its base, I cannot support these recommendations.
Robert Ross	Agree with suggestions	This section is just okay. It needs (and we need) to turn up the energy and passion dial here with some bolder recommended actions, such as: 1) getting to 100% coverage thru Governor & Legislative action asap (medi-cal for all via presumptive eligibility?); 2) bolder action regarding steps to UF and market/purchasing power (like combining/aligning Medi-Cal + Covered California + CalPERS in purchasing and pricing power); 3) full-bore and unapologetic assertion of racial equity and health equity/social drivers in quality and performance measures. Bolder, the report is strong on analysis and tepid on action.
Andy Schneider	Agree with suggestions	pp. 81 and 82, summarized in Table 7, outline a path to UF. What's missing is the state revenue changes that will like be necessary. I agree that there's no point putting the state through the mill of a referendum on UF without first getting sign-off by the federal government on redirecting Medicaid and Medicare funds and Marketplace subsidies. But even if the state gets this, it can't jump to implementation without making its revenue base adequate and sustainable.
Antonia Hernandez	Agree as drafted	
William Hsiao	Disagree	The draft report does not give concrete new actions and targets to move CA forward toward UF in parallel while the state works with federal government on federal funding.
Cara Dessert	Agree with suggestions	Overall this section was strong, but one nagging thought: I believe we could state more strongly in this section that even if we don't obtain federal approval or this approval becomes a long term goal, we could still significantly improve healthcare for CA. Related to question12 below: While I do agree that federal funding is an initial question that must be explored and answered before we see what options are possible, this draft seems to

Name:	Response:	Comment (if not "Agree as drafted"):
		define "threshold" as an initial obstacle to all progress on healthcare, which I disagree with. Certainly, progress and reform are far easier with federal funding, but even without – or with a long view on obtaining that, I believe this Commission has explored myriad ways in which to meaningfully improve healthcare for CA. Can we state that more clearly and emphatically?

11. With respect to specific next steps, the report states that obtaining federal permissions and federal funding is a "threshold issue" in developing a unified financing system for California. Do you agree?

Total Count:	
Yes	**7**
Not sure	**1**
No	**2**

Name:	Response:
Anthony Wright	Yes
Carmen Comsti	No
Sara Flocks	Yes
Jennie Chin Hansen	Not sure
Richard Scheffler	Yes
Robert Ross	Yes
Andy Schneider	Yes
Antonia Hernandez	Yes
William Hsiao	Yes
Cara Dessert	No

Report in its Entirety

12. Overall, the report accurately represents the deliberations of the Healthy California for All Commission from January 2020 through February 2022

Total Count:	
4 = Agree	**3**
3 = Mostly Agree	**5**
2 = Somewhat Agree	**1**
1 = Disagree	**1**

Name:	Response:	Comment (if not “Agree”):
Anthony Wright	3 = Mostly Agree	
Carmen Comsti	1 = Disagree	I have to vote “Disagree” here because of all of the issues and reasons I raised about the “Priority Actions and Next Steps” section of the report. To repeat what I said above, the bulk of “Priority Actions and Next Steps” section, including the discussion of the Administration’s current health care plan, the proposal that CHHS develop a concept paper on UF, and the proposed sequencing of actions, are deeply problematic and I cannot agree to them. Not only did we not discuss the vast majority of actions and proposals discussed in this section, but the proposal that CHHS take the next 2 to 3 years to develop a concept paper on UF fundamentally abdicates our responsibility as a Commission to providing the people of California, our state government, and our lawmakers with a viable path toward UF, including single-payer. The 2-3 year timeline for issuing a CHHS concept paper was never discussed at the Commission. Not only is it procedurally improper to include this recommendation in the report given that the Commission did not discuss this CHHS concept paper and the 3-year timeline, but this recommendation substantively means that the Commission has failed at our charge to deliver a plan for UF, including single-payer, to the Governor and legislature. It is the Commission’s charge, not CHHS, to establish a plan for UF, including single-payer. This recommendation kicks the goal post to 2 to 3 years down the road and hands our responsibility to create a plan for our state to a closed process within CHHS. As we’ve mentioned in our work on the Commission repeatedly, the need for unified financing is immediate – Californians will suffer and die because of delays. I frankly question the purpose of this Commission if the result is that we hand our work over to CHHS staff to chew on for another number of years of delay. The recommendations in this section have not been discussed by the Commission, had never been presented to Commissioners prior to their inclusion in this draft report, and conflict with many of our efforts to ensure that the process of

