Transcript provided by the Kaiser Family Foundation[1]
*(Tip: Click on the binocular icon to search this document)*

# The Affordable Care Act in California: Briefing and Panel Discussion February 19, 20149

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

**DREW ALTMAN, PH.D:** Hi, everyone. I'm Drew Altman. On behalf of Kaiser and Peter Long of Blue Shield California Foundation, welcome to all of you and thank you, all of you, very much for coming today. And welcome to Secretary Dooley and the great panel that we're going to have coming up today. And Phil Schiliro will be coming over from the White House. So it just should be a great program. I see a lot of old friends here—old friends and friends here today. So, thank you very much for coming.

Much of the action on the ACA and ACA implementation is obviously in the states, so we're going in the next several months to be bringing the states to Washington, from states where they're expanding Medicaid to states where they're not expanding Medicaid. We will have states that have embraced the ACA. And we will have states that like the ACA about as much as I like the New York Yankees, which you know is not very much.

Imagine for a second a different world-- in a world where there was bipartisan support for the law and all sides had a stake in its success. The Congress would watch the states. It would treat the states as 50 different experiments. It would see what works and what doesn't work and then it would make changes in the law to improve it. Not every change in ACA

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

implementation would be treated as a political controversy and a daily headline. We are not living in that world. Right?

But, as a former state human services head, kind of like Diana, who was in state government when the big issue was not health reform, it was actually welfare reform, I can tell you that whatever does or does not happen in the Congress, one of the things that the states really do is they watch other states quite closely. There's actually no shame in state government when it comes to borrowing from other states, if you think someone has a good idea or a better approach. Actually, we treated that as a virtue in state government.

And we did a lot of that in New Jersey when I worked for Tom Kean. I shouldn't have mentioned New Jersey because I know what you're all thinking about right now. Alright we kept the bridges to New York open. I think we did that because we worried that we might have to escape sometime.

We are starting with California today because, while everyone in California watches the Maverick surfing competition— I know that's your image of us, it's not true— everyone else in the country is watching ACA implementation in California because California is a giant state with a big and diverse uninsured population that has embraced the law, has political will, has money for outreach. Maybe not enough money but has money for outreach and has been out front implementing the Affordable Care Act.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Both its successes and its challenges, they really matter for other states and they really matter for the country and we will be talking about both of them today. You often hear, "As goes California, so goes the nation." Since I'm originally from Boston, I never wanted to believe that. It was regarded as a sign of weak character to visit California in my family, and I have been there for over 20 years. When I went I thought I would get tall and blond, and you can see what's happened with that. I'm still waiting and I resent that.

But this time, it's actually really true. You just cannot imagine a successful ACA without the ACA being successful in California, and if the ACA falters in California, that would be a really big deal. So far that is not happening. California has challenges but it certainly looks like a relative ACA success story.

Here's one way of thinking about that, our data show that—I'll give you my fact for—my one fact for the day: Our data show that 22 percent of potential enrollees had signed up for the California exchange, Covered California, as of February 4th. That's actually the fourth highest percentage behind Vermont, Connecticut and Rhode Island. I didn't look, but I think the populations of those states might fit in LA. I don't know. Anyway, here's the fact for today: If every other state had enrolled the same percentage of potential enrollees, then enrollment in exchanges nationwide today would be 6.3 million,

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

which is about double what it is today and over that magic 6 million number, which many people now use as a goal or a target for national enrollment for the exchanges. If the rest of the states were doing what California is doing, then a lot of people would be talking about ACA's success right now.

I also like to look at California because of the important role that local government plays there, as it did in New Jersey when I was in state government. And that's true in many states. But we've not talked a lot about the role of local government, above the role of countries in the national discussion of ACA implementation, which is one reason I'm really glad that Mitch Katz is here today so that he can set us right about that. For us at Kaiser, California is obviously also our home state, so as a matter of patriotism it was important that we start with California.

Finally, we just have a great partner in this in Peter Long and the Blue Shield of California Foundation. Peter is helping us in at least a couple of really important ways. As I think you know, we are mostly a national and global organization and Peter and his foundation just know more about what's happening on the front lines in California than we do. Second, with their support we're doing a series of big surveys to gauge the impact of the ACA on the low income population in California as a supplement to national surveys that we're doing and you will hear about the first of those surveys from Rachel

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Garfield this morning. With his support we're also expanding Kaiser Health news coverage of the ACA in California so we can tell the story of what's happening with the ACA in California to the nation and that's very important.

Let me just tell you my one take home message I have from the survey and then I'll turn this over to Peter. It is that the healthcare.gov start-up problems, I think gave everyone a sense that this was just all about making websites work and finding healthy people to balance the risk pool. It is, of course, partly about that. It is absolutely partly about that, but when you look at, as you will see, who the uninsured actually are, how many have been uninsured for a long period of time, how many have never been insured, how many are minorities who present really special outreach challenges, and at who you most need to reach to accomplish not just the actuarial mission for the ACA, but also the social mission, which lies behind the ACA. This really is not just Travelocity or Kayak or Amazon.com. It's a vastly more complicated hands-on community-based outreach challenge. I don't know, but I image we will be talking a lot about that today.

Let me turn you over to Peter Long. It turns out that I am—he didn't designate me-- but I am the head of the Peter Long fan club. If you don't know Peter, there's actually nobody quite like him in our field. He has all the degrees from all the most excellent places and he has done a really

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

unusual array of things. He started, for example, South Africa's first national health policy advocacy organization working with us. He actually ran a Native American health center in San Jose. I don't really understand how he did that. And then, in what must have been the high point, not just of his career, but of his life, I'm sure more important than his marriage or his three absolutely wonderful children, he was my right hand senior vice president for several years before moving on to his current position.

Peter will take us from here.

**PETER LONG, PH.D:** Good afternoon. Thank you, Drew. Although I had worked for Kaiser Family Foundation many times over more than 20 years, which is hard to imagine, this is the first time I've had a chance to partner on a project and co-host a public event. I think we should do this more often, given the quality of our panelists and the turnout here today.

I want to acknowledge Diane Rowland and the team at Kaiser, and the Team Rachel. So, if anyone saw the report, there's a quiz, all three members of the team have the first name Rachel. So it's Team Rachel who designed the survey. I just want to acknowledge their great work. I mean, one of the advantages of parting with an organization like Kaiser Family Foundation is the quality of the product, the independence and the willingness to seek the truth, wherever the truth will lead you. And that's one of the values I think I've learned.

How about if I do the mic? Would that be good. Alright. Let's do the rest of this with the mic on and it's going to go much more smoothly.

But I want to—let me acknowledge the team again, then, from Kaiser, leading with Diane Rowland and, as I said, Team Rachel who put together this report. I think it really is a remarkable report and it's a great baseline for as we start the implementation of health reform. I also want to acknowledge yet one more Rachel, Rachel Wick, from the Blue Shield of California Foundation. And Christine Maulhardt on our team who runs our communications and Rakesh Singh who helped put this event together today.

I'm a historian and researcher by training, so I live by the motto, if we fail to learn the lessons of the past, we are doomed to repeat them. Before we talk about the present for a moment, I want to talk about the past. In every public speech I give about the Affordable Care Act, I use— I have one line that I say every time. This law is not self-implementing. I think a lot of folks believe that once the law was passed almost four years ago, that it— that's it, it's done. I think the five individuals who have spent the last 47 months of their lives trying to make this a successful reality in California will attest how non-self-implementing this law is.

I want to just take a moment and thank them before we hear from them about their contributions because they truly are

public servants in the best sense of the word in actually trying to implement this law to the best of their abilities to improve the lives of Californians. So if you could take a moment and thank them for their service.

Last October we released a survey summarizing the views of low income Californians about their aspirations and expectations for health reform. At that, actually Ron joined, Ron Yee from NACHC who is here with us today. I talked about—they gave us their aspirations or expectations of what they expected to see. How they expected the world to look different and how they interacted with health care providers, how they received services, and I called that the patient mandate. We had the individual mandate, we have the employer mandate. This was really what the patients expect from healthcare.

This comprehensive survey, I think, takes that work further in two critical ways. First, it brings the conversation back to people. As Drew mentioned, there's a lot of coverage around websites, institutions, regulations, contractors, court rulings. Ultimately the Affordable Care Act is about people. It's about the impact on their lives, on their ability to access healthcare, their ability to have financial stability and security, and that's how it will be judged.

It will ultimately be judged by the experiences of Americans living in Humbolt County, living in Fresno, living in

South Los Angeles. Are their lives better? Are they better able to access healthcare? Do they have higher quality care? Do they have better health outcomes? Are they not going bankrupt and having medical debt because they never had health insurance? This survey provides the baseline to see are we making a difference? Did the law work or didn't it? To me, this is the ultimate scorecard, which is what difference did it make in the lives of human beings.

Now I have the distinct pleasure of introducing Diana Dooley. So if Drew is the president of my fan club, I am the president of Diana Dooley's fan club, our Secretary of Health and Human Services Agency for California. Secretary Dooley assumed her role at the helm of the agency at a very dynamic time, as she can attest. In late 2010 California had become the first state to pass legislation to establish a health benefit exchange. It received an 1115 Medicaid waiver to create a bridge for reform, coverage program for low income Californians. With grit and pragmatism that I admire so much, she took the baton from the Schwarzenegger administration early 2011 and has driven that important work of ACA implementation forward for the last three years. She's made California an example for the rest of the nation. With more than half a million enrolled Covered California is now looked at as a success story among health benefit exchanges around the country. Through a collaboration between the state and

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

counties, the bridge to reform low income health program ultimately enrolled nearly 700,000 Californians into early coverage, and recently transitioned them into Medi-Cal and private insurance through Covered California.

