

Welcome. You're listening to a UC Davis Center For Poverty research conference podcast. I'm the Center's director, Ann Stevens. In November 2013, the Center hosted the conference, The Affordable Care Act and Low Income Populations: Lessons from and Challenges for Research. The conference featured top healthcare experts from across the country to discuss the rollout of the Affordable Care Act, and what the new system means for poverty in the United States.

In his keynote presentation, Mitchell Katz talks about the challenges of providing healthcare to poor and uninsured populations, and the changes required of county hospitals by the Affordable Care Act. Katz is the director of Los Angeles County Department of Health Services, which serves more than 10 million residents, about 1 million of whom have no medical insurance.

>> Good morning, everyone. I, I am happy to be, introduced, especially as, as a physician. Sometimes I can be an uncivil servant. my, when my son was first learning to, to talk, he, and, we were, we were talking, somehow the question of Dad's job and civil servant, he came up with simple servant, so.

I have spent the last two weeks as an attending inpatient doctor at Harvard General, which is one of the largest safety net hospitals, in the US. And, I try every year, although most of my, my job is administrative I try to spend two weeks working in the hospital.

And it's incredibly informative of the general work that we do in the areas of policy and the areas of research. It makes, makes it easier for me to see what's working and not working in our system. In part, very much related to the themes of this conference. When you're an outpatient doctor, which is what I, what I mostly do when I do clinical work, there is some part of the person at least their life has to be organized enough to get to see you.

Right. Even they, they have to get to an appointment. They have to get to a place. One of the, the things that's very sad and challenging about working in a county hospital is, you see the people who have been unable to follow up. The people who are presenting with very late stage cancer.

People who are presenting with incredible problems of addiction. And then you attempt to deal with their medical issues in an environment where there's nobody to take care of them when they're ready to release, be released. I mean, something that hopefully most of us can take for granted. That if we're sick, we go to a hospital.

We have pneumonia, right, we are well enough to leave. That we're not lea, leaving to live under a freeway, right? We're not leaving to, you know, go to a hotel room. One of our patients we wanted, we arranged for him to go to a hotel room because he didn't have a home, only to realize that he also then had no money for food.

Where people, we wanna be able to send people places. They don't have a ride. They're not able to keep followup appointments because of their difficult issues around child care. They're struggling in relationships with domestic violence and are unable to talk about the issues. And one, one of the things that, that you note as a physician is that the medical part is often the easiest thing, the most straightforward thing.

And the most challenging part of the medical interaction is the poverty. Trying to figure out how, how do you take somebody who now has a very serious diagnosis. They have a late stage cancer. They have serious heart disease, they're going to need a variety of tests. They're going to need a variety of medicines, and they're homeless.

Or, they're living on somebody's couch. I think that in general the health reform is going to make a huge difference, and I'm gonna move now into talking about how I think that will happen. But at the end of the talk, I wanna come back to many of the patients that I saw these past two weeks and think out loud with you.

Because while the Affordable Care Act is gonna grant people access to care who previously had difficulty, it isn't actually going to solve, on its own, homelessness, lack of food, no one to take care of you, in an abusive relationship, hooked on substances. When I think about the Affordable Care Act, I think it's very useful to break it into two halves.

In part because, as Anne was alluding to, it's so complicated that you need a cognitive way to think about it. And so, my cognitive suggestion is, think about it in two parts. Think about what is insurance reform and what is health system reform. I'm more interested in health system reform and I think that's the part that's going to most affect low-income people.

But the insurance reform will hopefully give us the means of paying for it. So, under insurance reform, more people will be covered under insurance. Those people who were covered will have more benefits and protections. And hopefully, that will happen at lower costs. Under the ACA, citizens, permanent residents, have to have health care coverage either through the private market or through the public program like Medi-Cal, which is California's Medicaid, Medicare, or Healthy Families.

Low and middle income persons are offered subsidies and cost sharing through the insurance exchange. No one can be denied coverage. I, as a clinician, I find this statistic sort of funny, or requirement. You know, absolutely, carriers must spend 80% of premiums on care, right. Well, why shouldn't 95% of money, you know, go to care, right?

Isn't that what we are, what we're meant to be providing? Keep in mind that that does not mean that 80 cents is going to care. That means that the insurance provider, from the dollar, is taking no more than 20 cents, and then giving 80 cents to the next group, which will have an administrative expense.