Name:	Response:	Comment (if not “Agree”):
		developing a UF program are transparent and allow for robust public engagement.
Sara Flocks	3 = Mostly Agree	It would be almost impossible to fully capture the discussions of this Commission, especially given that the pandemic disrupted our work, lives, society, state, and the entire health care system. However, it does an excellent job of capturing the facts of the discussions, though there are some adjustments that are necessary. The one element that is missing, however, is the urgency, passion, and emotion Commissioners brought to this topic, as well as the passion of every public comment. This is not a report on an esoteric subject. This is health care---something that people feel passionately about because it can mean the difference between life and death, between suffering and pain and well-being and robust health. It can mean losing a loved one because you can't afford cancer treatment or being denied care because of racism or transphobia. it means losing wages to keep health care or going bankrupt because your child is sick. It also encompasses mental health, which has become one of the most pressing health issues our society faces right now. All of the Commissioners are passionate about this issue and are moved by very deep feelings that something needs to change. We cannot have a system where "financial toxicity" is a medical term. I think that passion and urgency should be conveyed in the beginning of the report either through quotes or stories from public comment or something that conveys the importance of this work, this report, and the urgency of moving forward.
Jennie Chin Hansen	4 = Agree	
Richard Scheffler	2 = Somewhat Agree	There are still many interpretations of what the report asserts the Commissioners agree to, which is not supported by the survey results or the discussion that the Commission had. All the assertions made about what the Commission agreed to needs to be reviewed in detail.
Robert Ross	3 = Mostly Agree	A nice job with a very tough assignment. Lets land on these tough tradeoff decisions, and then bring on the boldness with the next or final draft. Should we eliminate health plans? No -- or not yet; but health

Name:	Response:	Comment (if not “Agree”):
		plans and intermediaries need to be tweaked or incentivized or modified to SERVE the equity-anchored, health for all aspirations of the system -- not the other way around.
Andy Schneider	4 = Agree	
Antonia Hernandez	3 = Mostly Agree	
William Hsiao	3 = Mostly Agree	There are omissions, errors and inadequate reporting of our deliberations. See my previous remarks.
Cara Dessert	4 = Agree	

13. Overall, the report describes the direction that California should take in developing a unified financing system including, but not limited to, a single-payer financing system for all Californians.

Total Count:	
Agree	**2**
Agree if the comments I’ve offered in earlier portions in the survey are addressed	**7**
Disagree	**1**

Name:	Response:	Comment (if “Disagree”):
Anthony Wright	Agree if comments are addressed	I agree that the need for federal permissions is a threshold issue. I think there are other "threshold issues" as well that we need to similarly be thoughtful about how we address them, such as what a transition would look like.
Carmen Comsti	Disagree	Actions and Next Steps” section and “Steps on the Path to Unified Financing under State Authority” section of the report. To repeat what I said above, the bulk of “Priority Actions and Next Steps” section, including the discussion of the Administration’s current health care plan, the proposal that CHHS develop a concept paper on UF, and the proposed sequencing of actions, are deeply problematic and I cannot agree to them. Not only did we not discuss the vast majority of actions and proposals discussed in this section, but the proposal that CHHS take the next 2 to 3 years to develop a concept paper on UF fundamentally abdicates our responsibility as a Commission to providing the people of California, our state government, and our lawmakers with a viable path

