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Access to the Health Care Safety Net in California

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Summary

The proportion of California residents who lack health insurance coverage will decline substantially after full implementation of the Affordable Care Act (ACA) in 2014. The law contains various provisions to increase coverage, but the main modes of improving affordable coverage options are the expansion of Medicaid —the nation's primary public health insurance program—and the creation of state-run health benefit insurance exchanges, with federal subsidies available based on income levels.

Notwithstanding the important coverage expansions embedded in federal health care reform, there will still be uninsured Californians, and unauthorized immigrants will disproportionately fill their ranks. Health care reform promises to bring changes in the health care delivery system, including efforts to modernize enrollment systems, support infrastructure development, create medical homes that focus on primary care and prevention, and improve coordination of care, which should enhance care for low-income Californians. To stay viable in the post-ACA landscape, safety net providers will need to strategically reform care delivery in order to become partners with Medi-Cal and the California Health Benefit Exchange. Doing so will allow such programs to become or remain providers of choice for the newly insured. Yet funding changes embedded in the ACA, as well as state and local contraction of safety net funding in response to reform, could impact the safety net system's capacity to improve access for the remaining uninsured.

How are local health care safety net providers preparing to deal with bringing in newly insured patients and ensuring revenue sources alongside maintaining their mission to provide care to those who remain uninsured? We examine these issues in two ways. First, we highlight areas of anticipated strain through detailed mapping of safety net access (clinics and emergency departments (EDs)) for the largest group of the remaining uninsured (and one we can estimate): unauthorized immigrants. Second, we synthesize strategies and challenges for improving access for the poor—both currently and while preparing for reform—from two case studies of potentially highly impacted communities: Los Angeles and Monterey counties.

The simplest measure of access to care is proximity to a facility, as most Californians live within reasonable distances to hospital EDs and safety net clinics. And overall, unauthorized immigrants do not seem to fare particularly poorly on proximity measures relative to other safety net users, such as Medi-Cal participants. This is likely the result of safety net providers being located where there is community need, and because unauthorized immigrants generally reside in areas where there are other low-income populations.

We also examined access by using a more nuanced indicator, which measures the level of supply (meaning employees and hospital ED beds) at safety net facilities and also considers the likely demands placed on those facilities. We found that several areas in Los Angeles, Orange, Riverside, and San Bernardino counties have low clinic access and high demand—indicating some post-reform vulnerability because they are more likely to have high numbers of unauthorized immigrants, and thus the remaining uninsured. Fresno, Kern, and Monterey counties have areas where access to clinics and EDs is also low and the number of unauthorized immigrants is significant. If clinics in these areas focus on serving patients with new sources of health care coverage, some advocates fear that there will be fewer choices for the remaining uninsured, and it is likely that such vulnerable populations will rely more heavily on hospital EDs for care, which is among the most costly of care settings.

Although more detailed than any provided to date for the state of California, the spatial analysis of proximate access presented in this report does not fully capture the safety net's ability to provide or improve

adequate access to coverage. In L.A. and Monterey counties, the local safety net providers highlighted particular challenges for us. Among the most salient of concerns, our respondents identified their fear of safety net providers "squeezing out" those who will remain outside the scope of coverage under the ACA. This fear reflects an awareness of limited capacity among providers as well as barriers to delivery-system modernization (despite recent efforts to expand and improve services), combined with a realistic understanding of the importance of patient revenue. There is also concern among federally qualified health center (FQHC) providers over proposals to change their current reimbursement structure. Unknowns regarding which people will secure new insurance coverage and which people will remain patients of safety net providers post-ACA also contribute to these anxieties. Not revisiting the current payment system could risk their exclusion from health plans targeted toward those who may participate in the Exchange.

Our local area experts also offered insights into some of the particular strengths and strategies that will help safety net providers maintain their unique presence in communities. Through California's renewed Medicaid waiver, which is intended to serve as a "bridge to reform," clinics and hospitals are benefitting from increased funding and piloting expanded enrollment efforts, improving information technology (IT) and use of electronic health records, experimenting with delivery-system innovations, and improving "customer service." Innovative peer-education and outreach models have been both well tested and well received in high-immigrant communities, and they remain a promising approach to share information and address community concerns about the broader goals of the ACA. Safety net providers have also developed a heightened sensitivity to providing culturally and linguistically appropriate care, and connecting patients to other needed social safety net services, such as housing and transportation assistance. These are all strategies that may allow safety net facilities to maintain their credibility in their communities and become the provider of choice for the newly insured as well as the remaining uninsured.

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Introduction

Of all the states, California is home to the largest number of uninsured residents, with almost 7 million Californians (or one in five residents) lacking health insurance coverage in 2010 (Kaiser Family Foundation, statehealthfacts.org). Given the state's perennial budget constraints, the enduring economic downturn, and declines in employer-sponsored health coverage, California's sizable uninsured population will likely remain relatively large, even in the wake of reform. The federal Affordable Care Act (ACA), signed into law in March 2010, initiates such reform. The law promises to greatly reduce the number of uninsured residents in California, primarily through expanding the state's main public insurance program, Medi-Cal (California's Medicaid program), and through the creation of the California Health Benefit Exchange (referred to throughout as the Exchange), with federal subsidies available based on income levels.[1]

Despite the proposed large-scale expansion efforts, an estimated 3 million to 4 million Californians will still lack health insurance after the expansion provisions are fully implemented post-2014 (Buettgens et al. 2011; Jacobs et al., 2012; Long and Gruber 2011). The Californians who will remain (or become) uninsured include those who are currently or newly eligible but do not participate in public insurance programs, those who opt out despite the individual mandate and associated tax penalty, and those for whom the penalty is waived based on income.[2] Of particular note, unauthorized immigrants will constitute one of the single largest population subgroups projected to remain uninsured after the ACA is implemented in California accounting for anywhere between 25 percent to 40 percent of the remaining uninsured after the ACA expansions (Jacobs et al., 2012; Long and Gruber 2011).[3] The ACA continues to bar unauthorized immigrants from participating in the Medi-Cal program and prohibits their purchasing coverage in the Exchange.[4] More than any other state, California is home to the largest estimated number of unauthorized immigrants—about 2.6 million. (Passel and Cohn 2011).[5]

When they do seek medical care, the state's low-income and uninsured residents—some of whom are unauthorized immigrants—rely heavily on the state's health care safety net system (California HealthCare Foundation 2009). There is tremendous variation in local safety net systems, but most are some combination of public hospitals, county-run public health clinics, community health centers, rural health clinics, and free clinics. As part of their core mission, these providers see all patients—regardless of ability to pay, and (often)

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[1] Beginning in 2014, all citizens and legally residing noncitizens who have been in the United States for at least five years and have family incomes below 139 percent of the federal poverty level (FPL)—about $31,000 annual income for a family of four—will be eligible for Medicaid. New state-based health benefit exchanges represent an insurance-purchasing option for individuals and small businesses, with federal subsidies available to people with family incomes between 133 and 400 percent of FPL who do not have access to employer-based coverage.

[2] The individual mandate is the ACA requirement that most U.S. citizens and lawfully present noncitizens have some form of health insurance coverage by 2014, or else face a tax penalty. The ACA provides exemptions to the individual mandate's tax penalties for those who do not earn enough income to file a tax return and for others based on financial hardship, where the lowest cost health care plan available would exceed 8 percent of annual income.

[3] The range in these percentages is driven by the fact that they are based on different projection models (micro-simulation models), which vary in data sources and assumptions about coverage options and enrollment behavior. These models also produce different estimates of the numbers of newly insured California residents, and the number of residents who would be eligible for participation in Medi-Cal and the exchange but do not participate after 2014. See http://laborcenter.berkeley.edu/healthcare/ for more.

[4] Legal permanent residents (LPRs) who have been in the country less than five years are also not eligible for federally-funded Medicaid coverage, although historically California has used state dollars to provide Medi-Cal coverage for this group. Lawfully present noncitizens (including some LPRs within five years of entry) who are ineligible for Medicaid due to their alien status are eligible to participate in the Exchange and receive premium subsidies. (Siskin 2011).

[5] The other widely cited estimates of unauthorized immigrants, those from the Department of Homeland Security (DHS) are the same for California in 2010: 2.6 million (Hoefer et al. 2011). The DHS and Passel and Cohn estimates are generally in close agreement. There are no comprehensive enumerations of unauthorized immigrants.

legal status (Staiti et al. 2006). Hospital EDs are considered the "safety net for the safety net" because they play a large role in the care of the uninsured and Medicaid patients. Federal law requires that EDs screen and treat all patients in need of care (Siegel et al. 2004), as mandated by the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986. The safety net system not only comprises a variety of health care providers but it also relies on many different financing sources. Local, state, and federal economic circumstances and politics (e.g., the scope of indigent-care programs) can shape how extensive and effective the safety net is in any given area (Summer 2011).

The impact of the ACA on the safety net is largely unknown, but it is likely to vary across communities. Given the U.S. Supreme Court ruling in June 2012 upholding the constitutionality of the ACA's key provisions, coverage expansions in California will most likely move forward as outlined in the law.[6] Though the coverage expansions may be a boon for safety net providers in areas with many newly insured residents, it is also possible that the ability of some providers to supply uncompensated care[7] for the uninsured will become more limited (Hall 2011; Katz 2010). This may particularly be the case in areas where the remaining uninsured are predominantly composed of unauthorized immigrants and where financial resources are limited. The current robustness of the safety net, as well as the shifting distributions of low-income and remaining uninsured populations post-reform, will drive variation in the future (Staiti et al. 2006).

What is clear is that the ACA places safety net systems at a crossroads (Katz 2010). Many must balance their long-standing mission to stand as the provider of last resort for those left out of reform while positioning themselves to be partners and providers of choice for low-income, newly insured residents. Many providers recognize the need to plan strategically for upcoming changes in the health care system (Summer 2011), but safety net institutions also face the immediate strain of responding to a significant increase in the demand for services that accompanied the recent recession (CHCF 2010). At the same time, cuts in Medicaid (the largest single revenue source for safety net providers) have occurred in states (such as California) that face large budget deficits. If institutions that rely heavily on Medi-Cal patients are unable to become the provider of choice for newly insured populations, they may have even fewer resources to serve the remaining uninsured under the health care reform, exacerbating existing regional disparities in access. If funding for clinic capacity building embedded in the ACA is targeted toward addressing the needs of areas with high concentrations of uninsured populations, safety net providers could better invest in infrastructure and rise to the challenge of serving as primary care bases for a broad network of low-income populations.

