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. Lessons from and challenges for research. The conference featured top healthcare experts from across the country to discuss the role of the Affordable Care Act, and what the new system means for poverty in the United States.

In this presentation, Peter Cunningham discusses his research on how the Affordable Care Act might affect how safety net hospitals that primarily serve poor populations care for their patients. Cunningham is a senior fellow, a director of quantitative research at the Center for Studying Health System Change.
>> What we're gonna be talking about this afternoon kinda comes from a, a number of different sources the organization that I work for the Center Studied Health System Change.

We've done a lot of analysis of healthcare markets. These have been very broad in scope, they've also focused on safety net systems including safety net hospitals. We've done it nationally, they're referring to community trafficking study. We also did a study in California for the California Health Care Foundation 2009 and 2012, we studied six California health care markets.

Sacramento was included in that. And then we sort of used that experience as well as the experience of lots of other people now that we're, we are working with the federal department. Sort of health and human services, to help them develop a system for, monitoring and, and tracking, the effects of the affordable care act, on safety net hospitals as we move forward.

A part of that includes developing a quantitative data. To be so/ of safety net hospitals projecting but the effects of the Affordable Care Act are gonna be. Obviously, that's far in to the future. So today, I'm gonna talk mainly about what, what I, what we think are some of the most important research questions, hypotheses, as well as the conceptual framework for understanding what's, what we think is going to happen here.

So it's all, always useful to start with a definition of safety net hospitals and then, imply that my definition is consistent with the definition Dr. Katz used this morning that comes from the institute of medicine it's par the course. Most likely used, or cited. I guess one, one thing that I would add is, that in addition to providers that deliver a significant level of care to low income populations, that the provider by mandate or mission offers, offers access to care, regardless patient's ability to pay.

I think that's important because some safety net hospitals aren't necess, necessarily located in areas where, you know, there's very high uninsured population or very high Medicaid population. But because of their mission, they do take people regardless of ability, of their ability to pay. Now, what makes this definition difficult to operationalize in the research sense is really this area.

You know, what is significant level of care, because the vast majority of hospitals, short-term general hospitals deliver some amount healthcare to uninsured and Medicaid for all. There is a lot of possible to go to the hospital, and so some some obviously that's their mission. Doesn't mean a thing they do.

Others do a fair amount. Some do very little. So what, what's kind of starting to research where we haven't really been able to find a succinct definition as to, what's that line or what's that threshold? It's something that's gonna vary, basically, from community to community. So just, you know, so for now, I'll just kind of describe the different types of safety net hospitals.

And public hospitals. When we think of sitting in that hospital, I think most people think first and foremost of public hospitals, that these are owned and financed by city, or county, governments. Sometimes they comprise only of a single hospital. Sometimes they incorporate a large system. The LA County health care system.

Chicago, New York City. You know, so when we look across all hospitals, you know, roughly about a fifth are government-owned. The way that they, they're usually classified in data and, and these hospitals, they definitely provide a disproportionate amount of care to uninsured persons. And these are about 100 of the biggest, and you know

you might say the most hardcore safety net hospitals.

And they, they can and they estimate they can price 2% of hospitals of the provide about 25% of all other kinds of taking care. So definitely there's a big concentration cure to the uninsured in Medicaid in government hospitals or public hospitals. Not every, not every community has a public hospital.

I believe Sacramento is one example, there is no public hospital in Sacramento. So other hospitals stepped in to some extent of these to fill avoid. And a lot of these are academic medical centers also called teaching hospitals. So I believe in Sacramento, UCDavis is considered of the one of the big safety net hospitals.

And so these, and they receive government funds usually medicare subsidies, or teaching and also. There's also religious affiliated hospitals, and most of these are private. But there's also a lot of big hospital systems such as you know, Trinity Catholic Healthcare West, these are big major hospital systems, but they're religious affiliated.

Some people say they're acting more corporate these days, but they still have that mission to serve the uninsured. There's critical access hospitals. These are primarily rural, and, and this is a designation that the Federal government uses to to, to identify rural hospitals that basically they're the only game in down.

And it, and it's very difficult for them to survive so they get higher reimbursement from Medicare. Another probably 2,000 or some other credit hospitals. Most of these are not for profits but they also include some for profit. Again, most of these hospitals provide some amount of compensated care.

