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 in 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 this panel discussion, moderator Joy Melnikow, Director of The Center for Healthcare Policy and Research. Search and panelists Ron Chapman, Neil Kowatsu, Robin Afrime, and Chris Renavasen. Consider how academic research might contribute to successful implementation of the Affordable Care Act.

Ron Chapman is the Director of the California Department of Public Health. Neil Kowatsu is the Medical Director of the California Department of Health Care Service. And Chris Stritovozen, is a practicing medical doctor for the UC Davis health system, and for Comunicare health centers.
>> Well I can speak for community health centers.

And a little bit for hospitals. we, as an FQHC, we get an enhanced rate for MediCal, for Medicaid, and even from Medicare a little bit. And we also get a Federal grant. And so, it's exactly what Chris said If we can, for us we always say it's about our pair mix.

If we have enough of the, of people that are covered it absolutely helps us provide uncompensated care for them to document it. We do ask for a sliding fee scale. And it, it, it depends on your family size and income, what you pay on a scale, but. If they can't pay, we see them.

Hospitals tend to have charity or community benefits. So, and depending on how sick a patient is, they have to be seen in the hospital. The real problem, I think, is with specialty care access. Because, When, it's sometimes difficult if you have BeniCal to find a specialist. It's sometimes difficult if you have great insurance, to find a specialist.

But if you're uninsured, it's very very difficult. And that, that really is a problem. What happens is, a lot of people just wait. And they get very sick, and they go to the emergency room. And then they get seen in the hospital. It is also, medications. If you're uninsured, it's lab tests, X-rays.

We do have a prescription assistance program, which we work with the pharmaceutical companies to get medications for uninsured. That actually does work pretty well, but, yeah, it's a problem, it's an issue.
>> The fun imposed this year will actually will remain intact. We'll have to keep this,.
>> Yeah we, we answer your questions, so we think that the way that were paid will remain for the next few years, but I we also believe that it's gonna be much more based on pay for performance.

And there may be ways to look at payment for FQHCs that isn't based on a, a per visit reimbursement. But is based on quality incentives, capitation. That, that may actually change. I mean not, maybe not in the next five years, but. Soon.
>> Kim, kind of a, kind of a follow-up question then.

What do you then think about California compared to most of the rest of the country that each of the counties have a county. Indigent program different things and you know, very lost sometimes. Generously funded. And, you know? You only cover part of the care that. How does that, how does that figure in?

I mean, I don't know how it's structured here in this county. And whether we have some of that, Hospitals, I guess post ACA, or ACA implementation, how do those county programs figure in to. You know, to redesigning, reforming the system. And, I guess, are you, do you have data
>> So, I, I'll, I'll answer a little bit and I think Ron can, Ron talked about it a little bit.

Again it's about funding post-ACA the LIP programs. There has been for many, many years, a program called CMSP, County Medical Services Program. And that was, it's run through the state and mostly the rural. Counties in California have participated in Yellow County as one, and that's with the LIP program.

So, those those people under hun, 100% of poverty were on the LIP program have the health ready to be enrolled into Medical. And then there's those other people that make a little more that were sometimes on CMSP, sometimes weren't, and back and forth. But the, and so, the counties, the counties had a lot more money then.

But just like Ron said, it the theory was from the state's perspective that the counties are not gonna need all that money. And I think, I think in Yolo County, they retained 30%. The state took 70% back off that funding because the serious role, everyone is gonna be, everyone is gonna be covered.

So, you are just gonna need money for some public health. And well, we know that's not true. We know, there is gonna be a lot of uninsured and in the CMSB program through the state. The undocumented were not, are not eligible.
>> So, and, I mentioned the section 17000, I mean, that is unique to California.

And that's in State law and that puts a responsibility for indigent medical care on each county. But how each county interprets that law, it varies. And so you have some counties that have a certain political sway where they're refusing to take care of undocumented. They won't, they don't think the law applies to those folks.

And others that have a very completely opposite interpretation. So unfortunately, I don't know of a single database that would track the changes moving forward. Because it's so fragmented in that way it really is variable from one county to the next. Next.
>> Is, anything, there isn't any statewide reform of the especially the CMSB program that is going be part of the state reform effort.

>> The C-M-S-B program, which is her report from someone who works for them. Will only be, they're losing, we'll be losing ninety percent of all of the patients that they've been covering. So CMSP program, it is a program that would exist in the counties, to help, the people that.

There would, there are some people that are citizens that are still, still, will still be eligible for CMSP, but not, so 10%. I mean, there's not going to be very much, and, there is emergency MediCal for very, very sick. Undocumented people as we heard but
>> And of course CMSP is what 32 or some, its not all the counties.

>> Its not all the states. It's, it's only the smaller counties.
>> Mm-hm. So first I just want to say thank you to Chris and Robert for being here and kind of putting a face on. Talking about all the research talk policy around it. But a part of the healthcare system is, it's nice to see you guys here just representing that my question is a little bit more to Neal and to Ron which how great has a lot of healthcare.