But Secretary Dooley hasn't stopped there. She's now leading California's work on the Center for Medicare and Medicaid innovation centers State Innovation Model Grant. A lot of innovation there, but I think it's good. This work has a potential to transform California's health care, delivery and payment systems on a scale we have not seen before.

Most importantly, Diana's emblematic of exceptional public service. Having the opportunity to work with her closely on a regular basis over the past three years, has been a highlight of my current role and makes me, like Drew, proud to be a Californian. Please join me in welcoming Secretary Diana Dooley.

**DIANA DOOLEY, SECRETARY:** Thank you, Peter. It is really my pleasure to be here, and I feel a little bit like an interloper. I came really to listen, and Peter and Drew invited me to make a few comments. You have a wonderful panel here today, and they are all my colleagues and partners in this important work.

I'm just going to take a few minutes to give you greetings from California and talk briefly about where I think we are and a few reasons that I think we are where we are.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

I'm reminded very often in this work of a quote that was attributed to Albert Einstein in the '80s when I was involved with an organization called Beyond War. And about the atomic age he was reported to have said, that everything has changed save our way of thinking, and that's what this transformation of healthcare feels like to me. We have a lot of challenges. There is a lot of potential, but fundamentally, the system is changing and we have to change the way we think about it and the way we interact with it.

We're here today to talk about coverage expansion which is a critically important part of the Affordable Care Act. But it is just one leg of a three legged stool, and I will speak to it in just a moment. The other two legs of the stool are equally important and we have tried to pursue implementation of the opportunities that the Affordable Care Act has created in the other two areas as well, which are payment and delivery reform and wellness and prevention.

It would be very nice if we could do all of this work sequentially, but that's not really possible. To make it work we have to work concurrently through the steps that we need to take to make this work. The delivery and payment reform is a fundamental shift away from the fee for service system. At the heart of the Affordable Care Act is a recognition that we have to move to a system of population health and the management and treatment of illness and disease in a more comprehensive way

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

than we have in the past. The cost containment challenges that we have ahead relate to that need to integrate and coordinate care.

Indeed, at the beginning of this adventure, as I joined those of you that have been on this journey for a very long time, it seemed to me that one of the most fundamental challenges was to change the way we think about managed care. The lessons from the '90s, both good and bad, have to be applied differently and we're using different words of accountable care and coordinated care and integrated care. But it really is the same goal of managing care, but doing it differently, not just with managed care organizations but with the entire delivery system and working with the physician community and the clinic community and the hospital community together.

One of the things that the Affordable Care Act didn't do was change the whole system, as some would have liked with a single payor or Medicare for all. That's not what we got. We got an incremental approach to the system that exists. All of the players that were in the system before the Affordable Care Act are still in the system. In California we have tried to reach out to them as partners in reforming their own institutions.

We have accepted the challenge of the Affordable Care Act to initiate a dual demonstration project. There are only a

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

few states that have done this. We are working with what we call the coordinated care initiative in California. We have eight pilot counties and we have moved the launch date forward. I'll say that throughout this effort-- through our transition of adult day health and our transition of seniors and persons with disability and our transition of the CHIP program, which in California was called Healthy Families, has transitioned into our main Medi-Cal program--all of these transitions to integrated and coordinated care have been difficult, and in each one as we have approached the challenges and recognized that we weren't ready to go when we predicted they would be ready to launch. We have extended those dates as we have with our coordinated care initiative. One of my own personal philosophies is that it's better done right than on time. When we see that we're not ready to go forward as we intended, we will extend those deadlines and we have. But we remain focused and committed to a fundamental shift of the delivery system and we're doing that in very many ways.

One of the fundamental changes, I think, that we have observed in California, is the effect of the elimination of underwriting. We talk a lot about no pre-existing conditions. But from an operational standpoint, the elimination of underwriting in healthcare insurance is dramatically changing the emphasis in the priorities and giving us the opportunity to pay for wellness instead of the treatment of illness. And

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

encouraging the plans to not look for clients or enrollees on the basis of their health, but on the basis they will compete through the exchanges on the basis of the service they provide and the education and the assistance they provide to their customers.

We chose in Covered California to be an active purchaser, so we have standard contracts and standard benefits. This is going to be fundamental to our change in the delivery system over time.

In wellness and prevention, the governor issued an Executive Order in 2012 and we created a task force, Let's Get Healthy California, and we worked for six months to develop a plan that has transitioned into our innovation plan under the state innovation models program that Peter mentioned, and we're integrating wellness and prevention into our delivery system reform.

But to the issue of the day, the Covered California work that we have done, I think that as Peter mentioned, we took the baton in this administration. One of the advantages we've had in California is that it's not been as highly charged from a partisan standpoint. It was embraced by a Republican governor. Indeed, he had a proposal of his own in 2007 that mirrored the Affordable Care Act and had all of the basic elements, came very close to passing it in California alone. So when the Affordable Care Act was adopted, Governor

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Schwarzenegger and his administration embraced it, passed legislation to begin the implementation.

But in addition to inheriting this platform that had been created, we also inherited a $26 billion deficit. And Governor Brown was very committed and made very clear at the outset that we would work to be prepared to implement the Affordable Care Act but that would be dependent upon us getting the foundation of government stable through balancing the budget, which we were able to do with the help of the voters of California.

As we proceeded to the launch in 2014 that we are a part of now, we were doing work on several fronts to be prepared for that. I think that there are some things in addition to the bipartisan approach that California had. We have a tremendous network of dedicated partners in foundations, in the counties, in the advocate community. California has a long history of looking at healthcare reform. Indeed, when I worked for Governor Brown in the '70s, and like Peter, I went as a young analyst. I was 24 and thought I'd stay for three months and I stayed seven and a half years. But in the '70s we were already in second generation cost containment in California, and Medicare and Medicaid were only ten years old then. California has continued to look for ways to change the system and, indeed, there is broad constituent of interest in this subject in California.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

We have experienced and dedicated staff that we were able to recruit. We got Peter Lee from the Obama Administration. We have Tobey Douglas, who is one of the leading Medicaid Directors in the state. Indeed, when I agreed to take this job, one of the first things I did before we even started was assure that one of the two or three other states that were trying to get him couldn't. We have the kind of depth of leadership, Mitch Katz had such a fine reputation in San Francisco and LA is so lucky to have him. He and I started on the same day, January 3, 2011.

These partners have made this work, and we have had as a statement of our vision and mission at Covered California and through my agency of being transparent and being evidence-based. We want to share information, we want to reach out to stakeholders, we want to listen honestly without a precondition on the result. But to take advice, and incorporate it and be nimble and make changes, and we certainly have made them. The collaborative partnership attitude, I think, has been critically important to where we are.

California is certainly not ready to put a mission accomplished banner on the deck of our carrier here, but we have made progress. I am immensely grateful that we seem to be graded on the curve because by comparison, we're doing pretty well. But that doesn't mean that we're perfect or even that we're out of the woods. This is a long, very significant

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

change to our system that's going to take many, many years, and we have to be diligent and we have to be persistent and we have to work together with all of the various sectors and interests that we have.

When I was driving yesterday from one meeting to another, I went by the Methodist Church up near the Supreme Court. You've all probably seen the sign that's on the marquee. It's been there for a very long time. But it seemed to resonate for me on this trip and it was a quote from Nelson Mandela that said, "it always seems impossible until it's done." I don't think we're going to be done with this for a very long time, but we are very proud to be a partner with our California colleagues and with all of you throughout the country that are looking for ways that you can make it work in your own states. And I look forward to listening to the program today. And thank you both to the Kaiser Family Foundation and Blue Shield of California for making this possible.

**RACHEL GARFIELD, PH.D.:** Thanks so much, Secretary. I'm happy to be here today to present some new data on the uninsured population in California at the start of ACA implementation. In any discussion of how things are going or evaluation, you really need to know where you started. My role today is to provide that context, and let you know where things started off in California.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

My remarks today are going to be drawing from a report that we're also relating today that conveniently is also titled, The Uninsured at the Starting Line in California. You'll find a copy of that report in your packets or if you're viewing us on the webcast, it's available on our website, KFF.org for you to download. I'm only going to be able to really give a snapshot of what's in that report, so I would encourage you to go and take a look at it when you have some time.

The study that I'm going to present today is part of a larger effort at the Kaiser Family Foundation to try to understand how things are going with ACA implementation. One of the challenges that we identified when we thought about how we were going to do this was the availability of timely data. So we are undertaking several projects across the Foundation to try to fill that gap. Things like our monthly tracking poll that asks people what they think about the law, a separate survey where we're following a sample of people in California. And this project, the Kaiser Survey of Low Income Americans and the ACA. The goals of this project are fairly broad. You can see them up here in the figure for you to review.

Just a bit of an overview about the project: it is a telephone survey that as Drew mentioned is a national survey that's paired with some state specific samples, including one in California, which is the one that I'm going to be talking

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

about today. We do view this as the baseline survey. It was in the field before open enrollment and the plan is to go back into the field about a year into the law to try to measure how things have changed.

One thing I want to highlight, while this is, in fact, a baseline survey, it's really useful for much more than that. As many people have mentioned, enrollment did not happen overnight with a flick of a switch, so what was relevant in October or November or even December is really still relevant to what's happening right now and can inform ongoing implementation efforts.