Name:	Response:	Comment (if "Disagree"):
		toward UF, including single-payer. The 2-3 year timeline for issuing a CHHS concept paper was never discussed at the Commission. Not only is it procedurally improper to include this recommendation in the report given that the Commission did not discuss this CHHS concept paper and the 3-year timeline, but this recommendation substantively means that the Commission has failed at our charge to deliver a plan for UF, including single-payer, to the Governor and legislature. It is the Commission's charge, not CHHS, to establish a plan for UF, including single-payer. This recommendation kicks the goal post to 2 to 3 years down the road and hands our responsibility to create a plan for our state to a closed process within CHHS. As we've mentioned in our work on the Commission repeatedly, the need for unified financing is immediate – Californians will suffer and die because of delays. I frankly question the purpose of this Commission if the result is that we hand our work over to CHHS staff to chew on for another number of years of delay. The recommendations in this section have not been discussed by the Commission, had never been presented to Commissioners prior to their inclusion in this draft report, and conflict with many of our efforts to ensure that the process of developing a UF program are transparent and allow for robust public engagement. I do hope that the modifications to the other sections, which I have discussed throughout my responses, can be addressed and adopted. In those sections, much more can be done throughout the report to clearly discuss single-payer and to provide a more balanced discussion between the "direct payment" option (i.e., single-payer) and the "health plan" or "intermediary" option. In particular, much more needs to be said in the report explicitly about single-payer to satisfy our legislative charge "to develop a plan for advancing progress toward achieving a health care delivery system for California that provides coverage and access through a unified financing system, including, but not limited to a single payer financing system." That said, without major revisions to "Priority Actions and Next Steps",

Name:	Response:	Comment (if "Disagree"):
		I cannot agree with the recommendations of this report. I am most concerned with (1) the discussion about the Administration's current plan as steps towards UF and the presentation of this plan as being reviewed and recommended by Commission, and (2) the recommendation about the CHHS concept paper and 3-year design process. These recommendations should be deleted. I would also like the report to address the modifications and issues I raised regarding the other sections of the report.
Sara Flocks	Agree	
Jennie Chin Hansen	Agree if comments are addressed	I also would offer that the excellent legal appendix include the statutory elements of the federal PACE program as it brings together statute of Title XVIII and Title IX, achieving both unified financing of federal and state funding with risk based accountability and care coordination and integration all of which are intended in the large effort here in statewide "Unified Financing".
Richard Scheffler	Agree if comments are addressed	
Robert Ross	Agree if comments are addressed	Bolder. Did I say Bolder?
Andy Schneider	Agree if comments are addressed	
Antonia Hernandez	Agree if comments are addressed	Greater inclusion of health clinics and access to all
William Hsiao	Agree if comments are addressed	This report MISSES AN OPPORTUNITY to ADVANCE UF in a concrete and meaningful way. The Commission can and should do better to serve the common interest of all Californians. See my prior comments for specifics.
Cara Dessert	Agree	

14. Please offer any additional feedback or comments on the draft report:

Name:	Comment:
Anthony Wright	I appreciate the work into this comprehensive report that has done some of the deepest and most thoughtful work in the nation on getting to a fully universal health system of unified financing,

Name:	Comment:
	both in describing the benefit and in detailing the other decision points needed, and more. I think that report will also be useful to health reformers in other states, including the deliberations for our counterpart Commissions in Oregon and Washington going on this year. That said, I welcomed the sections, like around governance, which were California-specific about our history and the unique structures, challenges and opportunities in our state; the more this can be a useful guide to addressing California's specific issues, the better. While some of my proposed changes are edits and word choices, I recognize other suggestions may involve broader changes and more discussion, research and writing. I defer to the Commission about what can be done quickly in the final draft, or if there is interest or appetite in further discussion and time in this Commission process (which would make the document more useful for reformers, but recognizing all these issues could be more detailed and there's a need to draw a line somewhere.) In those cases, it might be useful for the report to identify issues where there is some particularly important issues to continue to work through, as a signal to policymakers, academics, advocates, and others. Again, thank you for all the work on this!
Carmen Comsti	First, Commissioners should be given the opportunity to write written comments to attach to the report. The online survey form is a completely inadequate format to express all of my comments and concerns on the report. To reiterate my thoughts in general terms, as I have said throughout my comments there are both problems with the process of the drafting of this report and concerns that I have about the content of the report. With respect to process, the recommendations in the final sections of the report – the Administration's current plan and the CHHS concept paper and unilateral UF design process for the next 3 years – was never discussed. It is emblematic of some of the process issues, particularly with the consulting team subsuming the role of the Commission, that I have raised since the beginning of the Commission's work. I sincerely had hoped that these process issues had been resolved. But these process problems remain as evidenced by the inclusion of recommendations that have never been discussed by the Commission nor even presented to the Commission. With respect to my concerns about content, the report remains imbalanced because it does not sufficiently