And the ones that probably provide more safety net work can be those that are located in communities where there is no public hospital. San Diego again is one community that comes in mind there, again the University of California, San Diego their medical school, they're a major safety net hospital where there's an medical center.

But you know, they don't fill Hospital, there's other, there's two other systems, sharps, and scripts. Private voluntary systems, that also are considered a big safety net for virus in those communities. So, if we just kind of focus on the 100 or so member hospital from the National Association of Public Hospitals.

This is, you know, in general one safety net hospital patients look like about a third are Medicaid 25% are Medicare 18% uninsured, and 19% commercial. And maybe the commercial is a little bit surprising because, again, we're talking about real hardcore safety net hospitals. We don't normally think in terms of, well, go there.

Well, a lot of cases speaking of hospitals provide by the, the key services in the community for trauma, birth care. Sometimes they are considered leaders in the community for other service lines like cardiac or oncology. So, it isn't a question that we do get prep the insured patients who go there.

Now, in terms of where in terms of where safety net hospitals get their revenue, again, these are the 100 or so members of the National Association of Public Hospitals more than a third comes from Medicaid. And then it comes out of the revenue from directory and personal services.

But subsidies, additional subsidies of this recourse you can share payments that are made to sort of compensate for the fact Medicaid usually pays people costs. It also helps. Medicare is another 21%. Commercial is 27%. And then subsidies. These would be from local, state, or other federal sources. And obviously, you only get 2% of the revenue directly I think from an insured person's and form of self pay.

So fill up the press to feel like you press all this about three fourths of revenue of for the major safety net hospitals come from government sources. So government funding is critical for these hospitals. So what, so what are safety net providers, kind of how are they doing now right on the eve of the implementation of the ACA?

And again, let me see, these are, it's always, one thing I'm going to always say is well it varies from hospital to hospital, community to community, community. But these are some broad general observations. One is that there's increasing demand for care by mature persons, and that's a result of recession the increase of local uninsured.

You see the continued erosion of employer sponsored coverage, and so, and then you see other hospitals. Sort of non safety net hospitals that have kind of cut back on providers to early care because you know they're trying to control their policies well. We're seeing a decrease in pulling subsidies.

And that's coming from and that's a result of a lot of state and global budget pressures, again, related to the recession reduce, and that includes reduce reimbursement for Medicaid and Medicare. So a lot of safety net hospitals are under a lot of financial strain because they're seeing the demand for uninsured care go up while the subsidies and payments that they get to support this go down.

We see increasing competition with other hospitals. You may wonder, well who competes for uninsured patients. Well no, they're not competing for uninsured patients. And again, a lot of safety net hospitals you know, they are considered the leader in their communities, for some service lines. And when that happens, other hospitals want to get in on that.

You know, they want to build a cardiac unit to compete with the safety net hospitals or build oncology. And then, and the real, many safety net hospitals are struggling financially. A lot of them have negative margins on average, I think the margin is like 2% per safety net hospital, and that's compared to 7% nationally.

I think that's for 2012. And then, as Doctor described making preparations for health reform as well. Doing various things. Streamlining activities. Increasing capacity to handle their expected increased demand. Developing linkages with primary care. But not all, not all hospitals are doing this. We saw this including in California Fresno, for example, is a place where there is no public hospital.

And for various political and cultural reasons, Pursna is I think, still is the only county in California that did not, put out the New England health program which is kind of a precursor to Medicaid, Medicaid expansion. And it's very little activity by any of the hospitals in that community to prepare themselves for reform.

So given that, here's kind of the conceptual framework that we developed for kinda understanding how do you think the Affordable Care Act is going to affect safety net hospitals. So, you know, I, I realize you probably can't read the fine print. I wouldn't worry about that for, for now.

But, you know, basically what's gonna be driving. What's gonna be driving this is the change in the number of uninsured people in the community around the, I mean the number of insured people in the community. But that's gonna create changes in demand for care at the hospital, which will in turn affect changes in hospital revenue and cost.

So that'll be kind of may driver, but there's gonna be a lot of things that kinda interact with that. You know, if, if you will, that relate both to state and local policies regarding, for example, whether this thing decided to expand Medicaid. You know, Medicaid reimbursement covers benefits.

And there was contextual factors in the community that will affect how hospitals respond to a core depth health reform. And this is obviously one big one. It's gonna be the number of uninsured, the characteristics of the uninsured. The community prior to reform. You know, the, the kinds of outreach and enrollment activities, you know, kind of a more grassroots approach to expanding coverage.