The goals of this report are to help health policy leaders, planners, and community-based organizations (CBOs) understand where continued demands on the health care safety net may be concentrated, and to identify strategies and innovations that may assist safety net providers to expand access to the underserved and newly insured in a time of high demand and fiscal constraint. First, we examine potential demands to local safety net infrastructures as measured and mapped against relative concentrations of the largest group left out of reform—unauthorized immigrants. We primarily focus on the concentrations of unauthorized immigrants because they rely heavily on hospital EDs and safety net clinics for their care, and we can examine their distribution across the state with new, local-level estimates. We juxtapose ZIP code level concentrations of the unauthorized population with safety net supply and accessibility measures, which

[6] On the issue of the ACA's Medicaid-expansion provision, the Court upheld the expansion, but with a critical caveat: The federal government may not threaten the states that do not comply with the loss of their existing Medicaid funding. That means the Medicaid expansion is now optional for the states, although to date California policymakers have indicated their support for moving forward with the expansion.
[7] Uncompensated care is health care that is delivered but not paid for by the patient or a third party payer source (insurance program or company). Much of uncompensated care costs come from visits to emergency rooms (Hadley and Holahan 2004).

allow us to assess how well the two align at the county and sub-county levels. Though new and informative, this analysis can only provide one portrait of access: that is, physical proximity. Adequate access, however, extends beyond distance and capacity. The ability of targeted populations to have or gain access to services relies on several institutional factors of safety net providers including their financial resources, organizational structure, and socio-cultural dynamics (Gulliford et al. 2002). Thus, to better understand how local providers are preparing to strengthen access to low-income and diverse communities in 2014, particularly in areas with high percentages of unauthorized and uninsured populations, we also present findings from case studies of Los Angeles and Monterey counties. These case studies predominantly rely on expert interviews with safety net providers and immigrant-centered community-based organizations (CBOs) to better understand how the safety net and other stakeholders may respond to the ACA, when access must be monitored and measured against multiple goals of serving the disadvantaged; maintaining or improving financial health; and providing innovative, integrated, and appropriate care.

The Role of the Health Care Safety Net

Although many different providers, institutions, and settings can be considered part of the safety net, the Institute of Medicine (IOM 2000) defined the essential characteristics of safety net providers as caring for patients regardless of their ability to pay for services, and serving a substantial portion of uninsured, Medicaid, and other vulnerable patients. In accordance with these defining characteristics, safety net providers tend to locate in areas with high levels of need, in order to improve access and mitigate utilization disparities of health care resources. Some, in fact, have strong incentives to do so.

Disparate access to safety net providers across geographic areas and among targeted vulnerable groups is an important indicator of alignment of resources with demand. Several analysts have noted that smaller urban and rural areas are increasingly favored as immigrant destinations (both for the authorized and unauthorized), in contrast to large urban centers. In turn, there may be a growing mismatch between health care resources (which are less robust in nonurban areas) and concentrations of high-need populations (Allard 2004; Artiga and Tolbert 2009). In general, there has long been a large divide between urban and rural access to adequate safety net resources, which is true for both citizens and noncitizens alike (Hadley and Cunningham 2004).

To inform safety net resource planning and allocation preparations for the post-ACA future, we provide a baseline portrait of access to safety net providers across California communities, drawing from multiple data sources, to examine robustness across and within counties. To do so, it is critical to map availability against potential population demand with sub-county-level information. In our study, we examine proximity to safety net providers at the ZIP code level. Although we focus primarily on unauthorized immigrants and their population concentrations, we identify and compare access for three other groups that are highly reliant on safety net systems: noncitizen immigrants, low-income (under 200% FPL) individuals, and Medi-Cal enrollees. These are not mutually exclusive categories (e.g., unauthorized immigrants are a subset of noncitizens; many unauthorized are low-income), but each group may be of different interest for policy-planning and development purposes. Ideally, we would like to examine county and sub-county estimates of the uninsured population as well, but this information is either not reliable or unavailable at smaller geographic levels. Fortunately, recent estimates produced by UC Berkeley's Center for Labor Research and Education, and UCLA's Center for Health Policy Research, based on a statewide projection model (referred to as CalSIM), have revealed the projected numbers of residents expected to remain uninsured after reform for large counties and regions (estimates become unreliable at midsize and smaller-county levels). In Los Angeles, the CalSIM model predicts that 970,000 to 1.27 million residents will remain uninsured by 2019.[8] Other Southern California counties (apart from L.A.) collectively will also have many uninsured residents after ACA implementation, ranging from 930,000 to 1.21 million individuals. Approximately 110,000 to 150,000 residents in the Sacramento region will be uninsured, anywhere from 300,000 to 410,000 residents in San Joaquin will be uninsured, and in the greater Bay Area about half a million residents (450,000 to 560,000) will remain or become uninsured (see Jacobs et al., 2012, for more detail). Our estimates focus on a subgroup of this uninsured population—unauthorized immigrants—and complement these county-level projections by providing a detailed picture at finer, local levels of geography.

[8] The range in estimates result from two different models: One is a "base scenario" model, the other is an "enhanced" scenario. Under the enhance scenario, outreach and enrollment are extensive, and enrollment and retention is assumed to be easy (Jacobs et al. 2012)

Before we discuss our findings, we will first define the health care safety net, and then describe in more detail the populations that safety net providers tend to serve.

What Is the Health Care Safety Net?

Safety net providers are united by a common mission: to provide care regardless of one's ability to pay, and, often times, immigration status. In general, safety net providers include public hospitals, community health centers, county clinics, and for-profit and nonprofit health care organizations (CHCF 2009). Counties in California play an important role in the structure and delivery of the health care safety net. Since 1933, Section 17000 of the California Welfare and Institutions Code has required California's counties to be the health care providers of last resort for the medically indigent. However, since there is no statutory standard for the services provided, there is significant variation in how delivery of services is organized. Many of the larger counties are considered "provider" counties, meaning that they operate public hospitals and county outpatient clinics that provide care to county residents designated as medically indigent.[9] Many "provider" counties provide care to the uninsured and medically indigent regardless of citizenship status, including L.A., but certain counties, such as Monterey, do not. (We compare these two counties later in our case study analysis.)

In this study, we define the health care safety net as all health care clinics, including federally qualified health centers (FQHCs) and FQHC look-alikes, as well as other non-FQHC clinics (i.e., other community-based clinics, rural health clinics, and county-based outpatient clinics). (See Text Box on page 14 for more information on FQHCs).[10] We also focus on all hospital emergency departments, as they must treat everyone in need of care and are important providers of last resort for the uninsured. We combine a variety of data sources to arrive at a comprehensive picture of safety net providers across California (see Technical Appendix B).[11] It is important to note that we do not include private physicians, because we cannot be sure that they see a significant share of uninsured, Medi-Cal, or otherwise vulnerable patients, although some private physicians do indeed play the role of a safety net provider. Nor do we include school-based health centers as we do not have comprehensive data on their locations, although they do serve an important role in providing routine health care services, including physicals, oral health checkups, and referrals.

For our analysis, we distinguish between all safety net clinics and hospital EDs, because they, in principle, serve different health care delivery purposes. Evidence suggests that use of EDs is intertwined with access to primary care services. For instance, Medi-Cal patients are more likely than the privately insured to visit EDs for nonurgent conditions, in part because they feel they get more timely and thorough care at EDs than at clinics (CHCF 2006). Uninsured residents and noncitizen immigrants, while less likely to visit EDs than their publicly insured and native-born counterparts, respectively, still rely on EDs for care (McConville and Lee 2008). Still, hospitals will bill the uninsured for services, and EDs are among the most costly care settings.

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[9] To fulfill the Section 17000 obligation, counties in California operate public hospital and clinic systems or they contract with private providers to operate medically indigent service programs (MISPs). Half of the counties in the state are "provider" counties. "Payer" counties (six counties) do not operate hospitals or clinics and must contract with other providers—typically nonprofit hospitals and community clinics—to provide care to those eligible for the county indigent program. Hybrid counties (six counties) operate public outpatient clinics but do not run public hospitals, so like payer counties they must contract with private hospitals to provide inpatient care. Counties not only vary in their delivery structure but also in their eligibility thresholds, scope of benefits, and extent of provider networks. Provider counties generally offer more generous coverage, with few placing restrictions on the availability of basic medical services.

[10] These clinic types are not mutually exclusive. For example, county-based outpatient clinics are often designated as FQHCs. For a description of the various types of clinics in operation in California, refer to Technical Appendix B.

[11] We identified and included a total of 1,596 clinic sites across all the different types of clinics; of these more than half (825) were designated as FQHCs. We included a total of 339 hospital emergency departments, all of which are general acute care hospitals with at least one emergency department station (bed).

What are FQHCs?

Like many other safety net providers, health centers designated as a Federally Qualified Health Center (FQHC) provide comprehensive, culturally competent health care services to medically underserved communities and vulnerable populations. However, FQHCs have distinct requirements, and they are reimbursed differently than other safety net providers. Health centers may apply for and be designated as an FQHC if they are located in high poverty or medically underserved areas, adjust patient fees based on ability to pay, provide detailed budget and staffing information, and have a specific plan for addressing population needs. Under this designation they:

- Receive funding under Section 330 grant of the Public Health Services Act and are reimbursed by Medicaid based on a prospective payment system (PPS) that approximates the reasonable cost of a visit, and at a capped rate based on reasonable cost by Medicare.
- Are governed by a community board composed of a majority of health center patients who represent the population served.
- Are required to provide other services, such as transportation and language assistance to their patients.
- Must meet other performance and accountability requirements regarding administrative, clinical, and financial operations.