Many people have talked about why are we doing this special focus on California. I just wanted to reiterate those comments that California really is a bellwether state. Not only is the state often on the frontlines of policy innovation, but it's sheer size means that it makes a big difference for what happens for the nation as whole. Fifteen percent of uninsured people in the country live in California. So, the success of the law there really has implications nationwide.

California's size also makes it an excellent case study for some of the challenges and opportunities in implementation. It's a highly diverse state. There's a lot of other simultaneous policy changes going on, and so it really is an interesting place to try to look at some of the complications and some of the opportunities that might arise.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Before I launch into what the uninsured population in the state told us, I just wanted to give you a little bit of a reminder of who we're talking about when we talk about the uninsured. Here I've pulled out some of the demographics of this population and these are uninsured adults in California. What you can see is that the majority of them are pretty low income, that is, living on family incomes below 138 percent of poverty, which, as most of you know is the Medi-Cal target range. This actually mirrors generally what we see nationwide.

But there are some particulars to California that we don't see in other states, and those are the measures of race, ethnicity and citizenship. Over half of uninsured adults in California are of Hispanic race ethnicity, and this has important implications for outreach and enrollment efforts which I'll come back to at the end of my presentation.

In addition, we estimate that approximately 20 percent of uninsured adults in the state are undocumented immigrants and as most of you know, these individuals are not eligible for assistance under the ACA. As we're thinking about what people have told us and how things may change, it's also important to bear in mind that there is a population for whom things may not change quite as much in terms of availability of coverage.

When we conducted the survey, one of the main things we wanted to ask people about was, what were their prior experiences with the health insurance system before the ACA?

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Here I've highlighted just a few of the findings there, and I want to point out just a couple of things. For a majority of uninsured adults in California, they have really been outside the insurance system for quite some time. Half tell us that they've lacked insurance coverage for more than five years, and 22 percent tell us that they have never had insurance coverage in their lifetime, and so these people are being asked to purchase or enroll in a new product to them-- something that they may be not that familiar with.

Most of the uninsured adults in California do not have access to coverage through a job, either because they're not working or the employer doesn't offer it. The pathway that's going to be available to most of them is going to be either the Medi-Cal expansion or Covered California. What you can see in the bars on the right there are that notable shares actually tell us that they've some experience with these kinds of coverage before. That is they've either tried to sign up for Medi-Cal or have tried to purchase insurance on their own. In the vast majority of cases these were not successful efforts and people were not able to obtain coverage either due to eligibility or cost. So, again there's going to be a great need for education about what has changed under the law.

We also wanted to find out or get some information about what would be people's experience in actually enrolling in coverage or using their coverage. Here we obviously have to

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

turn to the experience of people who have enrolled in coverage or do have coverage, so, some of these results draw on the population with insurance coverage in the state. I don't want to run through all of the numbers for you, but I just wanted to highlight that while most people tell us they didn't have difficulty in either actually enrolling in coverage or picking a plan if they had a choice of plan, again, notable shares tell us that they did have some difficulty, either in assembling the paperwork or comparing costs or comparing services across plan.

In addition, most people are generally satisfied with their coverage. They say it's quite good. But, again, notable shares tell us that they have either needed a service that has been outside the scope of their benefits, typically ancillary services like dental, or that they unexpectedly faced high costs.

Now, of course, the ACA includes a host of provisions to address many of these challenges that we've had with the health insurance system for quite some time. But, again, there's going to be a need to re-set expectations and teach people about what has changed under the law. In addition, I think it's important to note that some of these challenges were in place even before the ACA and may be somewhat inherent to the complexity of health insurance coverage, and not necessarily only related to what's been happening with the law.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

A third area we wanted to try to get some information about was what would happen to people's interaction with the health – excuse me, healthcare system? And here you really need to draw on the experience of people who do have coverage so that you have a benchmark to align that to. Again, not to walk you through the specific numbers, but just to point out that what we found is that a lot of uninsured adults in the state need to be linked into the healthcare system. They tell us that they don't have a usual source of care. They haven't been receiving preventive care. Many also tell us that when they're sick, they've been putting off care. There's going to be a need to link them to a service provider, perhaps help them navigate this health insurance system.

There is likely to be some unmet need among the uninsured population. About a third or 30 percent tell us that they have an already diagnosed illness, and so we expect that that share is actually higher knowing that most uninsured—excuse me, the prevalence of undiagnosed illness is higher among the uninsured population.

Last we asked a series of questions that tried to get at people's readiness for the ACA. Do you know what's coming? Do you have the right tools in place? Here, I've, again, summarized some of those findings. You can see there are some areas that may need some attention as well. Asking people about their knowledge of these new coverage options, that is

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the two sets of bars on the left, you can see that many who are in the income range targeted for these specific provisions told us that they really didn't know anything about this. This was, of course, before open enrollment. There's been a lot more media attention to the ACA over the last few months. But when we look at national polls that try to gauge knowledge, we actually don't see much movement on these measures.

We also found that some uninsured adults in the state may face some logistical challenges in enrollment. So things like do you have a bank account that makes it easy to pay your premiums? Do you have easy access to the internet? And that these logistical challenges may be particularly acute among the Hispanic population in the state.

Last we looked at how people are interacting with the system. And this is important for different outreach avenues. And while about half of the uninsured in this state have contact either through a social service agency, or through the healthcare system, that is they have some contact, about half don't. While these avenues are important outreach avenues, again, there's a share of people who are not going to be able to be reached through that means.

In conclusion I wanted to just draw out some of the policy implications that we included in the report. This is just a sample. When I was looking at this yesterday, I realized that it may seem a little bit negative but, in fact, I

was actually just trying to draw out the policy implications that seem particularly actionable as a way to set up perhaps our panel conversation. I'm not going to read them to you. I'll leave them for you to review at a later date. But just in summary, there are many people who are outside the system who have been outside the system for quite some time who are going to need some targeted outreach in order to be linked in.

There are other people who have had previous experience with the system who are not coming into this with a blank slate, and so they may need some education efforts to help them understand what has changed under the law.

In conclusion, I also wanted to note that I didn't have much time to go over our findings related to providers, but particularly relevant to our panel, we have some findings in the report showing that clinics, in particular, clinics and health centers, are really going to be at the front lines of this effort, both in surveying the people who gain coverage and also in outreach and enrollment efforts.

So on that note, I'll conclude. And I'd like to actually invite our panel up for the next segment of the presentation.

[Audio Off: 00:36:47 – 00:37:11]

**PETER LONG, PH.D.:** So actually, Rachel, thank you. That was the perfect set up for the panel. Because I wouldn't want anyone to think that this, you know, we didn't need these

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

four individuals and thousands of others to make this happen. It would have happened on its own, at all. So this is like an aerial 1240 or what's the term in, you know, freestyle skiing, or half pipe. These guys are slope-style experts.

It gives me great pleasure to introduce the panel. And the way we'll do it is I'll introduce them and kind of ask them a question to get them started. But I'm excited to hear. They're on the front lines and they have been for the last, in many cases, a lot more than four years, but with this ACA for the last four years.

I'd like to start with Toby Douglas, our Director of Health Care Services for the state. We've heard from Secretary Dooley that the early implementation is actually going very, very well. From your perspective, what are the one or two kind of key decisions, key things that have gone right, such that we've seen these strong enrollment numbers early?

**TOBY DOUGLAS, DIRECTOR:** Thank you, Peter. Thank you Drew for inviting me, pleasure to be here today.

I'd say that there are two big areas to focus on. The first is, as Diana mentioned, as well as Peter, California embarked on what we called our Bridge to Health Care Reform 1115 Waiver. As part of that waiver, we've embarked on an ambitious project to cover our insured through an early implementation of our Medicaid expansion. And that started in late 2010. We estimated we had, we thought a stretch goal at

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the time to enroll over 500,000 uninsured adults into the program, to move this. This was a county-based program that we worked with our counties. We had ten counties under our previous waiver doing a small coverage initiative, a very small one, and we would take that and we'd go state-wide, bring all 58 counties up and running and aim for bringing it up in pretty much all the counties.

Well where we ended up through this process, is we brought on 54 counties and we brought in under the cover of our low income health programs 650,000 individuals. And it was more than just covering them. What we were able to do and Mitch and others will talk more about it, but we brought them into delivery systems that we started the foundation. They were assigned to medical homes, to primary care providers. They were given core Medicaid benefits. We did receive some waivers of the benefit structure, but, in general, the benchmark, what we called the benchmark benefit, so they were beginning to get the benefit.

We also started to add on mental health and substance abuse disorder services. Again, what those did, especially as we look at the mental health and substance abuse, it started the process of us looking at how as foundations for going forward when our Medicaid expansion in 2014, what were the benefits we needed to include? So we brought the 650,000 on but we also worked on systems where we could make sure we would

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

link them, that we didn't lose all these individuals when we moved them from a county based program to our Medi-Cal managed care infrastructure.

We had several steps that we took on, doing that on an IT system front which is easier said than done when you have multiple counties inputting into their own local databases, bringing it into our statewide client index, and we were able to do that. We were able to do it as well by not just including information about the individuals for enrollment, but we also brought their healthcare information forward and were able to then transition that to our to Medi-Cal Managed Care Plan so that they had information about these individuals and their needs as they transitioned into Medi-Cal Managed care.