And then, and, it will keep winding down, so it will turn out less and less money will actually go to pay for people's care. Health plans will be held accountable for quality, and there is an essential benefit, which is a pretty wide benefit. Looking at both California and my own county so 7 million uninsured in California, 1.7 million in Los Angeles.

Medicaid expansion so this is people who are under 133% of poverty. 850,000 people will be covered. 390,000 in LA County will gain Medicaid. A much larger group will, are eligible for the exchange with subsidies. But this is a much more questionable number of how many people will actually enroll.

The way Medicaid will work is a little bit more straightforward in the sense that through Healthy Way LA, which is Los Angeles. The low income health program. Which is all of California. We have been enrolling people in a program. They will move into Medicaid, and people will be eligible, even if they do not enroll for Medicaid, when they get sick.

So, let's say someone is not in Medicaid, but they get sick in February. At that point it will be possible to enroll them. The exchange is more complicated, it requires a great deal more action. And how long people, how many people will do that, remains unknown. A very important concept, and I'll keep coming back to it throughout the talk, is the residually uninsured.

Those people who remain uncovered, a million in Los Angeles, 3 to 4 million in the state of California. we, California as a state made rich by immigration, has a disproportionate number of people who will remain residually uninsured cuz they will not meet the citizenship or residency requirements of the ACA.

And as we'll get into the delivery system issues making sure that we have a system for those people is of critical importance to the issues of health and poverty. Covered California. I list the number and every time I, I give the talk, I remind people that we all know people who are eligible for the exchanges but they may not know it.

You know, they are our gardeners and they're our babysitters, and they're the waiters at the places we go. And, the, the, the taxi cab drivers. And they're often very confused. And we can, we can do a public service just by telling people about how Covered California works and that they can enroll.

We're currently in an open enrollment period during which people can choose and up until March 31st, they can still enroll. After that they'll have to wait for the next open enrollment period of time. It's important for them because they face penalties if they don't enroll. And one of the interesting things that you can help them understand, many of us concerned about this issues of poverty feared that the exchanges would be too expensive for people to be able to engage in.

What, what they did which I think was very clever, although it has, it has a downside, but I, I still think was the right decision. They put together plans where there's quite a large copay, and because there's quite a large copay, it, it makes the plan with subsidy essentially free.

So, what, what it becomes is that, for the low-income person, there's essentially no reason not to sign up for the basic plans. The, the bronze or the silver. Because they avoid paying any penalty. You've, you might remember in the debate before, what people were saying is, oh, everybody will pay the penalty because it'll be cheaper than the insurance.

And, of course, we know that, that for low-income populations people don't have excess money. So, it's like, how, how's anybody sure \$150 a month, that's great price for insurance, but what low-income person has an extra \$150 a month to spend? So the answer is, they figured out, well, if they make the copays large enough, it will be essentially, with the subsidy, free.

So now, there becomes no reason not to do it. The problem is conversely, whether or not people will be able to afford care becomes quite a challenge. What it really does is, at the low level is, it prevents working people from bankruptcy. That's really the major, you know, benefit.

Because the, for the average person, what they're gonna wind up paying in copays if they actually need care, is going to be fairly substantial. So they're not gonna save a lot of money. But if they should have a serious illness, they'll be protected against bankruptcy, cuz there's a maximum amount that you can have to spend out of your pocket.

This is just showing where, where people at the exchange are living. The status created a good no wrong door approach, course the concept is right. It will always be challenging to make these things happen. And those of you who work in, in poverty with low income populations and, and poverty advocacy know that, that many of the systems, even ones that are rel, that seem to the people who create them, oh, this is so easy.

You know, frequently do not take into account language barriers, literacy issues. I, I, I have a, a particular patient of mine I've taken care of for a long time, and he called me up and said, I, I have a, a disability form that I need you to sign.

And so, I said, okay, well, I, I'm not in clinic till next week, but if you want to bring it by my office, I'm happy to, you can leave it, I'll sign it, and I'll send it wherever it needs to go. So he took two buses, brought the form, left it in my office.

I pick up the form, it's his signature that the form needed. Right, he, obviously his reading ability was poor, and so of course I couldn't sign it for him and I couldn't send it for him. And all I could do was call him and tell him to come back and pick up his form.