FQHC look-alikes (FQHCLAs) do not receive funding under Section 330 grant of the Public Health Services Act but are governed, operate, and provide services in much the same way. They receive enhanced reimbursement under Medicaid and Medicare, but they do not have other protections that Section 330 grantees receive (e.g., participation in the Federal Tort Claims Act malpractice coverage program and protection from anti-kickback safe harbors). Many FQHCLAs go on to ultimately become FQHCs. For more detail on safety net clinics, visit the California HealthCare Foundation for excellent primers: www.chcf.org/publications/2009/03/californias-safetynet-clinics-a-primer.

Who Uses the Safety Net?

Safety net users are among the most vulnerable people, whether defined by limited or no insurance coverage, low-income status, minority background, limited English proficiency, or immigration status. Although there is no comprehensive utilization data for all clinics, about 7.6 million Californians rely on safety net clinics for regular health services (CHCF 2009). While it is true that safety net providers serve uninsured populations, publicly insured individuals rely heavily on safety net providers as well, as do some low-income individuals with employer-sponsored coverage. A national study of community health clinics found that their patients are nearly three times more likely to be low-income (under 200% of the federal poverty level (FPL)), three times more likely to be on Medicaid, and 2.5 times more likely to be uninsured compared to the rest of the population. They are also disproportionately composed of Hispanic individuals. Children and women are also frequent users of safety net clinics. (Children are more likely to be covered under Medi-Cal or Healthy Families, and adults are more likely to be uninsured (CHCF 2009; Rosenbaum et al. 2010)). Yet it is also important to note that low-income populations in California rely on other sources of care, including private physicians, and some pool from multiple sources.

Immigrants, particularly noncitizens, are frequent users of safety net clinics, which may in part be driven by their higher rates of uninsurance. About one in two noncitizens in California lacked insurance coverage in 2010 (CHCF 2011), compared to one in ten native-born individuals and one in five naturalized citizens. In California, low-income noncitizens are much more likely to report that their usual source of care is a community clinic or community hospital (40%) than native-born (32.5%) and naturalized citizens (30.6%) (based on the authors' calculations using the California Health Interview Survey [CHIS]). Although there are no nationally representative data on unauthorized immigrants' insurance coverage, the Pew Hispanic Center estimates that 60 percent of unauthorized immigrants are uninsured nationwide, and smaller-scale studies indicate that they have the highest uninsured rates among all immigrants (Passel and Cohn 2009; Goldman et al. 2005).[12] The unauthorized population reports the largest access barriers (e.g., not having a usual source of care), even after adjusting for health insurance and health status (Bustamante et al., 2010; Goldman et al. 2005). Contrary to popular perceptions, research has shown that noncitizens and unauthorized immigrants do not disproportionately utilize safety net health care institutions, such as hospital EDs, compared to others (Berk et al. 2000; DeRose et al. 2009; McConville and Lee 2008).

Actual demographics for public hospital clinic users are not known, but the California Association of Public Hospitals (CAPH) estimates that about 50 percent of the patients served by public hospitals do not speak English as their primary language, and it is reasonable to assume that the same holds true for public hospital clinics. Similarly, licensed primary care clinics in California that report patient-language data reveal that 43 percent of their patients do not speak English as their primary language. California's FQHCs report that most (83%) of their patients had incomes below 200 percent of the FPL, the majority were Hispanic, and 45 percent were uninsured (CHCF 2009).

How Is the Safety Net Financed?

Because safety net systems rely on a mix of patient revenue (most of which comes from patients covered by Medi-Cal and Healthy Families), safety net clinics depend heavily on funds from government sources, including federal, state, and local governments. Medi-Cal is the major source of funding for California's community clinics, composing about 70 percent of net patient revenues and nearly 50 percent of total revenues (CHCF 2009). An important aspect of Medi-Cal funding for clinics designated as FQHCs involves enhanced reimbursement from Medi-Cal based on a prospective payment system (PPS) rate that approximates a "reasonable" cost per visit, and from Medicare at a capped rate.[13] The second largest source of funding for FQHCs comes from federal grants (Section 330). A small portion of funds comes from a combination of patient fees, generally paid on a sliding-scale fee schedule based on patients' income levels. In addition, a small share of revenue comes from philanthropic and private donations (CHCF 2009).

Other funding comes from state-administered, limited-benefit programs that target specific conditions or populations, and county indigent care programs (noted earlier), in addition to private grant sources for operating support. For instance, the state runs a number of programs that are geared toward specific

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[12] Most of the published studies on unauthorized immigrants and health care coverage and access are conducted on a smaller scale, because there are no nationally representative data on unauthorized immigrants. They also tend to be conducted in areas with high concentrations of unauthorized immigrants, primarily Latino or Mexican-origin immigrants.

[13] In 2000, the cost-based reimbursement payment system of FQHCs was changed at the federal level to a prospectively determined approach, or the PPS. A primary objective of this change was to create financial incentives for clinics to reduce their costs, operate more efficiently, and increase state control over their Medicaid budgets. Clinics that kept their costs below their payment amount would profit; conversely, clinics would lose money if their service costs exceeded the payment amount. PPS also afforded states an increased ability to budget the cost of clinic Medicaid expenditures.

population groups, most of which are tied to certain services or health needs. In some cases, these specialized programs provide additional or wrap-around health care services to groups that may have insurance coverage through other sources, such as Medi-Cal (e.g., the California Children's Services (CCS) program). In other cases, the program provides specific types of services (e.g., family planning services through the Family PACT program or pregnancy-related services through the Access for Infants and Mothers (AIM) program) for those that do not have any other source of insurance coverage. All of these programs provide at least some level of services, regardless of immigration status.

For public hospitals, much like clinics, patient revenues from Medi-Cal constitute a primary source of funding. Medi-Cal not only pays for patients currently enrolled in the insurance program but also retroactively enrolls those who are not participating at the time of their visit but are eligible (thus, Medi-Cal pays for those hospital-based services). Medi-Cal also subsidizes care for unauthorized immigrants who are seen and treated at a hospital ED and would otherwise be income-eligible for Medi-Cal. Another important source of safety net funding for public hospitals is government funding specifically designated for uncompensated care. More than two-thirds of government spending for uncompensated care comes from the federal government, most of which goes toward payments to hospitals in the form of disproportionate share hospital (DSH) payments. DSH payments are provided to hospitals that care for a large share of uninsured and publicly insured patients, and states have considerable discretion in how they calculate and allocate DSH funds among hospitals (Bachrach 2010).

Under health care reform, safety net systems could both gain and lose revenue, a high priority and concern, as well as a source of anxiety, among stakeholders. Currently, one-quarter of California community clinics are in the red, suggesting tenuous financial health (CHCF 2009), and state budget cuts to clinic funding have impacted clinic programs throughout the state. The ACA expansion of Medi-Cal, in theory, should result in new revenue from patients who were previously uninsured if those patients continue to receive care from safety net providers. Some FQHCs, in fact, that successfully draw in or maintain newly insured patients will likely see a significant infusion of new Medi-Cal dollars from cost-based reimbursement. The ACA will also enable hospital EDs to be reimbursed for providing emergency care to unauthorized immigrants who would otherwise be eligible for coverage under the Medi-Cal expansion. In addition, the ACA allocates $11 billion through the Health Center Trust Fund for major expansions of community health centers and placement of health care professionals in underserved areas (Katz 2010). But the ACA also reduces Medicaid DSH funding annually—a loss totaling $20 billion by 2020—on the premise that certain hospitals will not need as much funding because they will serve fewer uninsured patients. Safety net hospitals rely heavily on these payments, and depending on location and patient mix, some hospitals may see reduced funding with no corresponding offset for uncompensated care. The impact on hospitals could be enormous, especially in locations where the amount of uncompensated care does not drop as much as expected, including border areas or locations where there are high concentrations of unauthorized immigrants. Finally, beside federal funding changes, it may be difficult to maintain local government and philanthropic support for the safety net system once it is clear to residents and the public that many of the remaining uninsured are unauthorized immigrants.

How Does Safety Net Access Vary Across California?

Stronger availability of resources matters for understanding how the uninsured interact with the safety net system. One study found that increased availability of community health centers (based on closer proximity) improved access to medical care for the uninsured in terms of having a usual source of care and reporting more ambulatory visits (Cunningham and Hadley 2004). Although not analyzed, researchers speculated that greater access to health centers may reduce the probability of ED use and inpatient hospital stays. A California-based study found that proximity to clinics had a greater influence on access (e.g., having a usual source of care) for those with limited English proficiency than for those who are proficient in English (Cordasco et al. 2011). This suggests that there is a significant relationship between language barriers among immigrants and availability of services.

After implementation of the ACA, as low-income adults who are citizens or legal permanent residents (LPRs) gain insurance coverage through either Medi-Cal expansion or participation in the Exchange, the ranks of uninsured are projected to shrink. As these groups exit the uninsured population, the proportion of remaining uninsured that is unauthorized immigrants will become higher still. At that point, the public and policymakers' preferences to subsidize their care at EDs and clinics may decline. Public sentiment regarding the role of government in providing health care to the unauthorized is mixed, and it appears to vary depending on whether coverage or access is at issue. In a 2007 statewide survey of Californians, about half (53%) opposed providing *health care coverage* to unauthorized immigrants (Baldassare et al. 2007). However, another PPIC survey focused on Los Angeles found that 61 percent of respondents thought that unauthorized immigrants should have *access to public health care* (Baldassare 2004).

Now we turn to understanding the current capacity of the safety net in communities throughout the state, drawing special attention to those communities with a disproportionate percentage of unauthorized immigrants, because that population is most likely to remain uninsured after 2014.

First we describe the share of each county's current uninsured population that is likely to be unauthorized immigrants. Next we examine a basic access measure—distance in miles to the nearest clinic or emergency department for likely safety net users by county—to understand how safety net access may vary across users and whether the unauthorized have differential access to safety net providers compared to other safety net user groups. Then we turn to a more robust measure of access, which incorporates the number of safety net providers within a certain distance but also incorporates a measure of provider capacity along with potential demand for services. We then overlay this access measure with estimated counts of unauthorized residents.

