PAYERS & PROVIDERS

CALIFORNIA EDITION

Calendar

April 2-4

Hospital Association of Southern California annual conference. La Quinta Resort. Regional hospital executives will make presentations on a variety of relevant issues. $795-$895.

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April 11-13

Annual Western Leadership Health Care Academy. San Diego Convention Center. Hillary Clinton will be the keynote speaker at this conference for physicians, medical practice managers and nurses. Sponsored by the California Medical Association. $795-$1,195.

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April 28-29

Second Annual Telehealth Summit. Hyatt Regency Newport Beach. Best practices and innovations in Telemedicine. $350-$470

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E-Mail info@payersandproviders.com with the details of your event, or call (877) 248-2360, ext. 3. It will be published in the Calendar section, space permitting.

Helming The ACA's Biggest Success

Peter Lee on Beating Exchange's Enrollment Projections

The story of the Affordable Care Act has been limned with woe: Balky websites, people supposedly losing their insurance coverage, declarations by many prominent voices that it is a "trainwreck," among other less-than-charitable descriptions.

But there have also been successes, and the Golden State can lay claim to many of them. The biggest one of all may be the **Covered California** insurance exchange. Forecasters with the **University of California** projected that a maximum of 830,000 residents would obtain coverage through the state's exchange. It topped the 1 million mark earlier this month, with open enrollment continuing through Monday.

Peter V. Lee

Peter V. Lee is the executive director of **Covered California**, having taken the job after serving as the longtime chief executive officer of the Pacific Group on Health. Lee, who spoke at the annual Keenan Summit in Burbank on Tuesday, sat down with ***Payers & Providers*** publisher **Ron Shinkman** to provide his thoughts on how Covered California has performed to date, and what may lie ahead.

Q: Final enrollment numbers could be 40% higher or more than the highest projections. Given all the challenges both the federal and state exchanges have had (your counterparts in Minnesota and Oregon have resigned due to poor performance) why does California stand out so distinctly? What did you do right?

A: In the end, I think we did pieces right on every one of the three main foundations of success. We had a good mix of plans in every one of our markets, and our decision on standard benefit designs was consequential. That makes it easier to communicate (what's offered), and easier to enroll. Number two, our marketing and outreach was effective. It was based on from day one, having a multi-faceted marketing approach, starting with community-based outreach, rolling into electronic and social media. And third, our enrollment processes. We did a lot of focus on getting our basics basically working. We wanted to make sure things

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In Brief

Signatures For Ballot Proposition Submitted

The Santa Monica-based advocacy group **Consumer Watchdog** has gathered 840,000 signatures to place on the November ballot a proposition that would raise the current cap on noneconomic damaged related to medical malpractice.

The proposition is also tied to proposed random drug testing for physicians, which Consumer Watchdog claims is necessary because substance abuse by doctors can lead to medical malpractice and the endangerment of patients.

"Voters should have the right to enact the patient safety protections the legislature has denied them for decades," said **Bob Pack**, who brought the signatures to the Los Angeles County Registrar-Recorder's office to file earlier this week. Pack allegedly lost his child due to malpractice connected to an intoxicated physician.

Gov. Jerry Brown signed into law in 1975 the Medical Injury Compensation Reform Act. It capped medical malpractice damages at $250,000, a sum that has not been adjusted for inflation. If passed by the voters, the cap would be adjusted upward to about $1.2 million.

The California Medical Association has been staunchly opposed to raising the cap. "If a sufficient number (of signatures) are validated, an initiative that would increase costs, limit access to care and threaten the existence of community clinics across California will be appearing on the November ballot," a statement posted on its website said this week.

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Lee (Continued from Page One)

worked 90% of the time for 90% of the people. It was not to say we did it all right. We tried not to have too many bells and whistles, but when we did is when we stumbled. An example of that was when we aspired to have a provider directory. It was a really, really hard thing to do. Some of the most sophisticated purchasers in the country have wrestled with it for years and failed, and we tried to have it almost on day one. It was overambitious. It was for all the right reasons, but generally we focused on the core functionalities.

Q: Aside from the core functionalities, there have been few technical glitches in the exchange platform. What did your team do in terms of details to avoid the issues hit by virtually every other exchange? Was there lots of testing involved?

A: It didn't work as we wanted it. We dropped the ball on getting (benefit, subsidy qualification and payment) notices out, when effectively we were being barraged by huge enrollment. That led to consumer confusion, and long wait times on the phone. We are really careful in not claiming we had a perfect consumer experience. And on Dec. 23, our deadline for coverage (becoming effective) on Jan. 1, our system slowed down a lot. But you can't build infinite capacity. If you do, you pay a lot for it. That's one of those tradeoffs. I think on some levels, we had many of the problems faced by many other exchanges, but on the whole, we focused on functionality. Our business process is also shared by the (**Department of Health Care Services**, which runs the Medi-cal program). We had very clear lines of authority, and clear decisionmaking processes. That discipline to focus led to our relative success.