And that is, that was a state disability form. So, you know, not, we're not talking about, we're talking about a form that theoretically should be created to be understandable to people who might need to apply for disability. So I want to, having talked about that, okay, people are gaining coverage, so that's what you should take from the first part.

A lot of people are gonna gain coverage and a lot of people are gonna be left behind. now, the part that, that I'm most interested in is, how do we create great health care systems for low income people. And, that's, that's the thing that gets me up in the morning.

You know, makes me really want to go to work. How do we make great systems? We ought to improve the quality and efficiency. We need stronger work force and infrastructure, and a greater focus on public health and prevention. I'm glad Ron's gonna be talking this afternoon. I think it will be familiar to you that the safety net of those providers who provide a significant level of health care to the uninsured, Medicaid, and vulnerable populations.

One nice thing in the ACA is that it provides incentive payments for primary care. I think this'll be a very active

interest for researchers. Which is to say, you'll have a little bit of an experiment going on. You have no incentive payments, then you'll have incentive payments, and then you'll have no incentive payments.

And, the question is, in that sort of time series analysis, you know, what does happen? Obviously, the hope is that at the end of the two years, people do not abandon patients because they no longer get the incentive payments. But there's nothing that would require the providers continue to see patients beyond that, those two years, which we're hoping is that you're gonna improve capacity and that people, once they take on patients, will continue to see them.

These are just pictures. Let's see the second one, that was the hospital I was at for the last two weeks. We have a, a large system that includes the hospitals, the comprehensive centers, and our emergency services agency. So I'm gonna talk about some of our challenges in meeting the health reform both as the second-largest county system in the US, as, basically, Los Angeles is a third of California when it comes to care of low-income people.

And, I think that the challenges that we face are the same challenges that everybody faces, who works in, in safety net county systems. So, woefully inadequate infrastructure. And I, I spent a lot of my time,. People might think, especially if I get new MPH students who want to come and meet with me and they say they're really excited, they want to work on health reform, and I say that's wonderful, what do you want to do?

And they tell me it's so important to get people into care, and I agree, and I say, but you know what? The real thing I want most is, I want the phone in my center to get answered. That's really what I want. And I, I'm incredibly happy because I now have that working in half our centers.

Why wasn't it working before? Was it, you know, lazy, you know, simple servants? No. All of my large comprehensive health centers, you know, which are, you know, have maybe 20, 25 full-time equivalent physicians working, taking care of thousands and thousands of patients. Two phone lines going into the center.

So if one person is talking to somebody and one person's on hold, everybody else gets a busy signal all day long. All day long. So, how do you provide access to high quality care when people can't even call their office to schedule an appointment? typically, systems like ours, we were created to care for people who had no form of insurance.

So, we never developed the infrastructure to be able to bill insurance. Now, one of the challenges I've been working on, which I think, again, gives you a sense that, you know, what, what the modern servant is doing is not high policy, but, you know, very in the trenches work is, I have to create now a billing system, which is actually a little bit odd because the movement is to bundle payments to ACA's, decapitated payments, various ways of not creating an itemized bill.

But the world hasn't yet moved. So at the moment, in order to work with other providers in a system where people are going to, say, a federally qualified health center, coming, they wanna, they see a patient at that center. They want to send the patient to us because the person, say, has cancer and needs specialty care not provided by a federally qualified health center.

But in order for them to do that, given that the patient is insured, that money is gonna come out of the capitation paid to them. So they wanna know, well, how much is it gonna cost? Well, I run a system that, despite a few has never had any costs.

We never, I mean, we have a total cost. I can tell you what it costs to run the whole thing, \$3.7 billion. And I can tell you how much revenue we get from the federal, state and county government. What the system has never developed is, how much does a visit cost?

How much does a surgery cost? Cuz we haven't been billing anybody. And then I'll say a minute about what I view as the sociologic challenge. And, and to those of you who do research or policy development in the field of poverty, I think you'll immediately understand what I mean.

It's a wonderful thing to want to devote your life to the care of very low income people. And I'm very passionate about

that. I feel that everybody deserves the highest form of care, rich or poor. Having worked my whole life, though, in systems for low income people, I also can't help noticing that sometimes people who work in systems stop treating people as, in the best way possible.

That it is not many patients that I've talked to in my own system have, you know, told me experiences of being told, sit down. You know, the doctor will see you when the doctor will see you. You don't have a choice, you're lucky to be seen here. Things that really should, should never happen.