Name:	Comment:
	discuss single-payer as we have been charged to do. The report conflates a single-payer system and a multi-payer system with health plans as the same under the rubric of “unified financing”. The report must adequately distinguish between the two, because as I have repeatedly said and as the Commission has repeatedly discussed through our meetings, single-payer and a system with health plans “intermediaries” are not the same. It also bears repeating that a system with health plan intermediaries or any other risk-bearing intermediary should not be considered a UF system. The Commission has had distinct problems with definitions, particularly with defining the so-called “intermediary” scenario. Much of the confusion with basic definitions is a result of the deeply problematic assumption by the consulting team that a system with health plan intermediaries is a kind of UF system. Because of the lack of clear definitions, the report as drafted misleadingly and inappropriately implies that the benefits of single-payer would also occur under a system with health plans. As the report is currently written, I cannot agree that we as a Commission have fulfilled our charge to develop a path to achieving single payer. There is no discussion of single-payer in the report, barring a passing mention of the term. There is no definition of single-payer in the report. And the bulk of the proposed next steps are incorrectly presented as steps towards single-payer and even worse are presented as necessary steps on the path towards single-payer. Importantly, may of the next steps were not discussed by the Commission and the first time we saw such recommendations were when we received this report. To be clear, the recommendations that the Commission has not discussed are (1) CHHS writing a concept paper on UF and given unilateral authority to design a UF system over the course of then next 2 to 3 years; and (2) tacitly approving the Administration’s current plan for reforming the current system, which is not a plan towards achieving UF. Moreover, there is a hole in the report’s recommendations on next steps because the draft fails to discuss the need for state legislation necessary to apply for federal waivers and the need to engage and involve the legislature in the UF design process. Californians cannot wait another day for CHHS to redo the work of the Commission in a manner that is not public and where stakeholders are only engaged after a plan is submitted. Moreover, while I appreciate the dedication and work of CHHS staff, the Administration cannot and should not do this alone. As the Community Voices report made clear, one of the exceedingly apparent problems with our current system is that low-income communities, Black, Brown, Indigenous and other people of color communities, and other underserved communities

Name:	Comment:
	are not included in decisions about their own health care and on health care system design. Underserved communities have not been treated with dignity and respect. The recommendation to hand over the process of UF design to CHHS where stakeholders are not engaged until after a system is designed would be in direct contravention to the clear demand from underserved communities in California that they be included in the decision-making processes of the design and implementation of our health care system.
Sara Flocks	*Note: Sara Flocks' additional comments are provided at the end of this report in Appendix A.* I will offer written comments on the Decisions and Actions section with comments on each sub-section since there is too much to comment on in a box. A couple points that I think could be emphasized * I disagreed that a UF system should be responsible for addressing the social determinants of health. However, I do think the system can play a critically important role in addressing inequities in our society, not just health care system. For one, payment systems can be used to ensure that public hospitals, medically underserved areas, and disadvantaged communities receive equitable funding to make up for decades of neglect wrought by a profit-driven system. That influx of funding and medical services will improve health outcomes if done right, but in addition, health care is a huge employer with high union density that can offer good jobs with a career ladder. That can improve economic outcomes and provide jobs in communities that need them. A UF system has the advantage of being able to re-distribute resources more equitably. health care spending is not distributed equally. Some communities have an overabundance of resources, and people with good coverage are overcharged and often overtreated. Those resources could be shifted to underserved communities without an additional cost to the system or could be used as incentives to get bicultural and bilingual providers into communities that need them. This is not an issue with the report, but as we move toward a UF system we need more discussion on recruiting, training and retaining a health care workforce that is diverse, multi-lingual and able to address health equity issues. Right now, our health care workers are suffering burn-out, overwork, mental health issues and we are losing them at a rapid pace. We have to have structures in place to ensure there is adequate staffing, compensation, training, and safety for all health care workers. In addition, cost containment cannot come at the expense of good, union jobs. The health care industry is a major employer and economic driver. As we move to