Unauthorized immigrants currently make up about 8 percent of the state population (Passel and Cohn 2011)[14]. Their distribution across the state is not uniform, but nearly every county has some unauthorized residents (Hill and Johnson 2011). For example, in Monterey County we estimate that nearly 14 percent of the county's population is unauthorized (see technical appendix Table A1).[15] Other counties with large percentages of unauthorized immigrants include Imperial (13%), Napa (12%), Santa Clara (10%), and Orange (10%) counties.

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[14] Because there is no comprehensive data on the unauthorized immigrant populations, estimates vary across studies and depending on the data source used to approximate counts. See Technical Appendix A for more on estimating the unauthorized immigrant population in California.
[15] Technical Appendix A provides detail on our estimation method.

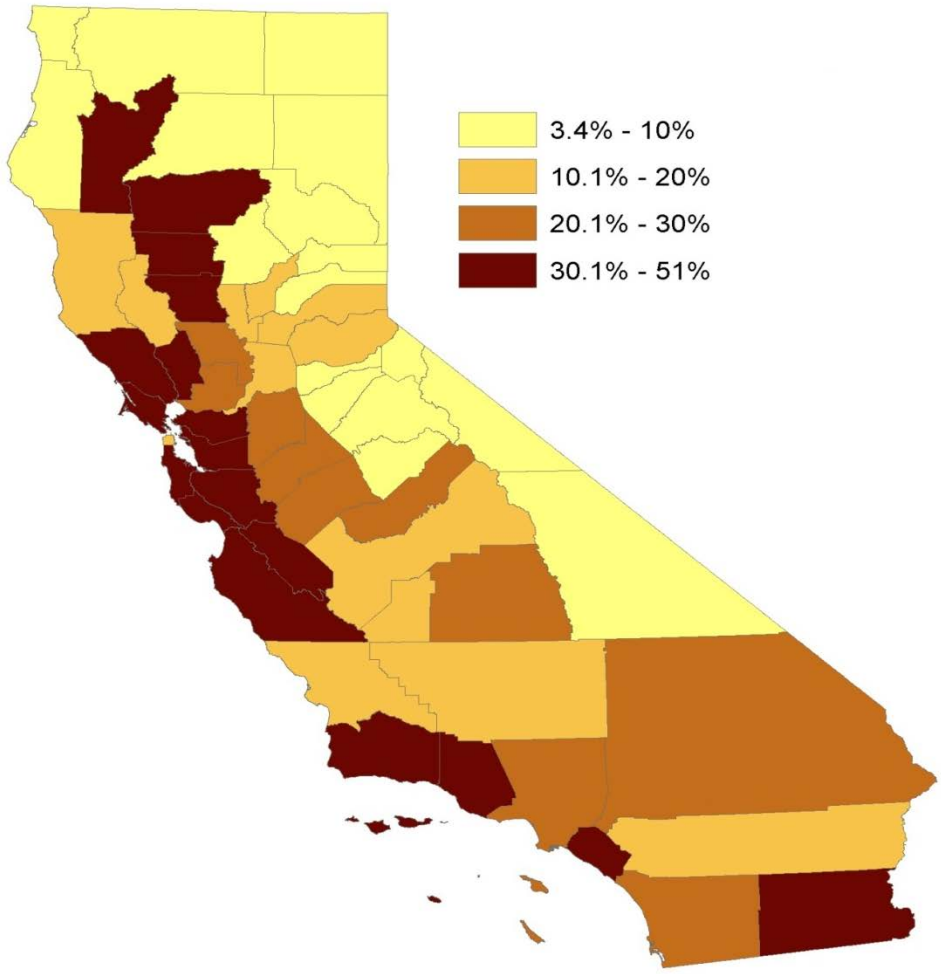
We estimate that more than 9 percent of residents in Los Angeles County are unauthorized immigrants, and they number nearly 900,000. Some communities within the state (which we approximate by ZIP codes) have populations comprised of more than 5000 unauthorized immigrants. (see technical appendix Figure A1). These concentrations clearly have implications for the health care infrastructure in the communities and counties where unauthorized immigrants reside in disproportionate numbers, both now and after the implementation of the ACA.

As mentioned earlier, the unauthorized are projected to be one of the largest groups to remain uninsured after the ACA is implemented. Thus, areas in which a large proportion of the uninsured are unauthorized may not experience significant increases in insurance coverage. This, in turn, may mean that local safety net providers will continue to serve large populations of uninsured. As shown in Figure 1, the distribution of uninsured Californians that are unauthorized immigrants varies by region and county.[16] The Bay Area and Central Coast appear to have the highest proportions of unauthorized among their uninsured populations. This somewhat counterintuitive pattern is driven by the relatively small uninsured populations in many of these areas, combined with relatively large population shares of unauthorized immigrants. The rates of the uninsured in the Bay Area are some of the lowest in the state, ranging from about 12 percent to 15 percent, while the share of the unauthorized in many of these counties hovers around 10 percent. In contrast, other regions—including Los Angeles, the Inland Empire, and the Central Valley—also have relatively high proportions of their populations that are unauthorized, but they have much higher rates of the uninsured as well, ranging between 20 percent and 25 percent. This renders the proportion of the unauthorized to the total uninsured population lower in comparison. So while nearly 900,000 unauthorized immigrants reside in Los Angeles, the county is home to more than 2.1 million uninsured, the vast majority of whom are legal residents.

Some exceptions to this pattern occur in Monterey County, which has a high rate of uninsured residents alongside a relatively large unauthorized population. In Southern California, the percentage of uninsured that is unauthorized is also high in Ventura, Santa Barbara, and Orange counties–places where nearly one in five residents are uninsured, and the unauthorized compose more than 30 percent of those uninsured populations.

[16] These estimates derive from county counts of the uninsured from the 2009 Census Small Area Health Insurance Estimates and 2009 estimates of unauthorized immigrants from the authors. To estimate the percentage of the uninsured likely to be unauthorized, we assume that 60 percent of the unauthorized are uninsured, which is based on national estimates from the Pew Hispanic Center (Passel and Cohn 2009.) See Technical Appendix A for more details.

FIGURE 1
Percentage of uninsured likely to be unauthorized immigrants, 2009



SOURCE: Authors' calculations are from 2009 Census Small Area Health Insurance Estimates (SAHIE) and 2009 estimates of the unauthorized immigrant population from Hill and Johnson, 2011.

NOTE: See Technical Appendix A for details.

Next, we turn to our examination of a common measure of access: the shortest distance that a county's population must travel to receive care.[17] Here we focus on safety net providers (hospital EDs and all health care clinics) and safety net users (unauthorized immigrants, those living below 200% of the FPL, noncitizens, and those insured through Medi-Cal)[18,19] to examine how access may vary across user groups and to determine if the unauthorized have poorer access than other safety net users. Distance to these health care providers can be measured in miles or minutes traveled. Neither measure perfectly reflects a person's lived

[17] Distance to the nearest facility is calculated from the ZIP code centroid of the population of interest to the exact location of the safety net facility.
[18] Population estimates for noncitizens and the poverty population are derived from the Census American Community Survey (ACS) five-year data files for census tracts, which we then aggregate to ZIP codes. Counts of Medi-Cal beneficiaries by ZIP code are from the California Department of Health Care Services. Unauthorized immigrant estimates are from Hill and Johnson, 2011. See Technical Appendix A for more details. Technical Appendix B describes how we compiled data on EDs and clinics.
[19] These population groups are not mutually exclusive.

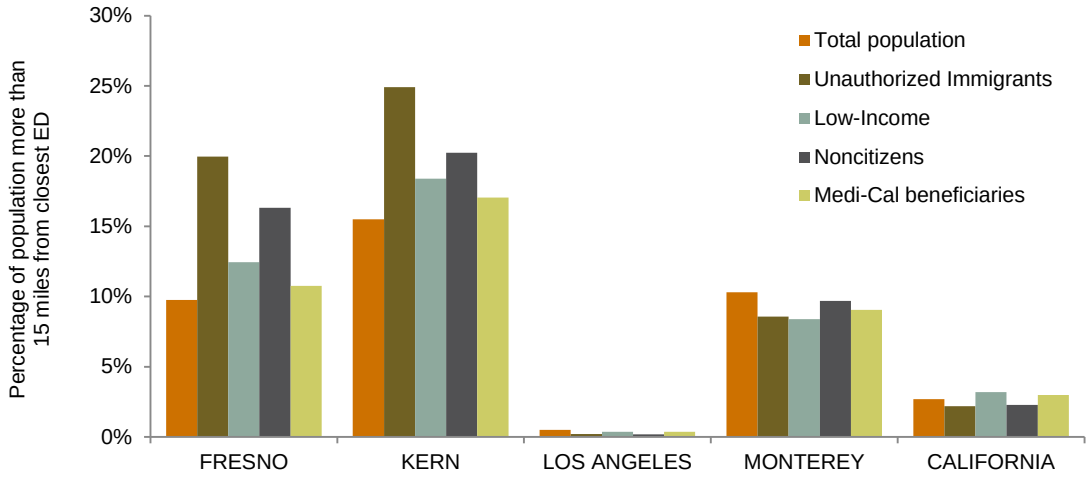
experience when traveling to care. For example, minutes can be thought of as the amount of time it takes to drive to care in a car. But not all patients have access to cars, especially among the unauthorized immigrant population or the poor. This population may be more likely to depend on public transportation or walking, and access to public transportation may also vary across the state. Thus, for our measure of distance to EDs and clinics within communities, we use number of miles in road distance.[20]

Most Californians live within two miles of a safety net health clinic (59%), and these percentages are higher for unauthorized immigrants (75%), those living under 200 percent of the poverty line (69%) noncitizens (71%), and those insured through Medi-Cal (70%) (see technical appendix Table B1). Close proximity (within two miles) to EDs is lower: 33 percent for all Californians, and between 35 percent and 39 percent for unauthorized immigrants, those living under 200 percent of the poverty line, noncitizens, and those insured through Medi-Cal. Because we focus on the types of providers most likely to serve the Medi-Cal population and the uninsured, it is not surprising that we find these groups live closer to clinics than the general population. Overall, it appears that the unauthorized have similar levels of proximate access (less than two miles) to clinics relative to all noncitizens, as well as low-income individuals and residents insured through Medi-Cal. This holds true for most regions of the state. Proximity to EDs is somewhat different: Counties in which unauthorized immigrants are less likely to live within two miles of EDs than other safety net user groups include counties with small populations of unauthorized immigrants (Del Norte, Glenn, and Modoc), mid-range populations of unauthorized immigrants (Yolo, Marin, and San Luis Obispo), and counties with large unauthorized populations (Sonoma and Stanislaus).