The other piece, and Diana talked about this, is that we made sure that we had Medi-Cal managed care in 58 counties that were not transitioning individuals. We went from roughly about additional 30 counties in late 2013, that we expanded managed care into those counties so that when we were ready in January, we were linking everyone to a medical home, everyone to a managed care delivery system. These were all foundational, and it has not been perfect. We have bumps and, you know, Mitch can talk about it. But for those are on the, you know, the 2 percent side whereas for the 98 percent it's been a smooth transition. But we're working through the rest. But that is a big, big piece on the low income health program.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

The other big area is our, what we call our California Health Eligibility and Enrollment and Retention System. So this is called Cal-HEERS, which outward facing to the public is our Covered Cal website or enrollment portal. We, again, this has not been a perfect implementation of the Cal-HEERS system, but what we had success was first of all it was a joint partnership between Covered Cal and Department of Healthcare Services. We had very clear chain of command on who was making the decisions and how to develop the system, what had to be in place in October, what could wait until later. There were not a lot of different, you know, bosses and a lot of finger pointing. There was clear sense between our vendor, as well as Peter Lee and with me on what decisions, what had to go.

We also had clear sense of priorities between Covered California and Department of Health Care Services. We had to make a lot of tough decisions about things that had to wait until later, that still haven't been implemented because we knew we had to have a system, a workable system, a consumer friendly system up and running October 1. So we delayed interfacing to our county eligibility and our welfare systems where Medi-Cal enrollment occurs in three different systems plus linking to our statewide client index system, so we had to hold off on that linkage of five systems until after January. We had to hold off on planned selection on the Medi-Cal Managed

Care side within the system because we had to focus on the core components.

We were able to get it up and running and we continued to work through, again, having that joint partnership between DHCS and Covered Cal. What that's led to is huge enrollment through the Cal-HEERS portal through Covered California. We have, as I said 650,000 that have come in through the low income health program. We have another roughly 875,000 that through the end of January have come on through Medi-Cal. That, coupled with many other avenues, we've implemented an express lane enrollment option for those on CalFresh, which gets to some of the slides of those who know about social services but for some reason don't know about Medi-Cal. Well, we're reaching out to all those who are on our food stamps program, we call CalFresh, saying that they can enroll. All they have to do is send back a form. They can go on a website. They can go call a phone number and they can link in. And that's already just in a couple of weeks we've gotten 65,000 who have enrolled through that. I'll stop there.

**PETER LONG, PH.D:** I think now you understand why we wanted to keep Toby in California. It's been remarkable in partnering with Toby, just both the vision, the clarity and then just being able to follow through. I mean, the execution has been phenomenal. It's not just that there are good ideas, but it's actually working through each of the phases. So, I

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

mean, it's a tribute in the sense that, you know, four years, many more than four years, but four years of very hard work. Thank you.

**TOBY DOUGLAS, DIRECTOR:** Thank you.

**PETER LONG, PH.D:** I want to turn to Anthony Wright, who is an advocate, who has been an advocate for many years for health reform, both in California and nationally. So, Anthony, he's the Executive Director of Health Access. What does implementation look like from the consumer's perspective? So, kind of how are people from your perspective, who have been a champion of health reform for many, many years, how do you see the early roll out?

**ANTHONY WRIGHT:** [Missing audio 00:45:00 - 00:46:02).— for repealing, rather than, that's, in my mind, that's the need to do more. That's the need to actually resolve those issues and we in California are trying to do that, and we're glad to have partners in the Brown administration, in the legislature and the counties to do that.

We were excited that in California, even before January, there were millions of people who had new consumer protections when dealing with their insurer. That we had over a million people in new forms of coverage, whether it's the 600,000 plus folks in the low income health programs. Again, when you're talking about repeal health reform in the last three years, those folks would have been thrown off of coverage

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

otherwise. It was a very surreal conversation from California to hear about the conversation in DC.

We had a million people already covered before we got to January through the folks that Toby mentioned were transferred on January 1 into Medi-Cal. There's hundreds of thousands of more. We have 750,000 plus through Covered California and we still have some time to go in our open enrollment period. If you also include the 400,000 young adults up to age 26 on their parents coverage, in California we have over 2 million with new forms of coverage as a result of the law. That's huge, that's big, that's life changing. I've certainly talked to a number of people who have had tears in their eyes. Who have talked about how it just dramatically changes their life situation to have that financial help that they didn't have before.

I will say that, again, the ACA, like the elephant in the dark room where different people are feeling it from different parts, you know, it depends on where you sit. If you're in employer based coverage, this is not the most dramatic change in the world. If you are in Medicare, there are lots of people in Medicare who called up Covered California in that first week wondering what they were supposed to do. They, thankfully, said, no, you don't have to do much. This is pretty much the same for you. You know, obviously the big changes are those people who have to buy coverage as

individuals. You know, who before were buying coverage in the least efficient, most expensive way possible, and who are now getting help to make it cheaper and easier. Let's be clear, health insurance is not cheap. It's not easy. But it's cheaper and easier. We are mindful of that.

But, again, let me just end on this question on just some of the things that we do need to think about: what is the next step to truly make this a universal system, truly make this one where people get the help that they need. Whether it is people who are excluded from the Affordable Care Act because of their immigration status, and who are excluded from any help whatsoever. There are folks who are excluded because of an interpretation with regard to work hours. If they have employer based coverage but their family members doesn't, the so-called kid glitch, that needs to be addressed. Folks who are just over that 400 percent of poverty level who are living in a high cost of living state like California are paying more than the 10 percent of income that we provided a guarantee to so many others, and those were some of the people who were highlighted during the plain cancellation issue.

And then finally, there is an open question about whether, you know, there's a lot of people who are incredibly grateful for the new subsidies that they are getting, but there are some people who it still is a tough, to be paying two or five or 9.5 percent of their income for coverage, and the

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

question is, is that help enough? Is it the seven foot rope to get out of the ten foot hole. For a lot of people, that's enough. They're grateful, but the question is, especially, you know, do we need to look more. I wish that the conversation was changed from a conversation debating a law that was passed four years ago now to one about trying to make the system work for everybody, even those that are not helped immediately in the current moment.

**PETER LONG, PH.D:** Thanks, Anthony. I think a theme is beginning to emerge in California defining some of our success is incredibly high ambition and relentless pursuit of what's next and kind of thinking through how do we keep improving upon it. How do you keep moving. I think that is, in some sense, the science implementation, which is you finish one thing, it actually makes you very aware that the other house in your room needs paint or that, such and such. So I think that's a theme in California in living there, in experiencing it, you really don't get a lot of deep breaths. I don't think we do a lot of toasting to success. And I've never seen a mission accomplished banner even contemplated.

With that, let's turn to the epicenter of the uninsured which I'm going to trump Drew here. As many people live in Los Angeles county as the state of Michigan, and there are the same number of uninsured as the entire state of Nebraska. So, the stakes are high in Los Angeles. Fortunately Dr. Mitch Katz is

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the Director of the health care system there. Mitch, can you talk to us from your perspective in Los Angeles County, and particularly pick up a little bit on the thread that Toby was talking about, the low income heath program, and early implementation from your perspective in leading one of the most important and largest counties in the country?

**MITCHELL KATZ, MD:** Thank you, Peter. I think as, Secretary Dooley said, and Toby reiterated, the waiver made the start of Medicaid a success. It may not be our tradition to toast each other, but I think the two of you should be toasted because it really was a smooth transition from the people who were in the low income health program into Medicaid. And just to imagine if we had not done that, in Los Angeles alone we enrolled over 300,000 people. Can you imagine 300,000 people arriving on January 2nd, okay, I'd like Medicaid now? Right, who would have handled all of those applications? Right? That would have just been the start of the process and, you know, people would just be learning what forms they needed and no, that form won't work and going back and then nobody would have been assigned anywhere. There would have been no experience in order to make assignments. I think it was a tremendous success for us and for the state of California.

When I think about it in the same spirit as Peter was saying that, okay, so where as Californians we want to then think about the next thing for Los Angeles which is the second

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

largest safety net system in the United States. All of the major challenges are about the delivery system. We have given people insurance. People will gain insurance, more people will enroll in the exchanges. That will happen. We know how to do that. The country's been doing that for some time in private ways. We know how to get people through whatever hoops they need to get the coverage they need. I don't have any doubt about our ability to do that.

I see patients in a small, for Los Angeles, East LA clinic. I see a lot of monolingual Spanish speaking patients, and I can tell you, as you may have experienced from yourself or from your family, insurance, which is incredibly valuable, is not health care. Right? Insurance may or may not enable you to gain health care, and just because you get health care doesn't mean you feel cared for. That's yet another dimension of whether or not the interaction leaves you, leaves people feeling healed, meets the needs that people have. Not necessarily, since it's relatively still a small proportion of things as medical care professionals that we can cure, we still want to leave people feeling cared for.

Well that's a huge change, certainly for Los Angeles, which has been traditionally an episodic emergency room driven hospitalization system. It's a system where if you saw in a clinic like mine, somebody who you thought might have cancer and needed a workup of a scan or a biopsy, you'd send them to

the emergency room. Why? Because that was the only way you felt you would be able to get them specialty care relatively quickly. There were no primary care homes, and we have now, throughout our system, established primary care homes. But like many of the other things we're doing, having a primary care home is not a yes, no. It may be yes, no, whether a particular person is assigned to a particular provider. That doesn't prove that the person feels attached to that provider or that that provider is ready to meet the needs of that patient. When I was a primary care advocate explaining the new system, one of the doctors got up at one of my open sessions and said, you mean, we're going to be responsible for all our patients' problems?