A sort of when I first got to Los Angeles I was shocked to find out that the system was still doing block appointments. That means that 200 women would be given a 9:00 a.m. appointment for a pap smear. So it wasn't really an appointment, right? It was a first come, first serve.

And, the women, of course, were smart enough to know this. So they would come at 6:00 a.m., . so that they could get the pap smear, get out, and get, get to work or take care of their children. So you'd have these long lines of women waiting for their 9 o'clock appointment.

I was shocked not only that it was still going on, but when I said, this can't, you know, we can't do this. This is, you know, 2013. Nobody does this. This is wrong. This was always wrong. But, but we cannot do this. People actually said to me. Well, you know, patients, you know, they all come on the bus anyway.

They don't know when they're gonna get here. They can't keep appointments. You know, I said, you know, well, you know, yes, you know, sometimes I can't keep appointments, right? And if people have a 9:15 appointment and they come at 11, yeah, then you have to tell them that next time they need to come to their appointment on time.

But there is a certain sociology that happens when you are only taking care of people who quote unquote have no choice. That's why my goal is to be a system of choice, a system that people actively choose to go to. So what happens to the half of the uninsured who gain coverage, both in Los Angeles and broadly, is, now they can choose to leave the system.

And when Medi-Cal happened for moms, LAC USC went from the hospital with the most deliveries west of the Mississippi, 8,000 a year, to under 1,000 overnight. Women voted with their feet. And the system allowed it. In part cuz the system liked the idea of being a system for people who had no choice, right, and it goes back to the sociology of it.

If you're only taking care of people who have no choice, then there's not the push to meet a particular standard, to meet their expectations and needs, cuz obviously they don't have a choice. They wait all day, well, they don't really have a choice. If people leave my system, or broadly, the safety net systems across California, we will not be viable.

If we lose all of our paying patients, we will not have enough revenue left to care for the people who remain uninsured. And those of you familiar with how county hospitals operate, or really any hospital, will immediately recognize, hospitals have huge fixed expenses. A hospital like LAC+USC 800 patient that, if that hospital is half empty, my costs for running that hospital will decrease.

Maybe it'll cost me 85%, but it certainly won't decrease down to 50%, because of the utilities and fixed costs. Those services where you always have to have a doctor on, a specialized nurse, a specialized pharmacist. now, I, I'm an optimist. I never would've taken a job like running LA county's health service if I weren't.

We have a lot of great advantages that apply to many safety net systems. We have university affiliations. We have salaried physicians. This is something I think about a lot as I help my parents who are my dad's 91, my mom's 86. They're in the Medicare system in a well to do suburb in upstate New York.

I can't tell you how many appointments they have been given for unnecessary care. Right, for procedures they don't need, visits they don't need. Why? Because Medicare pays for the thing, and so they keep getting sent for the thing. Whatever the challenges of the system that I have is, one thing I take tremendous pleasure in, we don't do any

unnecessary care.

Nobody, there's no financial incentive. Everybody is, you know, overwhelmed trying to take care of the people who need care. Nobody is sending people for unnecessary procedures in order to make money. We do have a variety of specialized services like trauma pediatric neuro-ophthalmology. We have great relationships with our federally qualified health centers, connection to other county services like mental health and general relief, and great alignment with our public employee unions.

LA safety net is changing. One thing I noticed when I was around San Francisco's health system. Any good thing that I did effort would be immediately dismissed. as, oh, well, you can do that because you're in San Fransisco. Well, that's because you can do San Fransisco, you know.

I, I have this sort of humorous opposite thing, any tiny thing that I do in LA, they go like, wow, you did that in LA?

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>> It's like the most trivial thing, it's like I can't believe you could do that in LA, well, then we can do it anywhere, so I think I've like, you know, gone on both ends of this.

Our new phone system is working, we have a disease registry operational. We have an electronic health record project that's on time and on budget. I wanna talk about eConsult only as an example of what great systems can do in terms of innovations. So, when I came to Los Angeles, one of the first things people told me about was how long the wait was for specialty care.

Not unusual in safety-net systems. Why? Because the legislation for federally qualified health centers allows for only primary care, so there's no specialty care. So it's fine so long as you need well care, or have minor chronic illnesses. Not so good if you have cancer or heart disease. So, you're faced, as an administrator, with, okay, it takes seven months to see a cardiologist, nine months to see a gastroenterologist.