Only small shares of Californians live more than 15 miles from EDs (less than 5%). In Figure 2, we highlight those counties where unauthorized immigrants are more likely to live far from safety net providers than other populations likely to rely on them, as well as counties with large populations or high percentages of unauthorized immigrants. Residents of a few counties do have longer distances to travel, including many in the Central Valley and in Northern California. In Monterey County, nearly 10 percent of unauthorized, poor, noncitizens, and Medi-Cal patients must travel 15 miles or more to reach the nearest ED. In only a few regions, unauthorized immigrants appear to be more likely than other residents to live 15 or more miles from EDs. Central Valley counties such as Fresno and Kern stand out. Clinic availability is better for nearly all counties (very few have residents that must travel 15 miles or more to reach a clinic), although San Bernardino appears to be an exception, with larger percentages of the unauthorized and all noncitizens needing to travel further to reach the closest health care clinic. This suggests that immigrants reside in areas with a less robust safety net system relative to other groups (see technical appendix Tables B1and B2 for all counties.)

[20] Rather than in Euclidean distance ("as the crow flies").

FIGURE 2
Percentage of population that lives more than 15 miles from closest emergency department, in selected counties, 2009



SOURCE: Authors' calculations.

NOTE: See Technical Appendix B for details.

Access to care for the uninsured depends not just on distance to a facility but also on the capacity of nearby clinics and EDs to provide care relative to the demands placed on the facility by all potential users. For every ZIP code in the state, we calculated an access score that measures the level of supply at safety net facilities within 15 miles (and within 30 minutes' travel time, which is shown in Technical Appendix B) and also takes into account the likely demands placed on those facilities (see Davis et al. 2009, for more on this measure). Supply for EDs is measured by the number of emergency room treatment stations (beds), and supply for clinics by the number of primary care providers (including physicians, nurse practitioners, physician assistants, and certified midwives). Demand for safety net services is measured by the size of the population living below 200 percent of the federal poverty level in census tracts that fall within 15 miles of the safety net facility.[21] It is important to note that we have information only on clinic provider capacity (supply) for about 60 percent of the clinics in our sample, and thus our access measure for clinics is limited, particularly in areas with significant county-based clinic operations. Another limitation is that we do not have information regarding how safety net resources at each clinic are organized and deployed, and the actual availability of the services provided. Thus, this measure is best understood as a proxy of access rather than a comprehensive indicator.[22]

The resulting access score can be thought of as the average accessibility of all persons within the ZIP code, which incorporates both resources available at nearby facilities as well as the demand for those resources from all surrounding, proximate areas. The low, medium, and high levels of access categories are constructed by dividing the access scores for all ZIP codes in the state into thirds (tertiles), so that low access ZIP codes have scores in the bottom third of the distribution across the entire state. In the post-ACA environment, when it is estimated that up to 40 percent of the remaining uninsured will be unauthorized immigrants

[21] Other studies have used the population under 100 percent of FPL to measure the demand on safety net facilities. We chose to use 200 percent because other studies indicate that 93 percent of patients at community health centers have incomes below 200 percent FPL, thus providing a potentially more accurate measure of demand.

[22] In addition, this measure cannot incorporate contextual circumstances such as crime or violence, socioeconomic status, concentration of private physicians, transportation infrastructure, or other community factors that influence how low-income populations interact with and access the health care system.

(Long and Gruber 2011), capacity measures are best anticipated by viewing current safety net access simultaneously with measures of unauthorized immigrants. Therefore, we also overlay cross-hatching to indicate large populations of unauthorized immigrants, defined as 2,500 or more per ZIP code. Concentrating on areas in which current access is lower and where a disproportionate share of the demand likely comes from unauthorized immigrants will point out areas where the safety net may experience strain to accommodate the health needs of the uninsured if the anticipated cuts to support the remaining uninsured are realized.

Once clinic and ED capacity and potential demand is taken into consideration, it becomes clear that limited access for the poor and unauthorized to safety net facilities is not simply a rural issue. All major regions in California contain areas with relatively low levels of access to both EDs (Figure 3) and clinics (Figures 4) and several have substantial unauthorized immigrant populations (technical appendix Figures B1 and B2 provide maps of the entire state).

Very few ZIP codes in Los Angeles County are characterized by high levels of access to either EDs or clinics. Areas characterized by low clinic access and sizable unauthorized populations include the Lancaster/Palmdale region in the northern section of the county; parts of the San Gabriel Valley, including La Puente, El Monte and Whittier; and communities near the Port of Los Angeles, including Long Beach, Wilmington, and San Pedro. ED access in Orange County is generally medium or high, but clinic access is lower countywide, and there are substantial populations of unauthorized immigrants in the county. In the Inland Empire, Riverside and San Bernardino counties have nearly universally low levels of clinic access and large unauthorized immigrant populations, but ED access is better in the more populated parts of those counties. San Diego County has few communities with high levels of ED access, but it appears to have better clinic access, even in areas with more than 2,500 unauthorized immigrants. Substantial areas of Imperial County have low ED access and almost completely overlap with large populations of unauthorized immigrants. Clinic access is medium or high in those same areas of the county.

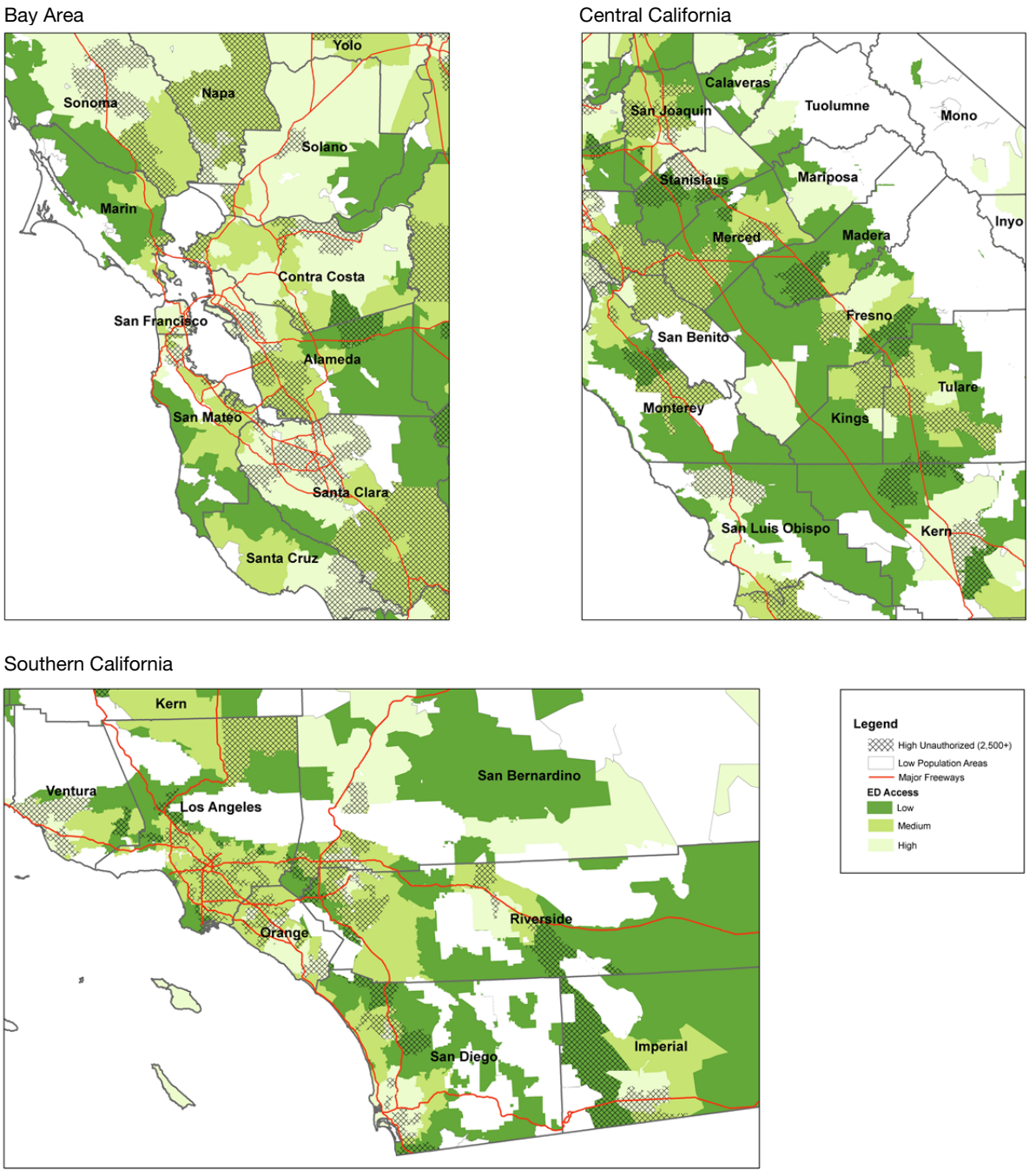
Most parts of the counties surrounding the San Francisco Bay have medium or high access to EDs but somewhat lower access to clinics. Most parts of Napa and Sonoma counties appear to have fairly good clinic and ED access, even in the parts of the counties with large unauthorized immigrant populations. There are no areas of low clinic access in Santa Clara County, even in the parts of the county with large unauthorized populations. The eastern (and more rural) part of Alameda County has poor ED access but no areas of poor clinic access. Most of the unauthorized immigrants are concentrated in the western part of the county, where clinic access is better. Unauthorized immigrants in Contra Costa County are more likely to live in areas where clinic access is worse than they are in other Bay Area counties.