Well, of course the answer is, it's not your responsibility to fix every problem, but yes, we're going from an old model where the doctors, the nurse practitioners and other physician assistants who saw our patients went from being responsible for, what did they deliver in that session? Did I give the person the right inhaler? Did I give them the right medication? To what are the set of issues that need to be addressed? Part of why the task force that Secretary Dooley has set up is so important is in very low income populations, the real challenges are not medical. Real challenges are housing, they're food security, they're chronic stress, they're abusive relationships. Those are the things that really

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

determine people's health. As providers, as physicians, you know, the best that we can do is try to deal with the medical parts and try to help guide people through those other parts; so, making sure that we have robust delivery system.

To us and to the country, that means that we have to have the right provider seeing the right patient at the right time. There is no way in Los Angeles or from what I've seen, anywhere, where you can use the current visit model and succeed. American medicine is based on the visit model. You're sick, you go see a doctor. It's one-to-one interaction. It will not work in Los Angeles. It's absolutely impossible. If that's the model, then we'd have to already agree that we've failed. There aren't, in the specialty area, it's not clear that there are enough specialists I could recruit, that they would wish to come to us, or even if you look at the data that specialty care produces the kind health benefits that we want it to.

We've gone throughout our system to an e-consultation model where primary care doctors like me can consult a specialist. A third of the time no visit is necessary at all. The specialist gives advice to the primary care doctor enabling the primary care doctor to manage the illness. A third of the time a visit is necessary, but some crucial piece of information needed to be done before the visit to make the visit useful, such as a patient with Hepatitis C needed a

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Hepatitis C viral load or genetic test. If you had sent that person under our old system, first visit's waste. Gastroenterologist, herpetologist says, I can't judge, please do these labs and come back. A third of the time we've eliminated a pointless visit. A third of the time, a visit is necessary, but now we can actually judge whether that visit has to happen immediately or in two weeks or whether it can wait two months. I just give that as one example. There are 50 more. But what's important to recognize is that unless we go to alternative models whether they're group visits for diabetic or teleretinal screening for eye exams, we will fail. The delivery system cannot succeed on a visit based model.

I want to end by just mentioning how a delivery system deals with the issue of the people not covered under the ACA. The tradition of Los Angeles and it was of my previous county and many other counties in California, is that we don't ask people about their immigration status. I would say of interest, although I know this is a very hot political issue, I have never once met a doctor or nurse practitioner or physician assistant, no matter what their political stripe was, and believe me they come all political stripes, who asked or was interested in a patient's immigration status prior to taking care of them. It's just not part of the medical model. Whatever your political beliefs are, when you see a patient in an exam room, you are not prepared to tailor your care to their

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

immigration status or to ask their immigration status or to know their immigration status. It's just not a sensible thing.

Second, again, no matter what your political stripe is, because of EMTALA laws, if you fail to create a system for those who are left out, all that happens is that people wind up in the most expensive, least efficient place to receive care in the hospital, so that actually doesn't make any financial sense either. Where it does challenge a system like mine, is that Medicaid comes under managed care with certain access standards, 30 days for a visit to see a specialist. Whether or not in some cases that visit is really necessary. But we agree that we don't want reviewers spending critical healthcare dollars reviewing these sheets. We set reasonable goals, but then my system needs to meet those goals for everyone, because I don't ask. Then I have a much greater task because I need to improve my system for everyone, which is a great goal, but means that we'd have to watch, you know, our finances and really push non-visit based models in order for us to succeed.

**PETER LONG, PH.D.:** Thanks, Mitch. Mitch is not just painting a room, he's building a new house, but I think that's spirit of why, you can see a sense of why it's successful, is pushing to what's the next level of quality and thinking through the next issues. But you've raised a great segue into Dr. Ron Yee who is formerly, he is a Californian, but has recently moved, the last six months, to become the Chief

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Medical Officer of the National Association of Community Health Centers. Before that he was the Chief Medical Officer for United Health Centers in Fresno County who saw 47,000 a year. So he knows a lot about the front lines of a lot of what Mitch was talking about, I think, resonates with you. We heard in the survey results that community health centers are a critical access point, are today and will be going forward. What's your sense of the early experience of implementation in California and then even in your new role nationally?

**RONALD YEE, MD:** Sure. Thank you, Peter. First of all, I do want to thank the Kaiser Family Foundation and Blue Shield California Foundation for doing these types of studies. As you mentioned earlier, I was involved in the previous study you did, having to do with electronics and the availability to our patients. These kind of studies, I think, are really critical. So I want to thank you for doing that, first of all, on behalf of NACHC and all the health centers that we represent out there and the 22 million patients that we care for. So, thank you for that.

I also want to thank Secretary Dooley and Tony Douglas for having the foresight for the state to get stated early. On the frontlines that really made a big difference for us. I think getting started early was helpful. The Health Resources and Services Agency also contributed some funds early on in the going. I think California received $21 million. That helped

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

120 health centers to really get up and running quickly, to hire some, and certify some counselors. Those two things really helped us, so getting started early, but then also that extra kick with funds from HRSA really helped us a lot.

On the frontlines, I did have to make some phone calls and check in with my colleagues since I missed part of the implementation part, but, the overall, I think, implementation piece is consistent with Peter mentioned earlier, some of the electronic challenges with healthcare.gov was experienced on the front lines. One of my colleagues I spoke to, an operations officer actually, said at the very beginning they're running about 45 to 60 minutes per patient. This one health center actually hired and trained 15 counselors and they got through five to seven patients a day, which was not good.

That was the start, but he said, as time went on, things were refined, and as we noted, improved. In January, they're averaging about 15 minutes a patient, which is pretty reasonable. I think overall we've moved through kind of that transition of working through the bugs and details, people getting used to their new positions and how to do the enrollment. What they've done is they've noted, they've shifted from more of the outreach efforts to the enrollment, because now the people are showing up.

The other interesting thing is we thought there would be a big influx of patients coming in, but actually what we're

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

seeing, for the health centers, at least, since we have a grant under the 330 Public Health Service Act, we have a sliding fee scale, so we have some grant money to help people that don't qualify for Medi-Cal or Medicaid. They are actually converting from the sliding fee scale to Medicaid. For health centers, that is a good thing, because now people are insured and we have some reimbursement for that. We can use those funds, but usually run out very quickly, that we use for sliding fee under the grant. We estimated before in our health center, we were running out, like, half way through the year or two thirds of the way through the year taking care of those patients who had no coverage, so now we're able to stretch that a little bit further. Still not totally adequate, but we can stretch a little bit further to take care of those that are either undocumented, don't qualify for Medicaid or the health insurance exchange for whatever reason.

What we're seeing on the front lines is a nice transition. They're able to handle the capacity. They're picking it up well, and I think the state has done a really great job, the California Primary Care Association also has done a great job to support us in the field. They're doing, like, lunch seminars. They've created a whole network to support outreach and enrollment. I think the health center networks, as well as the primary care associations across the

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

country have done a great job to really pick up the ball to help us to get patients enrolled.

I think overall it's going well. We're just waiting to see how things continue to go, but it wasn't the big rush that we expected. We thought there might be, you know, January 1 comes in we had all these new patients come in, but what they're saying on the front lines is, it's the usual kind of experience and character of people. You don't come in, usually, until you need to, so until you're sick, or you might get a notice that says, hey, you need to do an introductory physical or get plugged into the system? Patients aren't really accessing that quickly. It's actually nice because it's a very gradual process where we're building those patient panels for or providers.

Also they're converting a little bit over, we're seeing a little bit of change in the payer mix, which is very important to stay alive and to survive financially in the health center world, is if we can get a little bit more of the Medicaid population that helps offset all the services we do that we aren't reimbursed for. Like all the enabling services, transportation, health education outreach. Those are not reimbursed directly. So that really helps us a lot to make up a little bit of that difference even though there's still a deficit there.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

I would say, overall, it's been going very smoothly. We appreciate all the foresight and the support we've gotten from the federal government and on state level from the CPC and our networks.

**PETER LONG, PH.D:** Thanks, Ron. So, Toby, you have a reprieve. So we didn't get the tidal wave of access demands that some had predicted. But I know you think a lot about ensuring access that the Medi-Cal coverage is more than just an insurance card, it actually leads to access to care. I think we heard Secretary Dooley mentioned, we are coming out of a very challenging, would be modest word for our state budget environment in California. How are you balancing the need to expand access to but also in our current budget environment?

**TOBY DOUGLAS, DIRECTOR:** Thank you, Peter. This is a question we get a lot and it's always next with well, your rates are the 50th, the lowest in the nation. You just need to increase the rates to Medicaid providers and that's the solution. There's a lot more than just looking at rates. First, do you want to give just some of the overall context, we did go through, as Peter said, a very difficult time. We proposed 10 percent payment reductions for many different services. But we did that carefully looking and continuing to monitor access, and what we've done is looked at where we had access pressures and actually change some of those decisions on, especially as it relates to physician services, looking at

specialty pharmacy. We looked at some other services, like, nursing facilities and we ended up not recouping for several types. Because we focused, and I wanted to make sure we had preserved access.

That's one piece. The other is, is the fact that we have managed care, and Mitch touched on this too. Managed care in California comes with many requirements in terms of access, timely access as Mitch said, requirements on making sure that individuals have access to specialty services. All these drive requirements on our plans to make sure that they're providing and contracting with sufficient primary care providers, that they're, whether getting into letters of agreement, which means that they might not have a set contract but they have access to specialty services, giving protections to our Medi-Cal beneficiaries that are now over roughly six million that are in managed care now and growing in the state.