Q: There's still quite a bit of resistance to the ACA in other parts of the country, but what has been going on here suggests that California continues to lead on healthcare policy implementation. Do you think other states more resistant to the law will begin following Covered California and the state's example? Have you been asked for advice from other states?

A: I actually have multiple calls a month with the other exchange directors and with the federal marketplace. I've learned a lot from my colleagues in other states, and I think they have learned a lot from us. It is absolutely one of my hopes that other citizens in other states say "why don't we have insurance like they do?" Because it means there are 5 million Americans who would have had health insurance but for their states not implementing (the ACA) as effectively as we have.

Q: I would say that's a low number.

A: It is a low number, because we're only counting the exchanges, and not Medicaid expansion (which has been rejected or is still under review in half the states). It could be 15 million, easily. And I very much look forward to a time when we all, with Medicare, embrace it. Medicare was a very controversial law. We had the (**American Medical Association**) say it was the "fall of Western civilization," that it was a "Commie takeover."

Q: Yes, but there's a lot of vitriol still surrounding the ACA, and most of it in Medicare's case went away after the program went into effect.

A: I do think it is absolutely the case, and that is unfortunate, that it may take another presidential election to get beyond it. The

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In Brief

The California Secretary of State requires about 500,000 signatures to place the initiative on the ballot in November.

State Gets Failing Grade For Price Transparency

California has received a failing grade on healthcare price transparency, according to a new examination of state-by-state practices by the **Catalyst for Payment Reform** and the **Health Care Initiatives Improvement Institute**.

However, the Golden State was not alone. Forty-five states received failing grades.

Massachusetts, which has mandated price transparency reforms in the past year, received the highest grade, a "B," along with Maine. Colorado, Vermont and Virginia all received "C" grades.

"Finding objective, timely, and comprehensive information on the cost of care is almost completely unattainable for consumers, with a few exceptions, and many of the existing reporting tools have a long way to go to be user-friendly," the report said.

California's **Office of Statewide Health Planning and Development**, which provides hospital chargemaster prices to the general public on its website, received poor marks for the data's utility ease of use and scope.

Price transparency has become an issue of greater concern in the past year, since **Steven Brill's** 2013 article in ***Time*** magazine that concluded that hospital chargemaster prices are wildly inflated but usually only used when charging – and collecting payments – from uninsured or underinsured patients.

Lee (Continued from Page One)

opposition is mostly political, not (policy-oriented). And I mean is this is about opposition to this administration and to the president and not wanting to give it a win, as opposed to rolling up your sleeves and looking at the policies undergirding it. These are very moderate policies that have been embraced by Republicans and even those on the conservative right. It's not a single-payer system. It involves private health plans. This is as about free market as you can get.

Q: You're a policy person but from the business world. Do you think your experience and perspective has played into the success of the exchange so far?

A: Personally, my background in California, I know many of the players. I mean the people who represent the health plans, the physician groups, the health plans, the consumer advocates, the employers. I didn't just work at the PBGH, but the **Center for Healthcare Rights**. We as a state have been struggling to make healthcare reform work for a long time, many of the players know one another, and I think they were ready to lean in and make this work. And having a few years in Washington has definitely been helpful to me. It gave me the perspective of how to work with people with (the U.S. Department of **Health and Human Services** and the **Centers for Medicare & Medicaid Services**. I could pick up the phone and talk to them, and they could call me and see how things were going on the ground.

Q: There has been some concern about timely payment of premiums by exchange enrollees. What has been the trend for Covered California? Do you think there's going to be a significant shed of lives in the coming months due to non-payment? The nationwide trend has been around 15%.

A: There will be a lot of churn in the exchanges. There's been a lot of churn in the individual market. People get jobs – hallejeullah. Some people I'm sure, and we don't have good data on this, signed up for two plans, trying to make their decision. We don't know what the right number is. It's interesting, the state of Washington, they require binder payments. When they give enrollment numbers, it's paid numbers, and we're going to be moving to that. My most conservative estimate is we might hit 15% for the churn, but that the numbers could only come in better than that. And back to the current enrollment numbers, that would take us down to 850,000, which is still better than the 830,000 number. The last thing I want to do is be on the deck of the aircraft carrier saying "Misson Accomplished." We seek to underpromise and overdeliver.

Q: There has been some criticism about the way Covered California has marketed to some ethnic groups, particularly Latinos. What changes do you expect to make in that area in the coming months?