Name:	Comment:
	UF we should simultaneously use public funding to ensure health care jobs pay living wages with benefits and retirement security, have career ladders, safety protections, staffing ratios, and protect against the encroachment of the "gig economy" into the industry. Lastly, I believe most Commissioners agreed that there is no role for corporate profits in the health care system. Some clarified that revenues and profits are necessary to provide high-quality services and high-quality jobs, which is reasonable. There is a role for private entities, but the current system of excessive profits & revenues (for non-profit corporations), the incursion of private equity into health care, and other forms of profit-driven health care are unacceptable in an equitable system that we are striving towards.
Jennie Chin Hansen	Very comprehensive and really impressively put together. I believe the State of California along with the progress of Covered California and expanded MediCal in the past couple of years is moving proactively toward more coverage of persons as well as more expected accountability of providers/health plans and systems in services and outcomes. These two factors, coverage and accountability for spend and outcomes moves the needle positively towards better and more comprehensive coverage. I am glad that Long Term Services and Supports was addressed since these issues are significant for all generations who experience complex co-morbidity of health, function and cognition. We need competency and skill in culture as well as skills, knowledge and ability to cover and implement best care and health in chronicity.
Richard Scheffler	This report is poorly organized and in many sections, hard to follow. It needs to be heavily edited and more clearly written.
Robert Ross	we need a section specific to health workforce. Also boxed examples of regional/local partnerships advancing health equity (CACHI, ACH's etc)
Andy Schneider	The draft reflects an enormous amount of work; I'm very grateful for all the hours someone(s) put in. The analytical findings are an important contribution to the field. The rest of the report also has the potential to be, but it needs some work. Not so much on the merits as on the narrative arc. Specifically, the draft doesn't tell the story or make the case as effectively as it could. The jump from "Goals and Values" to "Analytic Findings" is likely to be particularly jarring for the national audience coming fresh to the report. (I realize the national audience is not the primary one, but if at some point you want to engage with Congress it will be important). I would suggest inserting a short section on the state of fragmentation in California right now and, in broad strokes, how UF would differ. Simply citing to the consultants' work on this isn't good enough for the narrative. You need something along the

Name:	Comment:
	lines of what is now at pp. 75-76, but built out, in front of the Analytical Findings, which will then make much more sense. My other suggestion is to include an outline of the Next Steps in the executive summary. Only the wonks will read the 112 pages. Lots more people will read a 3-5 page executive summary that answers their basic questions: what's UF? why does California need it? how much will it cost? how do we get from here to there? If you make readers work through the entire report to answer these questions, you'll lose them. Also, you won't have something short and sweet that you (and we) can hand out to legislators, reporters, etc. as an explainer. Thank you again for all your work on this and for the opportunity to be part of it
Antonia Hernandez	
William Hsiao	This report can be significantly improved with a better logical structure. It can start with the Environmental Report and laid out the major problems in CA (i.e. equity, access, quality, cost and affordability, and sustainability.) Then show how an UF plan would address these major problems. Next, show the Commission's proposed and recommended actions to advance UF. Such an organizational structure for this report would show clearly how this Commission advances UF. The report does not address how the Commission would address the under-insured issue. These CA residents can't afford to access adequate health care. The report also does not address how the Commission may address the CA regions that do not have adequate clinics to serve the residents.

APPENDIX A

Comments on the Health Care for All Draft Report
Sara Flocks
April 2022

Thank you for the opportunity to submit written comments on the draft report in addition to the survey that I submitted online. This is a very detailed, impressive document and I look forward to our next meeting to discuss it. I also wanted to add that the Commissioner surveys were a very constructive part of the process that was both helpful to shape my thinking about the topics, but that also let me learn from the incredible and deep expertise, experience and knowledge of the other Commissioners. I high recommend that other governmental commissions and boards use the survey method.

Decisions and Actions

Engagement with the Federal Government
My first comment is on the section on page 43 regarding federal commitments. The draft report states that to engage with the federal government on permissions and funding, "the state will need to develop and refine a proposal for UF that *finalizes* (emphasis added) design decisions and implementation steps…" I believe the Commission discussed an alternative, more flexible strategy which would have the state engage with the federal government informally to gauge what would be possible and permissible at the federal level. Once we have a sense of what's achievable, that sets the framework for a formal process, where the State then fleshes out a UF system and is authorized to formally negotiate with the federal government. This allows for an iterative, more immediate process so the state can develop a system within the realm of what is possible.

Covered Benefits
I agree with everything in this section and just wanted to emphasize the importance of including behavioral health services as a covered benefit and to prioritize expanding the scope of services that are covered. Given the mental health crisis we face, the health care system has to invest heavily in behavioral health to advance the field, expand services, and the what services are considered as therapeutic. That also goes to the importance of an immediate plan on workforce recruitment, training, and retention, and the consideration of incentives to attract more behavioral health professionals that reflect the diversity of the state and specialize in the mental health impacts of racism, poverty and other structural determinants of health.