Now, again, that's not sufficient, but it creates protections. The other piece of that on the managed care is that we then have requirements on actuarially soundness under Medicaid rules that then mean the plans, what they end up— we look at their actual costs and they end up paying what it takes to make sure that they meet these requirements. While we look at Medi-Cal, fee for service rates and they're the lowest, or almost lowest in the nation, our plans don't pay those rates. On average they pay about 25 percent or more above that for

primary care and then when we looked to specialty, many of them pay 100 percent of Medicare or more, so you have to look at it in the broad context on what they're doing for their local needs.

The other piece is, we have gotten the primary care provider bump. It took a while to get it implemented but it is in place and that's providing, we hope will start bringing on other providers into the system. Now, it's not long lasting, but it does create an infusion and our plans are conveying that to their networks. You know, don't just see this as, you know, just a one time, you've got to look it. You're getting this over a long period of time and use it in that way.

Then that gets to what Mitch said, as well as what Diana talked about. It's not just about visits. We have to look differently. It definitely concerns us. We've got, you know, close to, we used to say, one and a half to 2 million. Well, we're already above one and a half, so, you know, at least 2 million more coming into the Medi-Cal system. We have to provide sufficient access. It's not going to be dealt with with just continuing on a visit based approached. We have to look at alternatives. We already have moved on the hospital side. We've moved to bundled payments. We have to look at bundled approaches to provide the right incentives to the delivery system on a local level to provide care differently. We are starting conversations, we are getting very good

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

progress with our local community health centers looking at the fact that we have the community health centers are foundational in California. Besides being part of our county health and hospital systems they are, you know, over 600 throughout the state. There are community health centers that provide about a third of our physician visits in the Medi-Cal program. Essential.

But, how can they provide even more access? How can they provide access differently? Right now they have a payment system that is visit based. How do we work with them to look at different alternative ways as Mitch said, so we can look at group based visits that they don't have to always know they have a visit? How do we do e-consults? How do we do other approaches? That's the wave of the future and how we need to make sure we have sufficient access. It's working with our plans on creating the same contractual requirements to drive them. Not just to look at community health centers, but with other physician groups to have the right incentives that they're not paid on a visit basis but they're looking at alternative ways and rewarded for providing care differently.

That's where we have to go to ensure access and not just solely look at rates.

**PETER LONG, PH.D**: That's a full agenda ahead, so health reform for us is a full employment for all of us on the panel. We're going to have an interlude, welcome Drew back to

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the podium and welcome our guest. And we will have time for questions. So we'll take a break for the panel and turn it back to Drew.

**DREW ALTMAN, PH.D:** All right, so a transition to Phil Schiliro just popped into my head. I told you how Peter Long worked for the Kaiser Family Foundation four different times. And that's a record at our organization that will never be broken. But Phil Schiliro has taken the Peter Long syndrome to a totally different level and to the ultimate level having now joined, I think the President's White House team for the fourth time. Is that right? After a brief escape to New Mexico. He's like the master CIA agent in the movies who thought that he could get away and then the president felt that the country needed him too much. I second that feeling. Phil is long regarded as one of the country's greatest legislative minds and policy minds. And he certainly is. He is also one of our foremost public servants. I would add that it is that commitment to serve the public which is, because I've known him and watched him over the years, always driven Phil in the roles that he has been in in the Congress and now in the Executive Branch. He's also just a wonderful human being. I thought I would say that too. To steal a baseball metaphor because I think I revealed my allegiance earlier, he's our closer today. He's our Koji Uehara today, if you're a Red Sox fan, and that's so because of his new role in the White House as the

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

adviser on health policy and health reform. Because of his vast knowledge of the ACA, and it's also true because he worked with Henry Waxman for so long and he has more than a passing knowledge of California.

So, Phil, we're very, very happy to have you here today and to hear the White House's view, the Administration's view and especially your view of what's happening right now with the ACA in California. Thank you very much.

**PHIL SCHILIRO:** Thank you, Drew. I thank all of you for being here today. I was on my way over and I know what you want me to talk about, but the Clean Air Act kept popping into my head, and there's some parallels because California was a leader on the Clean Air Act. It led the way for the federal government, it showed the way for the country on how we could have cleaner air and a strong economy.

There was a lot of debate in California on whether some of the things were technologically possible and how difficult the transitions would be to get cleaner air. As California showed it was possible, it made it easier to get federal legislation passed. I spent most of the 1980s working on the Clean Air Act. We ultimately got the 1990 Clean Air Act passed.

A parallel between that and the Affordable Care Act is in a difference. It took us a pretty long time with the Clean Air Act to get results, because we phased in auto standards,

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the whole acid rain program was phased in over time with power plants. The controls for ozone depletion were phased in over time, and it really took ten years until we could actually see what was happening translate into tangible results. I think most environmental commentators now acknowledge that the 1990 Clean Air Act was probably the most successful environmental law we've ever passed.

The difference with the Affordable Care Act is we're seeing the benefits so much faster than we saw in the Clean Air Act. And it's obscured by most of the national debate. Most of the national debate is focused on just one little piece, a website. I'm not going to spend any time talking about the website today because the website works. It's just a piece of what the Affordable Care Act is.

As in clean air, California is leading the way on the Affordable Care Act. The coordinated effort, the creativity in getting people to enroll, figuring out effective targeted strategies, are all making a huge difference. When we passed the Affordable Care Act, I always thought we had four goals. The first one was to increase coverage. Get more people to have health insurance because it's a good thing. The simple test I always followed was, I didn't know a single wealthy person who didn't have health insurance, so if it's good enough for every wealthy person, it should be something that was accessible to every other American.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

The second thing was doing this in a fiscally responsible way, and because we all learned through the process that bending the curve would ultimately help us balance federal budgets, that needed to be an essential component.

A third piece was something folks fought about for years and years and years, which was essentially the Patient's Bill of Rights, and that whole menu of reforms.

And the fourth thing was encouraging innovation and creativity in the healthcare system. Which as, I think everybody here knows, could be very hard in the way the health care system was.

I just want to run through each of those and the metrics and just really a status report of where we are on the Affordable Care Act. Everything I'm about to say is true. You may not believe it. I call this my "believe it or not talk" because when I do it with folks sometimes on Capitol Hill the response I get is well that sounds good but couldn't possibly be true. Yet it is. Now there's a debate on some of these pieces of the role the Affordable Care Act is having. That's a fine debate to have, but on everything else, it's indisputable.

The easiest one is coverage. You know the latest data we put out last week, which is more than 3.3 million people are in the federal and state exchanges. I think California has 750,000 approximately of that. We have millions more on Medicaid that we don't count, for reasons I don't quite

understand, but we don’t count the three million young adults between the ages of 22 to 26 on their parent's plan. But any way you cut that, that's millions and millions of people, and every day, thousands more sign up. The report we put out last week took us through January 31st. We're now in mid-February so the numbers are obviously higher and I hope we'll be able to put out new numbers relatively soon. But the coverage piece is going well, especially given how slow the start was.

On fiscal responsibility, and this is the part that you get into the believe it or not, the common assumption is that the Affordable Care Act will add to the deficit. In truth, CBO just reaffirmed two weeks that it's projected to reduce federal deficits by 1.7 trillion dollars over the next 20 years. That is more budget deficit relief than the sequester achieves, and it's something that's so contrary to what people think is true, and it seems counterintuitive, given the fact that we're getting more people insured.

The second fact that I think most of you know is that the Medicare actuaries put out a report in January which noted that this is the fourth year in row that we have the lowest rate of growth in health care costs in 50 years. It's the fourth year in a row we have the lowest increase in the rate of growth in Medicare in 50 years. That's making a huge difference to seniors on Medicare, but it's making a difference in federal budget deficit reductions. For seniors, we also

know that seven million seniors now are benefiting from closing the donut hole and that translates into $9 billion in savings.

Because of the 80/20 rule, we know billions of dollars of rebates are going back to consumers. There's also been a debate on whether the Affordable Care Act is having a positive or negative impact on job growth. In the ten years before the Affordable Care Act passed, over three million private sector jobs were lost in this country. In the 46 months since it passed over eight million jobs have been created, private sector jobs in the United States. No one would say that eight million jobs were created because of the Affordable Care Act. But if the argument is that the Affordable Care Act has killed job growth, we just need to look at the statistics. You have over three million jobs lost in the ten years before. Eight million jobs in the 46 months since.

I think on the economic piece, the Affordable Care Act tells a terrific story. On the Patient Bill of Rights piece, which you all know very well, all those reforms are in place now. They'll be taken for granted in a very short time, but the fact that women can no longer be discriminated against when it comes to premiums just because they're women. When someone who works hard as a roofer, a landscaper, a house painter, does anything where they have to use their back, their feet, doesn't get discriminated against anymore because of what they do. The fact that recisions are no longer possible. Lifetime caps are

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

no longer possible. It's a huge reform in our health care system and I think this morning it was noted that this is evolutionary. We're in the very beginning, and these changes will be felt for years to come. But they're making a difference already in the lives of people all over our country, especially when they get coverage.

I don't know if you've been able to follow any of the stories of how it's affecting people in their real life, but it's very powerful. The President gets those letters on a regular basis. People who didn't have insurance before have it now and are getting lifesaving medical care.