The major cities in the Central Valley have medium to high levels of ED access, but large and more rural areas have worse access. Clinic access appears to be poorer in more populated parts of the counties than in the rural parts, which seemingly is driven by the high demand for services indicated by the sizable poverty population. Large populations of unauthorized immigrants throughout the Central Valley appear likely to have lower relative access to both EDs and clinics. In the Central Coast, Monterey County has areas of low, medium, and high access to both EDs and clinics. However, areas in which access is most limited corresponds strongly with large populations of unauthorized immigrants, particularly in Salinas, Chular, and Gonzalez.

Though more detailed than any information provided to date for the state of California, the access measures presented in this section do not fully explain the experience of the uninsured or safety net providers when health care is needed and services are delivered. Factors such as political will, past policies, level of coordination

among providers, and the ability to plan ahead all impact the uninsured now and the potentially more vulnerable uninsured in the post-ACA environment. The next section will explore some of those factors in two very important communities for immigrants in California: Los Angeles and Monterey counties.

FIGURE 3
Safety net emergency department access and unauthorized immigrant distribution, by region and ZIP code, 2009

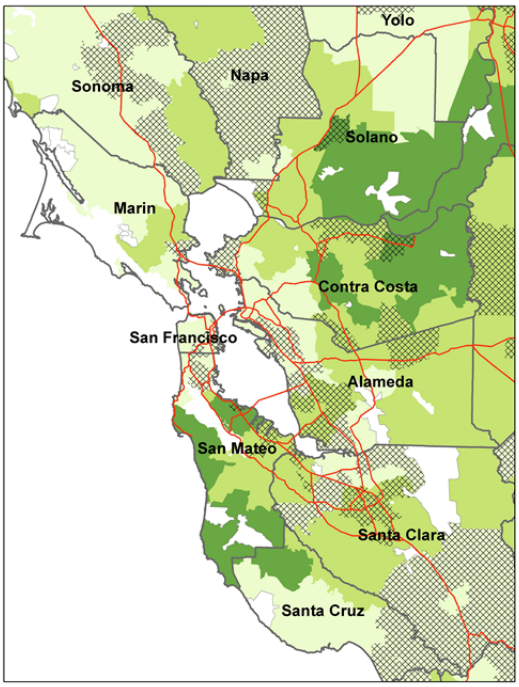


SOURCE: Authors' calculations.

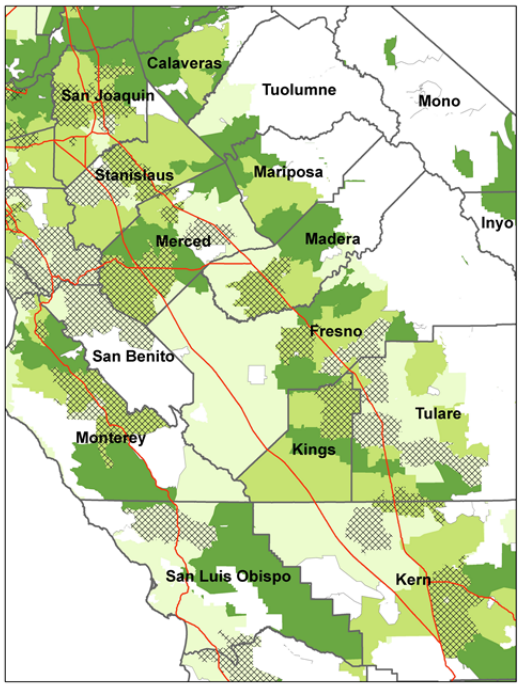
NOTE: See Technical Appendix B for details on access calculations. Low-population areas include ZIP codes that have fewer than 1,000 total population and also areas designated as parklands.

FIGURE 4
Safety net clinic access and unauthorized immigrant distribution, by region and ZIP code, 2009

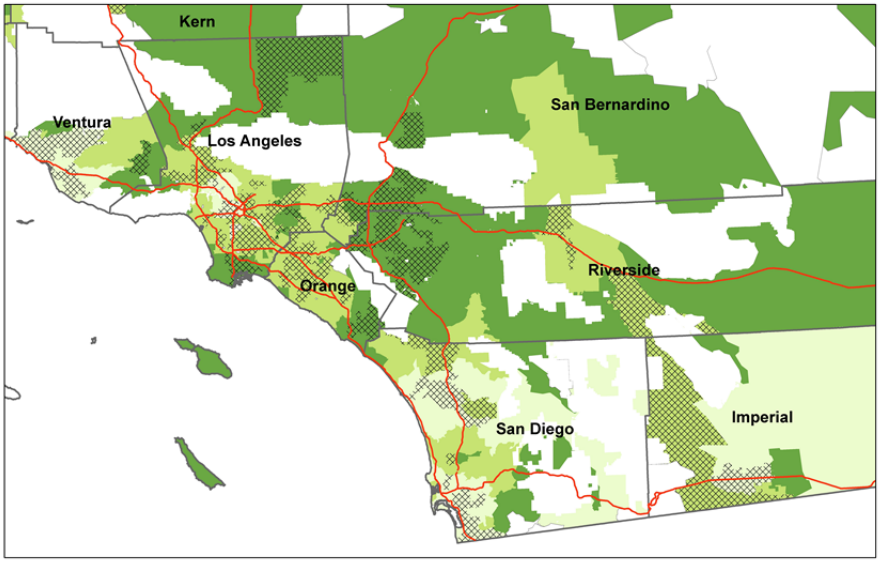
Bay Area

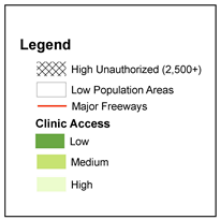


Central California



Southern California





SOURCE: Authors' calculations.

NOTE: See Technical Appendix B for details on access calculations. Low-population areas include ZIP codes that have fewer than 1,000 total population and also areas designated as parklands.

Perspectives of Safety Net Providers and Organizations

Our snapshot of safety net provider access is limited by the fact that we cannot perfectly predict Californians' responses to coverage expansions. In addition, physical proximity is but one measure of access. Yet adequate access also hinges on the infrastructure, financial health, reputation, and the mission of safety net providers, which in turn impacts how they deliver timely and culturally competent care (Gulliford et al. 2002). To ensure access, safety net providers must balance the dual concerns brought to the fore by the ACA: Hold to their mission to provide care for those who will remain uninsured and strive to become the partner and provider of choice among newly insured patients, by improving access and coordinating care in a more integrated manner. The ultimate level of local safety net system strain or viability after 2014 depends on how community-based organizations and clinics prepare the groundwork. It will also depend on various policy and practice decisions at the state and local levels regarding the extent to which outreach and enrollment are improved, and whether affordability concerns are adequately addressed.

There is some evidence to suggest that safety net providers will continue to be the provider of choice for low-income residents, even after coverage expansions increase options for some. After Massachusetts' health care reform, community health centers reported an increase in visits of 30 percent, despite large decreases in rates of the uninsured across the state (Ku et al. 2011). Researchers further found that most safety net patients reported that they used these facilities because they were convenient and affordable. At the same time, a recent Blue Shield of California Foundation (BSCF) survey of low-income California residents (under 200% of FPL) found that while most reported that community clinics/health centers were the most common place they received health care, many also reported an interest in switching their usual source of care if circumstances allowed (BSCF 2011).

To learn more about how community organizations and providers are thinking about and preparing for reform, we conducted case studies in two counties with high concentrations of unauthorized immigrants, Los Angeles and Monterey. Our estimates suggest Los Angeles County has about 870,000 unauthorized immigrants, accounting for more than 9 percent of the county's population. In Monterey, we estimate unauthorized immigrants are nearly 14 percent of the county population and number around 62,000. Both of these counties are areas in which proximate access, by most of our measures, are moderate to high. By highlighting these areas—both of which are "provider" counties that operate public hospitals and clinics —we purposefully chose to examine safety net systems that are somewhat more extensive than others, in order to highlight strategies for growth as well as survival. Yet both areas have high need that is only likely to grow after reform, not only because of high concentrations of unauthorized immigrants but also because they serve a diverse population of low-income residents. Combining the case-study insights with the baseline portraits of safety net accessibility and unauthorized immigrant concentrations provides a richer and more nuanced empirical foundation for understanding the role and robustness of the safety net—as it stands now and prepares for the future.

In total, we conducted about 20 semi-structured interviews, some with representatives of state organizations and experts, and about seven to 8 interviews with employees of providers and organizers in each location (see Technical Appendix C). Interviews were conducted in person when possible, and a few were over the phone. When conditions allowed, they were audio recorded with permission from the respondents, and they were transcribed after completion (see Technical Appendix D for examples of interview guides).

Los Angeles and Monterey Counties

In interviews with statewide providers and immigrant-rights organizations, our respondents emphasized the importance of understanding the safety net in Los Angeles County, which is critical to the health and sustainability of the state's overall safety net system. Los Angeles is the largest local safety net system in the state, and it is overseen by the Los Angeles County Department of Health Services (LACDHS). For years, L.A. County has made efforts to subsidize the cost of providing care for the area's large numbers of uninsured and unauthorized residents. At the same time, its safety net system has been under constant strain due to governance issues and financial constraints (Insure the Uninsured Project 2012), and several notable hospital closures during the past decade have underscored the challenge of safety net providers to provide quality and timely access to care.[23]

According to recent census data, residents of Los Angeles are extremely diverse. Thirty-six percent were born abroad, and nearly 60 percent are from Latin America (see Table 1). Most immigrants have been in the U.S. for more than 10 years. Seventeen percent of the foreign-born in Los Angeles are poor, which is only slightly higher than the state rate for foreign-born residents (16%). Nearly 12 percent of the foreign-born do not have cars, in contrast to 8 percent of natives in Los Angeles and 9 percent of the foreign-born statewide).