Provider Payment—Institutional Providers
The HCFA meeting on provider payments was full of extremely useful information and raised critical questions for decision-makers to answer, some of which are reflected in this section. However, I recommend that the section on "Equality Adjustments" in global

budgets be significantly expanded or even moved to the beginning as an over-arching question for all provider payments, institutional, outpatient or other.

The question raised is how should resources be moved from “haves” to the “have nots” specifically for hospitals. That question identifies one of the major problems in our system---that it is fragmented, profit-driven, and reflects the structural inequalities in our society. Redistributing health care resources is not just a provider payment issue, it is essential to addressing health disparities, improving overall health outcomes for Californians, and to reducing wasteful spending. This is also a very politically challenging issues with deep-pocketed interests who would want to preserve the status quo. So I would recommend expanding this section to flesh out those questions.

In addition, global budget adjustments should also reflect investments in the workforce, not just capital investments. Hospitals that provide living wages, good benefits, safe working conditions, and career ladders should be rewarded for their investment in the workforce that provides health care services. That would also be an incentive to create workplaces that retain workers.

Purchasing Arrangements and Role, if any, for Intermediaries
The conversations around purchasing arrangements, intermediaries, and care coordination were and are complex. The presentation in the report seems to make distinctions that are not necessarily reflective of the many robust conversations and presentations Commissioners had on these topics.

For one, there was strong advocacy from Commissioners and many members of the public to reject risk-bearing payments and reimbursement models. However, that does not preclude or prevent care coordination or eliminate the role of integrated health systems. Integrated health systems are a core part of the states’ health care system and many provide high-quality care with good outcomes. Given the scope of the reform the Commission is contemplating, it’s not impossible to think we could reimagine integrated health systems that are part of a UF system that does not use risk-bearing reimbursements.

Care coordination could also be done with risk-bearing payments, using the models of primary-care medical homes or other models that take the best of existing models and replicate them in a way that is not driven by maximizing profit.

I would recommend taking the existing models we have in California and seeing if there’s a way to engineer payments that support those models but do not involve the drawbacks of the current system of payments or reliance on health plans as intermediaries.

Cost Containment
This section seems too short and lacks sufficient details given the importance to a sustainable UF system, but also to winning political support. For one, cost containment does not necessarily mean that we’re taking money OUT of the system. Our current

system often pays high prices for low-quality, medically inappropriate, or unnecessary care in addition to wasteful spending. Spending also reflects inequities in our society with disadvantaged communities receiving less health care spending. Cost containment often means redistribution of resources in a more rational, systematic way that reflects the goals and values of the system, such as health equity.

Approaching cost containment from that frame opens up a much more nuanced, robust conversation that allows us to put the goals of the system first, then align payments to serve that purpose. I would add to the goals of high-quality care, access, equity and improved outcomes the additional goal of high-quality health care jobs.

Priority Actions and Next Steps
At the December 9th, 2021 meeting of the HCFA Commission, Professor Hsiao laid out "building blocks" for a Unified Financing system. He laid out clear, concrete steps for the state to take to lay the foundation for a UF system now that also anticipated the political challenges of implementing reform. I recommend that the draft report include these steps or at least reference his expertise in this area in the report. I may not have captured his presentation completely or accurately, but below are the concepts:

1) Set a prospective global health expenditure target. This closes the "checkbook" for health care entities and starts to address concerns about the cost of a UF system to taxpayers. It's critical to show the state is starting to control health care cost growth so that the public has confidence in investing in the system and paying taxes to fund it.
2) Distribute resources adequately and equitably to anticipate increased demand for health care services.
3) Workforce! (invest in, recruit, train, develop a diverse and culturally competent workforce early)
4) Data collection to aid in negotiations with providers. Ensure the state collects service costs and provider cost accounting certified by CPAs for each major service. Appropriate data is critical to be able to negotiate or regulate prices & reimbursements for fair payments and cost containment.
5) Form purchaser alliances among the various payers (Medi-Cal, commercial, etc) to start to align purchasing and break down fragmentation.
6) Develop the data infrastructure such as uniform clinical care and reporting system and a uniform data system for claims and capitated payments.