The last point on innovation and creativity, I see some folks in the audience who I've talked with a lot about this, I get very excited about hospital readmissions. Instead of talking about the Clean Air Act, I should have spent the whole time talking about hospital readmissions, but that's because there is a specific provision in the law to try to decrease the amount of hospital readmissions. The reason this to me is the gut so the law is it's intended to improve quality and lower costs. And if we could do that, that's the holy grail. That is how we'll have a sustainable health care system in decades to come.

As you may know, hospital readmission rates either went like this, or like this, but they never went down. In the two years since the Affordable Care Act passed, because there is

specific provision that provides incentives to lower hospital admission rates, there are 130,000 fewer hospital readmissions in the last two years. It's decreased by a percentage point. The average Medicare admission costs about $12,000. There's an incalculable cost the patient who goes in for surgery, gets an infection, or the surgery's not done right, and they have to go in a month later. There's an incalculable cost to the family of that patient because we're talking people who are Medicare patients so they're generally older who have to be with the patient. Have to take time off and then have to go back a second time or a third time.

If we could sustain this, if we could sustain the positive trends we see in lowering health care costs, we really will bend the curve. At the end of the day, if we could improve quality and lower cost, I think this Act will go down as one of the most successful laws that a Congress ever passed and a President ever signed. We have a long way to go to get to that point. We're still, as you noted this morning, in the beginning.

But from where I sit, and I haven't been sitting back there very long, and when I was on the outside I thought, this sounds awful, you know, what's happening with the law. You have to reacquaint yourself with the facts, but when you look at the facts and you look at the trends, there's a wonderful story that the Affordable Care Act can tell. It's having a

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

very difficult time getting through the noise, and there's a presumption of negativity with this law that's unlike anything I've ever seen before. But in the end, if we continue where we're going, I think there's going to be a whole different narrative because the law is working in so many different ways.

There was a terrific story in the *Boston Globe* about a month ago. I don't know if many of you saw it but the reporter started by saying she was not going to look at what the national debate was. She wanted to look at individual cases and see how they were affecting real people in New England. She looked at five cases and in all cases the Affordable Care Act was making a profound difference. There is one quote in that article that stuck out in my mind. It was a 62-year-old lobsterman in Maine. And he and his wife had insurance, had to cancel it to the previous year because it was a bad lobster season and his premium was $800 a month. When they looked at their household budget, the thing that had to go was insurance. Under the Affordable Care Act he's now getting insurance and it's costing less than $500 a month, and he's reinsured.

And the comment he had at the end of his part of the story was, I accept the fact that lobstering is a gamble. That's the nature of the business. We have good years and we have bad years. But healthcare shouldn't be a gamble. That's the bottom line. It shouldn't be a gamble for anybody in California or anybody around the country.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So as we go through these next five weeks of the open enrollment period, we're going to keep trying to drive that message. Because there are millions of Americans who as many conferences as there are, as hard as everybody is working to spread the word, still don't know about the basic benefits of the Affordable Care Act. They still, because I think I heard someone saying before I came in, people who have never had insurance, they don't quite understand what it is and that's an education process, and so it's going to take a while to work that through.

But with each story that shows success, with each story of progress, it's going to make it easier and easier. So I thank all of you for everything you're doing. I thank all of you for being here, and as you're thinking about the Affordable Care Act, think back to what the lobsterman said. This shouldn’t be a gamble. It should be a fundamental right. Thank you.

**DREW ALTMAN, PH.D.:** On behalf of the lobstermen, thank you very much, Phil. There's a few people in New Mexico who wish Phil wasn't back in Washington, but all the rest of us are really happy he's back in Washington.

I'm going to declare Peter Long not a moderator anymore, but an expert. Because that's actually what he is on California health care and a member of a newly enlarged panel. Now we're going to open things up so that we can have some

discussion with all of you. Just to use your house rules, you've all been here before. Tell us, who you are, where you're from and say something positive about the program or the ACA. No, you don't have to, you do not have to do that.

I think we've got mikes going around. Yeah.

**MICHELE ZAMPRETTI:** Hello, Dr. Lee. My name is Michele Zampretti and I'm with the National Association of County and City Health Officials. I want to thank you all so much for your presentations today and the excellent work going on in California. I guess this question is for Dr. Katz and maybe Mr. Douglas and perhaps others. What are your current linkages to the public health system and the local health departments within the 58 counties in California and how are you working with them to assure that they're involved in all the great work going on to cover the folks that need the help the most?

**MITCHELL KATZ, MD:** Well, it's a great question because, especially for low income people, improving basic public health and living conditions is critical and that's why Secretary Dooley had set up a task force that not only allows me in Los Angeles to interact with my public health department on issues of air quality, on issues of food safety, but really looks at the whole prevention model across California. I think that that's critical to improving health because we know, you know, the estimates are that medical care only explains at best maybe 20 percent of people's health. If we're going to make a

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

major difference in people's health, it's going to have to be those other forces.

**ANTHONY WRIGHT:** I think it's clear for broad community groups and advocates and others that, you know, in terms of the what's next of issues around prevention and wellness is on the forefront along with covering the remaining uninsured along with the delivery system issues that have been talked about so that when people get into coverage it's meaningful, but the question is, how can we do it. I think that there are some, California has been a leader. We were happy that there things in the ACA that were actually from California. Like the calorie counters on the fast food menus and a range of other things that California had started. There's a debate in California on everything from how soda should be labeled to walkable communities and, you know, those are all the things that we need to start processing to do it. We were excited that many of the counties did take advantage of the community transformation grants that were available in the ACA. Many counties took advantage of that and we're excited about that as another example of county leadership.

**MALE SPEAKER 1:** Yes. My question is for Dr. Katz and I think Mr. Douglas maybe as well. I was very interested to hear you discuss e-consulting and telehealth and cutting out waste in actual in-person visits. I want to make sure I understand the new Medicaid managed care situation. Are the

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

folks in LA county, is there a three or four or five competing Medicaid managed care plans that they're in? And is what you're describing some kind of all payor collaboration? Could you just give us more detail on that, please?

**MITCHELL KATZ, MD:** Sure. And Toby will fill in. So for managed care in California as a state, there is a two plan model set up in most counties, including mine, so there is a local initiative which was primarily the safety net institutions and a commercial plan, in our case Health Net. Then patients are assigned to a specific provider. My safety net system is a provider within both of those two plans.

Then eConsult is as a provider, any patient in either of those two plans has access to it, and we also use it for all of our community health center patients because community health centers are fantastic, but they're primary care. That's how they're set up. They don't have oncologists, they don't have hematologist, they don't have gastroenterologists. So there needs to be a smooth system of referral. Now, they can use the same internet platform to send people to us.

**DREW ALTMAN, PH.D.:** Next question. Do we have the mikes going around?

**FEMALE SPEAKER 1:** Hi. My question is for Director Douglas and it's on an issue that Secretary Dooley brought up earlier. I'm with the National Senior Citizens Law Center, and we're looking at how different states are implementing programs

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

to align benefits for Medicare and Medicaid beneficiaries. Since California is one of the first states to implement, I'm wondering if you have any lessons for other states who are moving forward with implementation?

**TOBY DOUGLAS, DIRECTOR:** Thank you. We're lucky that you guys are very active in California, and we're lucky to keep pushing us to make sure we implement in the best way for consumers. We have done many transitions, as Diana noted. One, the first big one was over 400,000 seniors and persons with disabilities. Those are on Medi-Cal only, but are disabled and their linkage to Medi-Cal is through their disability. We transitioned them from fee for service into managed care.

It went, overall, there were some bumps in the road but it was bumps that really have helped as lessons learned on many of the other transitions. I think the biggest areas and as we look going forward with the coordinated care initiative relates to the engagement. The engagement on terms that we did a lot of outreach to seniors and persons with disabilities through mailings, through phone calls. But that's not sufficient. When you're talking about these populations, you need to look at alternative approaches. We have done a lot of work leading up to this with the provider community.

Providers, you know, and Dr. Katz will be the first to say this are, you know, they're the front line of explaining,

understanding, helping, those on Medicare and Medicaid to understand their choices. We've done evening calls, where we lay out providers, whether it's in LA or other counties, learn about the coordinated care initiative. We've also teamed up with local grass roots organizations in California. The high caps that provide information on Medicare and given funding to them to do outreach and engagement and informing information on the front lines in these counties. So all of these are important lessons learned about how to do information and engagement.

The other relates to providing information to the providers and plans about the individuals before they transitioned. There are a lot of complicated HIPAA requirements about sharing information, and for seniors and persons with disabilities, we didn't transition the data to the plans until after the transition. Very soon after, about five days, but having the information prior to the transition helps assignment. It helps for the plans and the providers to know what type of care management. What we're doing is providing that information in advance of the transition to our plans and providers so they can work on care coordination and care management in advance. Thank you.

**DREW ALTMAN PH.D.:** Another question?

**MALE SPEAKER 2:** Yes, could you speak a little bit about your efforts to engage that vast population coming out of

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the criminal justice system? Specifically, the jails and probation and parole and then lastly the prison population?

**MITCHELL KATZ, MD**: This is a key group of people who could really benefit from the ACA. What we're working on in Los Angeles and we're very actively working with the sheriff's office, is a system by which people will become eligible while they're in jail, but they will immediately go on suspension because of the rules about not having federal benefits while you're in jail. But the advantage of qualifying them is that then the moment they leave the jail, all of the paperwork is done and they are therefore qualified.

Then, what we're working with the sheriff's office is that then they will immediately be sent to us as a clinic system where we'll initiate the beginning of their care with their now medical records, which we'll have from the sheriff. It's a completely major improvement from the old system which was basically people would just be sent out with a list of phone numbers of potential clinics.