How do you fix that problem? Specialists are incredibly expensive, often earning two or three times what primary-care doctors earn. Wasn't clear to me that I could even get, you know, hire that many, assuming that I could get the money to hire that many. So, what we did is, a innovation called the consult.

The way a consult works is, as a primary care doctor, I can electronically send a consultation to a specialist. So, I might send to a cardiologist, I might write my patient has congestive heart failure. They're on these three medicines, they're still short of breath, what should I do next.

In the old days, what I would have done is, I would have put that in as a referral. They would have gotten an appointment with the cardiologist in seven months. Now, I send it electronically, and you can see on the right, within two days, I'll get an answer.

And, I will then be able to better care for patient, my patient won't have to travel, which is a huge issue in LA because of the length of time in some of the rural areas that are far off, and I become a better doctor. Because now I've learned something.

And the specialist has more time to take care of the really difficult patients. So it's a, it's a win for everybody. A third of the visits fall into that group. So, we eliminated a third of the visits. Then the middle group is also a third. In this case, what the specialist says is, happy to see the patient.

But they need something before the visit. So, here an example might be, somebody has blood in their urine. In the old days, I would have sent a referral, which means they would have had an appointment in seven or eight months. And when they had that appointment, the first thing the urologist would have said is, you need to get a CT scan.

Come back and see me after the CT scan, to see whether or not you have a kidney stone causing the blood in your urine. Now, if I sent that consult, the urologist would say, do a CT scan, and then I'll see the patient. And so, what you do is, you make the visits more meaningful.

So, you essentially are saving visits even though the person needs to be seen. And the third, the last third need to be seen. But it, it basically cuts down the number of visits while promoting access. So, shows you, systems can innovate in the safety net when they're really thinking about access.

The failure of the safety net, which will happen if everybody leaves, will be disastrous for us. The residually uninsured will have nowhere to go. A huge number of the physicians, the nurses, the pharmacists, social workers have their teaching programs at, at county hospitals. And there would be, you know, a loss of the less profitable centers, and I'll just give you one example from Los Angeles.

I'm reading in the newspaper Cedars-Sinai says they're closing their psychiatric emergency service. Head of hospital explains, we've decided it's not a center of excellence for us. We're gonna focus on those areas that we think we do best. Hm, that's all? It's a non-profit hospital, not a, not a hospital in financial trouble.

And, they just make a decision they're not doing it. Right, well, county, right, will always be there to take care of people who need psychiatric emergencies as long as these county hospitals can survive. So success is the only good option. Increasing access, improving customer service so that people choose us, so that we provide good care for them.

And that we're still around for other people and that we enhance quality. And let me again return to the theme I started with and remind all of us that insurance is not care. Insurance is a financial way to pay for care. Having an insurance card does not guarantee that you get care.

Having access and an insurance card still may not get you care if you can't get to the visit because there's nobody to take care of your kids. Or because you're struggling with substances and there are no good options. Or because you are living under the freeway and that it is, that it is incumbent on all of us who do research and policy work and care to remember that the medical system is overwhelmingly built on a middle class model.

It's overwhelmingly built on a model that not only people have insurance, but they have families that are going to take care of them, they have homes to go to, they have rides to their visits. And that that actually is not at all the reality of the people that I take care of.

They are struggling to get through the day. I, I took care of somebody who needed to be put into the hospital, and I said to him, is there anything that you need to do, you know, before, you go into the hospital? And, I was thinking, you know, like, do you have a dog that needs to, to go somewhere, you have to arrange any childcare.

And he said, no, you know, how long will I need to be there? And I said, probably two to three days, and he goes, two to three days? I'll lose my job. And, this was somebody incredibly, acutely ill, who needed emergency treatment, right, but what he was thinking about is, I'll lose my job.

So I, I think that's a good reminder to us of how as we move forward, we should be optimistic. And, we should use, leverage the ACA in every way possible, for the people we care about. But we should never confuse insurance with care, and never forget the tremendous needs people have that are related to their medical things.

Thank you.

>> I'm Ann Stevens, the director of the Center for Poverty Research at UC Davis, and I want to thank you for listening. The center is one of three federally designated poverty research centers in the United States. Our mission is to facilitate non-partisan academic research on domestic poverty, to disseminate this research, and to train the next generation of poverty scholars.

Core funding comes from the US Department of Health and Human Services. For more information about the center, visit us online at poverty.ucdavis.edu.