A: It is very easy to be a Monday morning quarterback, especially in the middle of the first quarter. Some of the criticisms of our marketing to the Latino community were absolutely conscious. One of them was that the ads were too dry. We made a decision not to use humor. Other states made other calls. We made a judgment call. I think we've done a decent job.

Q: What is some of the outreach to the Latino community?

A: I feel very good about partnering with **Dolores Huerta** to use the fact that we're closing open enrollment on **Cesar Chavez's** birthday, which is a state holiday, to use that as a focal point for organizing. And when you think about young people, the 18-to-34-year-olds, and Latinos, it's the same. They're in city colleges, they're in Cal States, and that's where we are. They're in markets, so we've expanded to a range of markets that sell in Latino communities.

Q: Is this a long-term position for you?

A: Yes. This is a building process. I was at PBGH for 10 years, eight as CEO, and two where I negotiated a role to work on national health policy. I am generally not flighty.

Q: Do you see your success here as a potential entree into politics?

A: Absolutely not. Guffaw! Peter laughs out loud! No, this is not a steppingstone. It is an opportunity for hopefully helping to reshape healthcare for California and the nation.

(This was edited and condensed for space).

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Stop Showering Patients With Luxury

Some Respect And Sensitivity Go Much, Much Further

By Jim Lott

Convinced that catering to women was a good investment toward developing brand loyalty, hospital managers were knocking themselves out in the 1980s to make giving birth a pleasing as well as a joyful experience for new moms. Arguably, the best thing that came out of the movement was the expanded use of LDRP rooms, where mothers labor, deliver, recover and spend their postpartum stay all in the same room.

The worse thing the movement did was to reinforce for many consumers just how rich hospitals were and how expensive hospital care can be, as attempts to improve the patient experience took on the extremes of a gourmet brunch with the new dad and a ride home in a limousine with a brand new car seat for the baby, all courtesy of the local community hospital.

Well, here we go again. Hospital managers are trying to crack the code on improving the patient experience, as measured by their reportable patient satisfaction scores, using modest-to-ridiculous tactics. Brand loyalty is still a motivator, but threats of payment reductions and lower-valued positioning in health plan provider networks are driving the effort this time around.

Coincidentally, the the same hospital system that spearheaded the brunch-limo-car-seat-for-new-moms effort is now offering 5-star hotel services, including resort-like dining and towels wrapped in animal shapes for their patients. I don't question the positive visceral influences of such tactics on patients and their families; it makes them feel really good about their stay in the hospital. The latent, more deeply ingrained influence on opinions and perspectives about health care financing, though, should not be ignored. Quite frankly, it's this kind of nonsense that makes it difficult for hospital trade associations to lobby against cuts in Medicare and Medicaid payments. Hospital managers need to stop bribing patients with perks and showing off their shiny new equipment to every elected official whose vote against payment cuts they seek.

Cracking the code on improving the patient experience is not rocket science. Start with three basic premises, and you have the foundation for an improvement strategy:

First, unless your patients are having babies or are coming to you for an appearance makeover, assume that they really would prefer to be anywhere else away from you; all they really want is to go home…hopefully either cured or with a treatment plan for whatever ails them. If you understand this, then you will look for ways to shorten all wait times. Physician and hospital wait rooms and wait times are unpleasant experiences. Get patients to treatment rooms as close to sign-in as possible, and get your systems and processes together to get them out of your office or hospital just as quickly.

Secondly, becoming a patient starts with ceding control of one's dignity to you. Everyone who encounters patients –from caregivers to housekeepers– should do so with respect and take the time to connect with them. Stop talking at your patients, as I see most everywhere in the hospitals I visit, and start talking to them. And know that workforce diversity does matter.

Having a workforce that mirrors the population you serve enhances the patient experience and shortens healing times.

Lastly, create a culture that encourages kindness, going the extra mile and breaking the rules when doing so will lift the spirits of your patients. Nurses at one hospital brought a dying patient's very pregnant daughter in from another city to deliver at their hospital so that the patient could hold her grandchild before she died. Another hospital granted a terminally ill patient's wish for a pedicure and time with her dog. Children who undergo huge surgeries at another hospital first visit with patient ambassadors who take all the time needed to talk through and describe everything that will happen in surgery and at the hospital in terms children can understand.

The husbands of both terminally patients could not stop singing the praises for the care their wives received. And, as the parent of a child who needed a big surgery not too long ago, I am very happy that we took her to a hospital that provided her with a patient ambassador instead of gourmet meals and towels wrapped to resemble animals.

Jim Lott is executive vice president of external affairs and talent development For Cope Health Solutions, a healthcare policy analysis and consulting firm in Los Angeles.

Op-ed submissions of up to 600 words are welcomed. Please e-mail proposals to editor@payersandproviders.com