Los Angeles is currently home to the largest uninsured population in the state, with more than 2 million residents lacking coverage (Laverreda et al. 2009). As noted earlier, researchers have projected that after coverage expansions are implemented, around 1 million Los Angeles residents will still lack insurance coverage (Jacobs et al. 2012). Many of the remaining uninsured will be ineligible to purchase coverage in the Exchange or enroll in Medi-Cal due to their immigration status, although more noncitizens may be covered under emergency-only Medi-Cal after the ACA expansions.

TABLE 1
Select population characteristics, 2006–2010

	California		Los Angeles County		Monterey County	
	Native	Foreign born	Native	Foreign born	Native	Foreign born
% Foreign born	0	27.2	0	35.5	0	30.8
% in U.S. 10+ years	100	72.2	100	74.2	100	68.4
% U.S. citizens	100	45.6	100	45.8	100	27.1
% Unauthorized	0	29	0	26	0	47
% Hispanic	30.5	53.4	41.1	58.0	43.3	78.0
% Less than HS grade	9.3	36.9	10.2	39.0	11.6	55.9
% in agriculture	1.1	4.1	0.3	0.6	3.8	29.7
% below 100% FPL	12.8	16.2	14.7	17.4	12.4	17.5
% No vehicle	6.7	9.4	7.8	11.7	5.0	8.9
Speak English less than "very well"	4.1	58.4	5.3	62.2	7.2	70.1

SOURCES: 2010 ACS for rows 1–3, 2006–2010, ACS five-year estimates for remainder.

NOTES: Crowding is more than one person per room. Note that the estimates for percent unauthorized are for 2008, (Hill and Johnson 2011). This was the peak year for the estimated population of unauthorized immigrants in California, and estimates of the size of the decline since the peak range from 3.4 percent to 6.8 percent.

[23] Of the 122 licensed hospitals in L.A., the county owns and operates four: Harbor/UCLA Medical Center, Olive View/UCLA Medical Center, Rancho Los Amigos National Rehabilitation Center, and Los Angeles County/USC Medical Center. In the early-to-mid 2000s, the state shut down one major safety net hospital, Martin Luther King-Drew Hospital. It was closed in 2007 due to quality-of-care issues, and later it became an ambulatory care center. High Desert Hospital was also converted to an ambulatory care center.

A closer look at patterns in ED access within L.A. County reveals South Central neighborhoods have higher percentages of unauthorized immigrants, suggesting that ED care is likely to be particularly strained if residents use EDs frequently. These communities are where our L.A. case study was concentrated (see Technical Appendix E).

Given earlier literature documenting the vast divide between urban and rural systems, our state experts also advised us to examine a more rural county, particularly one with high shares of unauthorized and uninsured residents. Monterey County is not densely populated, and yet a sizable portion of residents is estimated to be unauthorized immigrants (many of whom work in the agricultural and tourism industries). More than 30 percent of Monterey's residents were born abroad, and nearly 80 percent of immigrants are from Latin America (see Table 1). Relatively small percentages of the foreign-born are citizens (27%), which is partially explained by their more recent arrival to the U.S.—32 percent arrived after 2000. The majority of immigrants in Monterey are not high school graduates (56%), and 70 percent do not speak English "very well"—two important indicators of disadvantage. Nine percent of immigrants do not have cars.

Recent estimates suggest nearly 22 percent of Monterey County's residents are uninsured (Havemann and Weinberg 2012), and we estimate that between 30 to 50 percent of the uninsured are unauthorized immigrants (see Figure 1). Monterey is considered a "provider" county that does not have an explicit policy of treating and subsidizing care for unauthorized immigrants. Monterey County has four hospitals, two of which are in Salinas, the largest city in the county. They are Natividad Medical Center (the county's public hospital) and Salinas Valley Memorial (a nonprofit public hospital).[24] Monterey also is home to a network of community health centers and county clinics. Clinica de Salud is the largest clinic network and operates seven FQHCs, and Natividad Medical Center is the county-run clinic. There are also two free clinics in the county, operating with very limited hours and seeing only some types of patients.[25]

In the remainder of this section, we overview key insights identified by those who are most intimately involved with providing care and advocating for services for L.A. and Monterey counties' most disadvantaged immigrant populations. We organize and present these insights as opportunities to strengthen and improve the safety net afforded by the ACA, as well as highlight the challenges to the safety net from the ACA, including issues of ongoing concern for providing adequate access to care for the remaining uninsured, including unauthorized immigrants.

Becoming the Provider of Choice: Strategies for Strengthening the Safety Net

"Exciting but daunting," captures the sentiment of many of our state and local level respondents, who are charged with the task of preparing safety net systems for the ACA reform within a very short time. In L.A. and Monterey, our local experts identified some of the unique strengths and strategies that help safety net providers maintain their presence in the community, and even expand under reform and possibly improve some elements of care for the remaining uninsured and newly insured.

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[24] Currently, Salinas Valley Memorial is for sale and Natividad is a likely buyer. Two other nonprofit public hospitals serve the county. The Community Hospital of the Peninsula is in Monterey, on the coast. The George L. Mee Memorial Hospital is in King City and serves the southern part of the county.

[25] The clinic in Seaside sees only residents of the surrounding area and can take only about 30 patients a week. The administrative director estimates 80 percent of the patients are unauthorized.

Building from Low-Income Health Programs

Under California's renewed 1115 Medicaid waiver[26] (approved in November 2010 by the federal government), which is intended to serve as California's "Bridge to Reform," as many as 500,000 uninsured adults will gain coverage through county-based Low Income Health Programs (LIHPs), supported by county funds and up to $3 billion in federal funding (California Department of Health Care Services 2010). The LIHPs expand on previous county health care coverage initiatives (HCCI), and they are designed to transition enrollees into Medi-Cal once it is expanded as part of the ACA, and to support more coordinated, patient-centered, prevention-focused care. Indeed, providers in counties that are implementing the LIHP[27] are working to expand coverage and provider networks (including pharmacies), move to a managed-care model, become more outcome- and prevention-oriented, and realize cost reductions. State membership organizations, including the California Primary Care Association (CPCA) and the California Association of Public Hospitals (CAPH) noted that some counties are already seeing benefits. They are piloting expanded enrollment, establishing medical homes (team-based health care delivery models led by a consistent group of physicians and practitioners), and increasing outreach and education so patients understand how to use a primary care provider, access specialty care when needed, and get prescriptions filled—all of which will make the ACA implementation more seamless.

Perhaps the biggest immediate advantage of the LIHP implementation is the infusion of needed funds to local safety net providers. ViaCare, the LIHP in Monterey County, is drawing in county and federal dollars to enable clinics to provide more services, including more for preventive services and behavioral health. However, this is only for those eligible for LIHP coverage—and the unauthorized are not. In Los Angeles, Healthy Way L.A. (the LIHP) is also under way, and eligibility is not limited by citizenship status (although LIHP funding is not used to cover those who are ineligible based on citizenship status). Evaluations of the previous and current waiver coverage programs (HCCI and LIHPs) has found that some counties have been successful in helping clinics regularly assess and monitor safety net patients' wait times and distance traveled to access specialty care, as well as with initiating efforts to improve access (Pourat et al. 2012). The evaluations also identified critical areas in need of attention (Pourat et al. 2012) for broader ACA expansions to be successful, namely improving efforts to coordinate care as part of delivering integrated services to various safety net populations.

Preparing for Delivery System Reforms

A key goal of both the ACA and the waiver is to redesign care-delivery processes to move away from the episodic treatment of disease toward better prevention and management of chronic conditions, through the use of health information technology (IT), integration and coordination of care, creation of medical homes, and monitoring and measuring outcomes. Respondents in L.A. County reported that public hospitals were striving to find efficiencies in care delivery, motivated by funds from the renewed waiver to support infrastructure development, demonstrate improvements in hospital-specific care, and to invest in new delivery models.[28] It is too early in implementation to evaluate the impact of these hospital-based reforms,

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[26] Section 1115 allows the Secretary of Health and Human Services to waive provisions of major health and welfare programs authorized under the Social Security Act, including certain requirements of Medicaid. Section 1115 also authorizes the Secretary to use federal Medicaid funds in ways that are not otherwise allowed under federal regulations (Artiga and Schneider 2011).

[27] A few counties have chosen not to participate in the LIHP including Fresno and San Luis Obispo. In addition, as of August 1, 2012, Santa Barbara and Stanislaus counties LIHP implementation status was still pending.

[28] As part of the renewed Section 1115 waiver, the Delivery System Reform Incentive Pool (DISRIP) provides about $3 billion (over five years) to support efforts by 12 county hospitals and five University of California hospital systems to improve the quality of care and population health in the communities they serve.

but safety net clinics report that they have learned to organize care delivery in more efficient ways over the years, often as a matter of necessity due to physician shortages. State-level provider organizations also noted that screening and patient checkups are typically conducted by skilled medical professionals (nurses, nurse practitioners, and physician assistants) as opposed to doctors and specialists. Such team-based models in which practitioners work collectively to serve at the top of their training may be an example of a delivery reform that is already occurring in some safety net primary care settings, exemplifying the spirit of the ACA.

To fill in gaps, some providers are implementing telemedicine and even Tele-ICU programs, and ACA funds will support the adoption of these efforts more broadly. Assembly Bill 415 (authored by Dan Logue and signed into law in October 2010), updates legal definitions of telehealth, streamlines medical-approval processes for the delivery of telehealth services, and modernizes the state's health care system by broadening the types of telehealth services that can be provided. Electronic referrals to more easily connect patients to specialists, making sure patients have lab work done before coming in for appointments, and using video translation services can also increase efficiency. Many of these innovations were in progress before the ACA was passed, and philanthropic support of expanding clinic capacity has been long-standing and essential.