Pre healthcare facilities more than most in the country and I'm wondering your perspective on how those systems have been looking. And that's maybe one model of how access to secure lifelines can spread, if they are allowed.
>> Were you referring to FQAC, or.
>> Community health center, I mean I, in general, not just.

>> Community health center. I mean, I, that's clearly a critical part of the medical. Network and you know? Robin you were alluding to people are looking for different ways of reimbursement. And how to, you know, pay for performance is something that we hear from CMS all the time, in all aspects, in-patient, out-patient care.

So, it's a very dynamic time. But, clearly, you're, you're right. It's a key part of the network for a lot of reasons. Closeness to the community, cultural competency skills for a lot of reasons. And what's going to be the hard part is kind of working through the reimbursement.

Dealing with the expansion, at the same time trying to advance. Quality is, you know, we're dealing with all the, kind

of the, day to day and real world challenges that Robin and Chris talked about. But, it's clearly going to continue to be important, you know, backbone part of the safety net.

Ron?
>> Yeah, I, I totally agree. You know, I, I ran a couple of FQHEs in Cilano County, so, and as a family doc was seeing patients every week in those clinics. I was also a chief medical officer for partnership health plan, MediCal, managed care health plan that was mentioned.

And I was able to go out and visit practices in a very large network. And, you know, there are lot of practices out there that in the help plan we call singles and doubles like Tennis. These are our dark standard 1z, 2z they are out there by themselves.

Some in community is in a neighborhood, in a, in a house converted into a clinic. And it, there, there's all, there are a lot of folks in practice like that.
>> Mm-hm.
>> Specially in rural areas and they are just not equipped to do electronic health records. Let alone the coordinated care and community outreach that a community health center.

Can do. So I, I think community health centers are well positioned to take advantage of all the changes going on under ACA, definitely. Changes that
>> Well, as someone who has worked in the free clinics JBMC Amani. I was. Medical director at DuPotti at one point, it's not really going to change.

Cuz I think that that's the really population of those clinics had been focused on this whole time. The challenges will do the same, I mean, it's not, the undocumented can get, you know, basic. They can see doctors in free clinics, and in our clinics. The, the problem is really what if they have issues that need, you know, imaging, specialty care.

That's really the limitation. What, what would be great, I think, for the free clinics,. and they do this to some extent, already, is to expand. You know, because really the medical students and the residents work in these clinics to learn, and so if you can reach out to specialty.

You know, have a cardiology day once a month where the cardiology fellows come and bring their ultrasound and do echocardiograms and. I know neurology has clinics that embody that sort of thing, that really helps a lot. Cuz at least you have this sort of internal you know, internal speciality referral system that.

And then you know, if you get them to see a cardiologist and they're compelled by the story. They have friends, you know, maybe stuff happens. So, you know, it's really sort of grass roots medicine in that way. But, I think, you know, that's, that's something I've always wanted to do more of at the free clinics.

>> Can I just say one thing, too? I think the use of telemedicine actually for specialty care access, particularly since you're a part of the university. We, CommuniCare participates in UC Davis Rural-PRIME, and because we. Two of our physicians teach in that program, and because we do that, we have.

They have given us telemedicine equipment for our three primary care sites. The issue for us is that we don't have, always have specialists on the other end. But I think for you and telemedicine isn't, isn't just distance. It's act, it's different kinds of access. So, we, we had a grant at one time at which went away which is too bad.

Where we had access to specialists. Throughout all of the UC's medical, medical schools. So, I, we have neurology. I think it was UC Irvine was neurology. I forget what, what UCSF, I forget what specialty we had there. But we had specialists, really, it was great access, and a, and a number at UC Davis.

But maybe that's something you can work out. And figure out, because some docs really like that, that form of providing specialty care.

>> Okay. Maybe the possibility of migration of your opinion. I, I think it's.
>> Certainly a possibility and there certainly would be motivation for folks and their families.

I just don't know of any data.
>> Studies?
>> Right. I dont know of any studies that would show whether that is happening or not.
>> That is a good research question.
>> I think actually what I, what I heard ,I am not sure. I don't know if I.

heard it on MPR, and I always believe MPR. But I, there was, a lot more had to do with the economy. When the economy was really bad, a lot of undocumented people went home. They went back to whatever country, mostly Mexico, but. It was easier to get a job there than it was here.

But the, the economy is picking up again so we may see more people coming over for jobs.
>> Yeah, I mean.
>> Picking up.
>> Yeah. I mean, my sense is the undocumented aren't here for services. They're here for jobs.
>> Yeah, yeah, really.
>> So I don't think.

It's really a battle.
>> Yeah.
>> I mean, you know those rumors that people were crossing. Women were crossing the border between Mexico and San Diego to have babies so they would be born in California. I don't believe that. You do?
>> Yeah.
>> Oh really, is that really.