There's aspects of the local delivery system, you know, how much competition is there between hospitals. What's the capacity? So the rest of we're gonna spend covering some these things in detail. First you know, what we think are gonna be some of the most important outcomes to monitor financial viability and performance is obviously one, because that's something that a lot of safety net hospitals struggle with.

And, I think, maybe, I don't know, I think a lot of safety net hospitals will say, well, we want some. Because we want resources to give human best in upgrade but, frankly for a lot of states hospitals survival is a good outcome they're not, they're not looking to rake in big profits.

And then I think along with it could, could seeking at hospitals maintain our mission to serve the amateur. Now what,

what do I mean by that? Which is what we've seen over the past decade, is that as a lot of safety net hospitals have struggled financially. They've begun to adopt some strategies that resemble almost private and even for-profit hospitals.

You know, trying to find ways to minimize their exposure to uncompensated care, develop service lines that attract more privately insured patients. And, you know, it doesn't mean that they're bad guys and their shirking their responsibilities. They're trying to survive in a, in an increasingly difficult Uu the key is their ability to provide services to those who remain unsure.

That's a lot and you just got of a graduate school. That was about the number of uninsured people. So that's a still a lot of uninsured people and a lot of those people who remain uninsured are going to be undocumented immigrants who don't qualify for the Medicaid expansions.

They don't qualify for the subsidies. And in some communities, and you know a lot of communities in California, a lot, a lot of the uninsured population are undocumented immigrants. Though we're not gonna really be, they're, they're not gonna be benefitting from the insurance expansions and the ACA, and so there's no real need to be a safety net hospital.

Hospitals, that are there to meet their needs. Another important outcome is quality of care. And I don't mean just the, sort of, quality measures that CMS is developing, like you know the 30 day readmission rates, yeah, that's important to some extent, but I think it's also, what we're also talking about are.

Sort of the types of quality measures that doctor Kess was talking about. Creating an integrated care system, with primary care providers trying to reduce unnecessary e r bills they check, create more coordinated care. You know, I think that's, that's the type of quality that. That we also, we all want to see in the healthcare system.

>> What's going to be the, how's the Manford Tier going to be affected?
>> Well obviously there's going to be more insured I think again CBO had been estimating maybe about 14 or 15 million in the first year Okay. It's gonna be kinda whether the state decides to expand Medicaid that a lot obviously be a big factor.

Because as of a result of a supreme court decision in 2012 states now have the option to expand Medicaid. And about 20, I think as of now, about 26 states are definitely planning. Into a span, some a lot of states are not, some states are in the sight.

Some states might flip like, close to home Virginia which is not, right now not planning to expand medically but they're going to have an election in, in a few weeks where the results. May result in a government that will disband Medicaid. So it's, so that's still kinda a moving target.

It's also gonna depend on the success of A-C-A enrollment efforts in states. So it's, you know again here's where we get into kind of the, you know, the talk of the politics of the A-C-A because, you know, for states it's not just. That's a decision that, they don't like Obamacare and they don't want to expend Medicaid.

They always wanna create obstacles, for the navigators, is who are the important. The outreach, program groups who are going around trying to, involve people in the exchange itself. How successful, those are or not though will effect demand for care. And as I mentioned, previously the prevalence of undocumented immigrants.

Certain communities and Fresno is one, where a lot of the uninsured population consists of undocumented immigrants. That's not really gonna, that may not effect. Demand for care in that community as much as other communities that have high uninsured rates but where most of the people are. Another factor is gonna be whether the hospital is included as an essential community provider.

You call the plan networks. So the Affordable Care Act requires the inclusion of safety net providers in high, sold

through the market places. But not all plans, not all providers need to be included and states have considerable discretion in terms of deciding whose included. That's gonna be a big factor, because, obviously, they wanna be in.

And it's not just whether they're included. But, you know? Kind of what, what the nature of the health plan is. And so, a lot of safety net providers are really nervous about this. And then, as I mentioned before. Competition with other hospitals for the newly. So how are other hospitals gonna respond?

Are they gonna see oh that, that safety net hospital use to have all these uninsured patients. Without coverage. So changes in patient revenue. Obviously with increased. And coverage. You're gonna get increases in patient revenue from Medicade and private insurance but this may not be commensurate with the increased demand to the extent that states cut back on reimbursement benefits.