I would say as we're talking about the issues of low income people in general, but specifically this population, that recognizing the challenge that people face when leaving jail is way beyond the medical issues, and part of what is so difficult is that people's housing situation, and ability to earn an income and have a place to go and maintain sobriety. What we're trying to do around that and I put it in the same

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

category as alternative to visits is supportive housing, which has been demonstrated multiple times in the end is revenue neutral. You can house people for the same costs as they will incur in the hospital if you focus on high users and this is a group of people for whom that would be a great solution.

**TOBY DOUGLAS, DIRECTOR:** I just wanted to add on, this is what Mitch has described for LA is our vision statewide. The governor put a big focus on reducing the prison population for low level offenders and this is really at the county level. It's just an exciting intersection between those initiatives and what we're doing with the Medicaid expansion. Both what Mitch described, but then you bring in, as I said the mental health and substance abuse benefits. We built out those benefits and how important besides bringing them into the health plan as well as the medical system is that integration with the behavioral health system and we're building out the benefits and making sure that there's a strong residential treatment benefit available. So many need those types of services. We're working, and there are issues around the residential treatment and IMDs but we're working through that. That we can have strong benefits for this population to reduce the prison population and make sure people stay in the community.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**DREW ALTMAN, PH.D:** I'm glad that question was asked. We haven't focused on that issue enough. But don't forget. Where you're from and who you are.

**VIC MILLER:** On? Yeah. I'm Vic Miller. Mostly retired fiscal economist. During the passage of the ACA there was discussion of the woodwork effect. People who were already eligible for Medicaid who would be drawn on by the ACA workings. Have you observed that and if you have, to what extent?

**TOBY DOUGLAS, DIRECTOR:** You know, we don't at this point. We have not been able to determine, we're working through, fast and furious on getting people enrolled. We definitely believe that there is population because we're bringing on kids. That there is some eligible but not enrolled populations pre-2014. The amount is still to be determined but there's no question that, you know, this gets back to some of the fundamental agreements in California of doing all the work that we did on outreach enrollment and simplifying the process. There's so many other pieces that we talked about, the streamlining and the enrollment, no longer having the documentation requirements, that have brought on. Whether it's kids or parents onto the program that before there were barriers to enrollment.

**ANTHONY WRIGHT:** We would agree, we wouldn't call it the woodwork effect. We'd call it the universal effect. It's

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

a good thing. It was a policy failure that we have so many eligible but unenrolled people in our systems and so we're pleased that the simplifications that were passed last year in our state to both get on and stay on Medi-Cal are bearing fruit and that actually transforms the program into a fundamentally different program. As much as the stats above, you know, suggest that there's a lot of long term uninsured, this also then makes Medicaid the safety net for the rest of us. People who are between jobs, people who are in community college and getting second educations, now have an opportunity to get covered in the program in between those life changes. And I think it fundamentally changes Medi-Cal's role in our society for the better.

**DREW ALTMAN:** Okay. We're going to take one more, just because of the time.

**RONALD YEE, MD:** Oh, I was going to follow up on it. Can I follow up on that really quick? You know, just anecdotally from the front lines, as I said, I spoke with some operations people, they've noticed that there are more and more patients coming in that previously were not insured. They're just finding out about it and that's not just for Medicaid. But also for Medicare. Some of our elderly and older patients are actually coming and they're, for the first time, finding out that they can actually qualify. It's very nice for them and as, I think, as Rachel pointed out in her study, is that

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

that security of knowing that that you have coverage for especially catastrophic injuries really is assuring to patients out there and brings them some security.

Okay, I also wanted to reiterate on Dr. Katz's points about what we call the social determines of health. Those are really critical. Just giving them health insurance and then access is the next thing, but also understanding the health care and we're really challenging the health center world dealing with these low income populations to understand, what are those socioeconomic factors that come into play such as housing, poverty, you know, joblessness. All those things influence the patients we take care of in the safety net. We're really trying to make an effort to understand that and actually doing multiple studies to find out the data on that.

I think that's really important to look at also.

**DREW ALTMAN, PH.D**: Who would like the last question? Who gets the last question?

**ALEX SANGE**: I think I do.

**DREW ALTMAN, PH.D**: I can't see.

**ALEX SANGE**: I have the mike here. I'm Alex SANGE.

**DREW ALTMAN, PH.D**: You get the mike, you get the question.

**ALEX SANGE**: I do, right? I'm with the CMS Office of Minority Health. I'm Alex SANGE and I am privileged to be a Californian by native. I'm wondering: California has done, I

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

think, a fantastic job getting folks enrolled as a melting pot. You know, a majority minority state who maybe don't speak English as a native language, have other cultural barriers to access that, may not be— in California they're intensified. And across the country we have to be concerned about them. I have to be concerned about them. I'm wondering from all of your different perspectives, from the plan, from the health center perspective, from the state and from the local county level, what are some of the successful models, best practices, what thoughts can you offer for us here as we think about patient literacy, patient education, provider education to really make this transition from coverage to care a reality?

**DREW ALTMAN, PH.D:** In less than two hours.

**RONALD YEE, MD:** I'll kick it off. You know, I think what Dr. Katz was getting at, he mentioned the patients under medical home and I think that's one thing that's really important. Because what that does is it has more of a team approach. We're really trying to do this in health centers and I think up to 40 percent of them are now recognized through the National Quality NCQA.

I think really changing the way we practice is critical. Not only to handle the volume of patients that we have, because we can no longer do this one on one care, but also drives us to go deeper. To really what are those factors that affect true health and wellness? How to prevent those

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

pre-diabetic, pre-hypertensive patients from becoming acute diabetic hypertensives. Then how do we look at all those determinants that affect their health care and access to health care? So addressing transportation, all those other things, I think is really critical.

I think there's multiple success stories out there in the field where health centers have actually really focused on those areas and found out those answers. In fact, next week I'm working with the SmithKlineGlaxo. They're actually doing a report out of innovations in health centers where they've actually found these things to help patients stay in care, so not losing diabetics that are lost to follow up. Keeping them engaged. I'm really excited about a lot of the work that's going on. And I think our goal at NACHC is to pull that together and really share those best practices with everybody else so that's a starting point.

**DREW ALTMAN, PH.D:** Anybody else?

**MITCHEL KATZ, MD:** I'd say better minority physician and health care providers. I can't tell you as a Spanish speaking provider how often the previous doctor got it wrong, in part because they spoke in English and the patient responded in English. They naturally assumed that the patient understood, because the patient said, yes, or no, or okay. Right, and they got it completely wrong, what was actually the issue. So payments, a loan payment programs, we've been very

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

successful in working with Secretary Dooley and the state office in increasing that. That makes a big difference in terms of getting providers who represent diverse California.

**DREW ALTMAN:** Okay.

**ANTHONY WRIGHT:** The—

**DREW ALTMAN, PH.D:** Go ahead.

**ANTHONY WRIGHT:** On the issue of outreach. I mean, I think there has been some attention on while California's numbers have generally been good, there's more work that we need to do, certainly in the Latino population and others. I think there are lessons to learn about what we're doing successfully. The question in California is always scale. You know, I mean, if you're doing something really great in East LA, you're doing something really great in East LA, how do you do it for a state of 38 million people? That's great. There's a lot of in person assistance that we just haven't been at the scale of. You know, California had a goal of having nearly 10,000 in person community enrollers. You now, we're at the 4,000 mark and – in the first several months were in the hundreds, not the thousands.

But those were the Spanish speaking troops that we needed in place. Part of it is just ramping up to get to the scale that we need. I also think that there are some barriers that we need to address. It's been good that we've been able to get the education that enrollment is not going to be used as

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

an enforcement mechanism for immigration. We have hundreds of thousands of mixed status families. That that also goes to another lesson from earlier work in California with universal children's efforts in counties, which is that if you can actually make a case that you're opening up the doors to everyone, then you get more people enrolled both of the newly eligible but also the previously eligible. Efforts around the remaining uninsured we're proud that there's a bill in the legislature to address the covering of all Californians, including undocumented. And, you know, that's part of the next step.

There's a range of things that we can do both on the ground, in the near term, but also in the long term to get them included and then obviously there will be a demand driven change. Mitch knows very well that in San Francisco, you know, once they set up Healthy San Francisco, the provider system had to change. Video medical interpretation because, you know, funnily the word for once in English is once in Spanish, and you don't want to take the drug 11 times. You know, there's all sorts of things that you can totally recognize that need to be address and the medical systems are going to have to adjust to some new constituencies. Which we think is a good thing.

**DREW ALTMAN, PH.D.:** Okay. Thank you very much. I'm – you know the secretary said there was a lot of work still to be done and I'm so glad we ended on that question, because it's

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

such an important one. I think we should have a separate forum on outreach strategies as soon as Peter funds it.

We've got to make some choices and we will about the next states that we'll feature in sessions like this, but I'm very interested in the states you'd like to see us feature. So feel free to send Rakesh Singh an e-mail or send me an e-mail. I'm happy to have it with your suggestions about the states you'd like to see us bring in and focus on.

I'd like to thank the Secretary. I'd especially like to thank Rachel. You have no idea how hard it is to do these big projects with the national surveys and the state surveys. Sometimes it's hard to watch, it's so hard to do, and I'd very much like to thank the panel. It's just been a terrific panel, and Peter and our partners at Blue Shield of California Foundation. And thank you very much for coming.

We are adjourned.

[END RECORDING]

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.