I don't believe it.
>> I'd say L.N.D. in Stockton and that happened. And then they go home?
>> Yeah they go home.
>> Oh. Okay, I was wrong.
>> That's
>> But there is actually a.
>> I'm still about breakfast juice foreign countries
>> There is actually. There is the opposite direction migration for healthcare ulcers so this is more the case in Southern California.

Especially around San Diego. But Mexico actually has more comprehensive health care than the United States has had until now. Mexico went to expanded coverage for their low-income folks probably about eight years ago, ten years ago. And so there are a number of people who work in southern California, especially around San Diego, who when they need serious health care they go home.

To Mexico, and then they'll come back to work, but anyway so it actually works in both directions. Also for dental care, I think that's true which is, is a, you know, the unspoken. Nobody covers kind of thing. So it, it happens both directions so it would be fascinating to study.

I think it would be very hard to get the data. Yeah.
>> Especially now
>> Mm-hm.
>> So yeah between states you could study that yeah, it would be interesting. Yeah?
>> Robin profile of the 7,000. 1,000 or so patients that are uninsured that you've seen in your your system.

And I thought I saw that almost half of those wer individuals who under the current eligibility regulations, would be eligible. And then that number is actually larger than the number of

>> Yeah, well that's how it broke down when we looked at the numbers but I don't I don't think all of those people are actually going to enroll.

But the biggest, the biggest number, and I actually really do believe this. This, and it may even be larger, is the number of people that will be eligible January 1st under expanded Medical. From 100, to 138% of poverty. That is the core of people we have been seeing for years and years and years.

That are uninsured. And these are citizens, this is not undocumented. So I, that, that is and either health centers are saying the same thing. That is a really large percentage of our current patients that we're seeing that, that should be eligible to get Medical January 1st.
>> Colin?

>> So, on a related question. There will be movement. And has been moved in and out of the UK.
>> Mm-hm.
>> Under the new system. Do we expect there to be more movement, in and out, eligible for Medicaid, and subsidized insurance.
>> Well, actually one of the really good things is that eligibility renewal is just going to be annually now.

Under the new MediCal, rather than twice a year or quarterly. So the more often people have to go in to renew their, their Medical, the more often they fall off. So there should be a lot more continuity now that they only have to renew once a year.
>> Yes, yeah.

>> All states?
>> Yes, this is, I can only speak to California.
>> You know what is different, kind of like little towns that can have 120 or 140, 120 to 140.
>> Yeah, and that will help, and I was going to say, that will, that does happen.

That really does happen. It has to do with their work.
>> Right now, if they bounce, every three months, I think it is. Every three or four months. A they can lose coverage. And so it sounds like now the one's that there on there on for a year even if there income is moving up and down.

And so the that should smooth things out a bit. Because and it seems like that's a wise choice that you can only enrolled in covered California once a year. If you fall off MediCal in the middle of the year then you're uninsured for six months so.
>> And that's really good for continuity of care.

>> Yeah.
>> Well it's good for continuity of care if the, if the your FQHC is going This is the expanded medica. So, so, that, that is very true and. It's very individual by the FQHC whether we're going to enroll as providers in the insurance companies. Because they're a really bad payer for us to be perfectly honest with you.

Like one of the worst payers so we which sounds funny to say but it's true.
>> Was it. Oh, yeah. We get, we get a.
>> rate.
>> Increase the rates that. Yes and in the State of California they said they're absolutely not going to do that. They don't care that it's in the law.

They are not going to do it. So we, we decided. I, I, I decided in CommuniCare that we really should, we're gonna be enrolled. So in Yolo County there's four plans that are available. There's Anthem Blue Cross, PPO and HMO. There's Blue Shield PPO, there's Kaiser and there's, Western Health Advantage which is just an HMO.

So we decided for the first time in our history to actually enroll in a private insurance company. We have for dental. We do have, we do take private insurance for dental. And we do take private insurance, we're just out of network. Not HMOs, but for PPOs. But we decided, and just because of what most of you are saying.

Is that they're, they're probably gonna be our patients, they can be family members of our patients. And we don't wanna lose them. We wanted to be available so that they could continue to come to Communicare. But I don't, I think it's a really small number. But we decided to do it.

And so, what they, what they are actually paying individual physicians, it's the commercial rate. But under covered California, in order to enroll, as a provider and the health insurance. And the companies you actually, their gonna be reimbursing less than they do for commercial. For FQHCs, they'll reimburses us commercial.

But it's still a lot less that we get from Medical and from Medicare. So is that gonna be a problem for getting other providers to sign up for these networks? Cuz I'd say that's also true for everybody.
>> We I think in Yolo county, Sutter, and Woodland health care.

Which is Dignity, are gonna be enrolling in not all of them. They're gonna choose, which, their one. And then there's Kaiser. So there's always Kaiser so.
>> I don't know. What's the Med Center doing?
>> I'm not sure. That's a good question.
>> WHA I know.
>> Yeah of course so.

>> Sure.
>> Any other questions. All right. Well, thank you very much to our panel. That was really informative.
>> Pleased to meet 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 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.