We said that in recent years budget problems. And also Medicade has historically covered On the exchange plans. Are hospitals gonna be paid at what are essentially Medicaid rates, or are they gonna more resemble private, the more generous private insurance rates? Now the big issue which was made even more significant by the, by the Supreme Court decision last.

Estruder. Part of the reductions and public subsidies. And, and so most safety net hospitals get revenue, they get additional subsidies from Medicaid and Medicare through disproportionate share hospital payments. But as part of the, the Affordable Care Act, these subsidies are going to, to increase over time, because the rationale is they're no longer needed as we, as there's more insured people.

Well, that, that rationale was developed before the Supreme Court decision when it was presumed all states would be expanding Medicaid. Now you have the fact that probably that maybe half. Half of the states may not be expanding Medicaid and so, that's, that's gonna create a potential catastrophe for some safety net hospitals who are in states where there are, they have very uninsured rates, but they're not gonna see much of an increase.

Is in, in, in demand because the state's not expanding Medicaid. But the federal government isn't having their subsidy. That's gonna be major issue to watch. There's also risk of further reductions in other state and local subsidies. You know, I think the fear is that again. State and local official who are used to subsidising the safety matter.

And they say, well, those subsidies are no longer needed, or they're not needed as much because we saw the uninsured problem. Again, we're gonna stay uninsured. It's not completely solved. And so once, and there's also the immediate impact on hospitals cost. Obviously to the extent that hospitals can reduce their compensating care.

That's a big impact in cost. But, there could also be a potential increased cost, because a lot of hospitals need to expand capacity to handle the expected increase in demand. There's upgrades in infrastructure. Health information technology in particular, that are needed to sort of handle these new, delivery systems.

There's gonna be some increased regulatory burdens, due to the Affordable Care Act. And that, that has to do with, serving the community benefit. It reporting and monitoring community right there. And then penalties there for, for failing to meet quality standards meant that have been mandated by Medicare and that's the, the hospital readmission rates these other things coming online.

It's not just a question of being penalized. Has flair, but, you know, they're gonna need to make upgrades in their infrastructure, as well as care processes. And that's gonna add to the cost. And then you've got the organization and dynamics of the local health care system. I think Ian will probably talk some more about the system capacity, especially primary care.

But you know, it's expected that there's gon, there's already primary care shortages and those are gonna be made worse. And that's gonna put pressure on hospital emergency departments. Hospital consolidation competition. We already talk about that. The structure of insurance markets. Again you know, what are the networks gonna look like.

Are they gonna include safety net providers. Again, sort of the concentration of care to the uninsured. You know, so is

it concentrated in one big system, or is it more dispersed? And then these two things, experience with Medicaid manage care, and then we probably don't have time And now, some safety net hospitals do operate their own Medicare management plans.

And they have experience with the risk. I think that's probably, for those that have that experience, that can give them a leg up. Innovations in care delivery and payment. We get those, these are some of the lesser-known. Features of the ac but you know it's really there's a lot of different models we target display.

And we've only got about ten seconds left to cover but you know basically they're trying to achieve better value in healthcare. Incentivize to providers to assume all responsibility. For the care of patients, rather than the current system, which providers are incentivized to provide more, and more, and more, without really, the outcomes.

And encouraging greater integration and coordination of services, to reduce the fragmentation that exists, of care. These are, and you've probably heard of these, HCOs. This using separate medical poems. You know it I think probably the biggest implication through safety net hospitals.Again it's restructuring this, the system to incentivize primary care.

Reducing the for end patient care. Increase the alignments between hospitals and primary. Healthcare providers in the community potentially taking on the greater financial risk of patients, which some safety net hospitals are better able and have more experience to do than others. But then there's also some variables. The need for more funding, for, for inter, infrastructure and staffing So I think, just to kind of wrap up, what we think, are we gonna be some the key predictors of success for safety net hospitals with this health reform.

One is strong financial performance prior to the ACA. Because hospitals are, if they had negative margins and they're in debt, they're not gonna have the resources Primary care training develops in in their service lines so that they can maintain their patients that become insured or entrap other insured patients.

And again, updating your infrastructure and capacity and making sure there are representative help finding.
>> I'm Ann Stevens, the Director for the Center of 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 nonpartisan 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.