As part of delivery system reform efforts, providers must measure and monitor patient outcomes, and not just report the number and types of services delivered. This has necessitated the adoption of electronic medical record (EMR) technology among providers. For many clinics, this started in advance of the ACA (in the late 1990s, in some cases), and stimulus funding through the American Recovery and Reinvestment Act (ARRA) of 2009 provided significant support for hospitals and physicians to adopt EMR. Though one provider in Monterey reported a rocky start to the EMR transition, improvements are expected by the time electronic records are required in 2014. Many of L.A.'s community health clinics are now using some sort of electronic data system, and some have adopted EMRs. L.A.'s major Medi-Cal health plan, L.A. Care Health Plan, recently approved a large grant to connect some of L.A.'s community clinics to Health Information Exchange (HIE) organizations, which allows the free and secure flow of electronic health records to the point of care. The goal is for providers/clinics to be able to share relevant patient information across networks, reduce duplications in tests and services, and improve quality of care. These technologies will be relevant regardless of income or immigration status, though there is certainly a learning curve for providers to use them effectively and efficiently. The ACA appears to have served as a motivation for safety net providers, although waiver funds and ARRA investments were critical to scaling up some of these delivery-of-care transitions.

Expanding Capacity and Improving Coordination

Coordination is an increasingly important topic in the broader context of ACA-driven changes to improve patient care and promote cost-effectiveness. Our respondents primarily spoke of coordination in terms of strategically coordinating with other providers to enhance capacity and ensure adequate access. Other facets of coordination not mentioned, such as coordination to better align the financing and delivery of care, and coordination to improve the cost-effectiveness of care, are also certainly important strategies for preparing for reform.

A range of specialty care, in particular, is a critical need in both rural and urban safety net systems, as several of our respondents noted, and even urban areas with high numbers of physicians per capita may not have enough physicians who accept Medi-Cal patients. With funding from the waiver, however, nine public hospitals are increasing their primary care workforce, and residency programs are expanding. Monterey has taken advantage of increased funding to expand capacity in community health clinics. Clinica de Salud just

opened its 10th clinic (and its first in King City) in April 2012, and it expects to increase patient capacity by about a third. Natividad Medical Center has applied to expand its residency program, with the hope that Natividad residents will continue to practice medicine in the area where they were professionally trained.

In Los Angeles, some respondents noted that the ACA funds to expand clinic capacity presented an opportunity for the very large clinic systems to better coordinate facility location decision-making and staffing considerations. One said: "I think that with the passage of the ACA we kind of recognized, OK, we got to look at this and figure out where there aren't FQHCs, and where we need to go." Part of the motivation to better coordinate efforts has been the anxiety among many clinics regarding capacity constraints. However, given the large network of providers within L.A. County, better coordination between clinics and hospitals and within different types of hospitals (county-run and private) will be increasingly important in improving care.

Improving the Patient Experience

With the understanding that the viability of many clinics rests on their ability to both maintain and draw in a new pool of insured patients, part of preparing for reform means actively training frontline providers to improve "customer service." For some of our respondents, strategies to enhance patient experience included improving the appearance of the clinic waiting rooms, developing the customer-service skills of the intake staff, and fostering loyalty by reminding patients of the important role clinics have played previously when they had no insurance to cover their care. Understanding the need for improvement, the Community Clinic Association of L.A. reports that it is working on a new initiative to conduct virtual training programs for its providers to work on customer service.

Important for the ACA expansions, clinic staff may also be better positioned to assist patients in navigating eligibility determination and enrollment systems, which may be quite challenging for certain clients. In fact, the ACA requires all state-based health exchanges to fund "navigators" —people who help individuals and families find the appropriate health plan to address their health care needs, and to educate people about their coverage options. Because they are required to provide translation services (given higher percentages of patients with limited English proficiency) and have incentives to see patients adequately and appropriately insured, safety net providers may be ideal navigators. Clinics in L.A. have been largely successful at providing core bilingual translators on-site, though most providers underscored that there was always need for greater language services.

Clinic representatives also mentioned the experience and abilities of community health providers to discuss culturally and gender-sensitive matters, including testing for sexually transmitted diseases, teenage pregnancy, birth control practices, and the importance of preventive practices and screenings. In these ways, clinics could strategically position themselves as offering a higher quality patient experience, because they are able to better communicate with and respect the needs of their clientele than in other facilities. In addition, some providers noted that clinics represent a place where all members of the family could be served, regardless of immigration or insurance status. This implies that mixed-insurance-status families may find safety net clinics a more convenient option to receive health care than private physicians or HMOs, and many community educators are trying to disseminate this message.

Innovations in Connecting Patients to a Continuum of Services

Common to both Los Angeles and Monterey counties, clinic groups noted that one of the unique strengths of many safety net providers is the broader role they play in their communities of connecting patients to other needed services, including transportation assistance, housing services, educational assistance, and especially legal aid for immigrants. As one respondent noted, "They are not just going to the clinics for their primary medical care. And I think we've been doing that since before the medical home model became, you know, the hot thing to do with the ACA." In serving as a safety net connector, clinics may already be the provider of choice for Medi-Cal patients, because no other institution plays that role for them. If that model is fostered and scaled, it could situate clinics as the medical home for the newly covered, an important cornerstone to improving coordination and continuity of care under the ACA's Medicaid expansion.

Organizations that have invested and worked closely with immigrant and underserved communities are often pioneers in developing and testing strategies to educate residents on topical issues that affect their families. One innovative model of outreach and education regarding the ACA and its impacts, eligibility for services, and the role of safety net providers in communities is the *promotora* model. These are dissemination programs that train volunteers in communities (although some are paid) to educate residents on various timely issues (e.g., health updates, the ACA, education, immigration reform) that affect the Latino community. Dissemination occurs in a peer-to-peer manner, and it is influential because the educator (often a woman) is someone who is well respected in the immigrant community and speaks the language of community members. It has proven successful enough that it is being replicated and tailored to target non-Latino minority communities. For instance, among L.A.'s Korean immigrant population, the promotora model targets elders. In the African-American community, church leaders serve as promotora educators.

Remaining the Provider of Last Resort: Challenges to Sustaining the Safety Net

Maintaining Their Mission

Among the most salient of concerns, our respondents identified their fear of providers "squeezing out" those who will remain outside the scope of coverage under the ACA. This fear reflects an awareness of limited capacity among providers—despite recent efforts to expand—combined with a realistic understanding of the importance of patient revenue. For some experts, the outlook for the remaining uninsured and particularly the unauthorized population is not optimistic. In Los Angeles one local expert observed, "Nobody wants to see that happen [squeezing out the unauthorized]. But I think that in the current funding environment it becomes difficult, and clinics have to make choices about how they meet their bottom lines."

The fiscal reality is that providers who continue to serve high numbers of uninsured residents may not be able to keep their doors open because of DSH reductions for public hospitals, and because some newly insured patients may choose to seek primary care at other facilities. One provider in Monterey noted that currently "[Medi-Cal] patients have funding, and that funding is the one that keeps the public clinics alive." The doctor went on to explain that for an uninsured patient, his "hands are very tied because there are very few things that I can do for them." In the end, he said he often refers uninsured patients, including unauthorized immigrants, to a specialist in the ED.

Moreover, state budget deficits have necessitated cuts in funding to community health centers, and the federal funding appropriation for health centers was reduced for the first time in 30 years by $600 million in

2011 (Kaiser Commission on Medicaid and the Uninsured 2012). Additionally, recent debates over revising the PPS reimbursement structure to FQHCs have hit a political nerve. On the one hand, the current reimbursement rates are meant to offset and subsidize the care that these clinics provide for the uninsured. And FQHCs have often defended their PPS rates (which vary across FQHCs based on patient demographics and health profiles) because they deal with high-needs and difficult-to-serve populations, including patients with multiple behavioral and co-morbid conditions. Though some FQHCs understand that there is a need for discussion and revision of the payment system, there is also a need to be protective. Says one provider: "We're already trying to stay out of the red. And we're being asked to do way more under health reform than we were before. So that's the tension there." On the other hand, state policymakers have noted that the high rates of reimbursement make many FQHCs undesirable for health plans to incorporate into their primary care networks. This is particularly relevant in debates over whether FQHCs can and should be included as partners of choice in the provider networks of qualified health plan options offered through the Exchange, and if so at what level of reimbursement.

Immigrant-rights organizations are also concerned that increased coverage options through Medi-Cal and the Exchange may not increase enough to offset the slated declines in DSH payments to public hospitals. Until expansions are realized, it is difficult to predict how much DSH payment reductions will hurt hospital finances, and which hospitals will be hurt the most. Yet it is reasonable to assume that hospitals with high concentrations of unauthorized immigrants and low shares of newly covered populations will be hit the hardest. However, the extent to which DSH reductions impact California's public hospitals is contingent on how DSH payment structures are revised, which is an important federal and state policy decision. If the algorithm for payment is restructured to incorporate areas with the highest percentage of *remaining* uninsured residents, the reductions may not be as detrimental as some currently fear, especially if hospitals can increase their share of newly insured patients over the first few years of the ACA implementation.

Barriers to Enrollment Expansion and Delivery Reform

There will undoubtedly be challenges with expanding enrollment under the ACA, and technology is a big component in determining how well expansions will work. Getting systems to "talk to each other" is difficult given current and sometimes dated IT structures in clinics and hospitals, but it is essential (Coughlin et al. 2012). Community clinics in L.A. particularly noted struggles with LIHP implementation as they relate to IT and billing, as the county's system "wasn't as sophisticated" as other counties. As a result, L.A. clinics are having a difficult time getting eligible individuals enrolled into the Healthy Way L.A. program, and discerning or verifying which patients are eligible to draw down matched waiver funds and which are not. Los Angeles, unlike Monterey, has made a local policy decision to continue to use county indigent care funds to cover care for those not eligible for waiver funds (many of whom are unauthorized immigrants or recent legal permanent residents). But without a seamless verification, billing, and care-management system, a community clinic representative noted that some FQHCs could not get paid in a timely manner for the visits that had already occurred, compromising their fiscal viability. As noted earlier, using meaningful health IT to foster delivery system integration will be an important infrastructure advancement for safety net systems. Early evaluations of the LIHP and HCCI found that counties that were able to successfully modernize and adopt health IT to improve health care coordination and delivery did so because county leaders were strong advocates of this goal, obtained stakeholder support, and formalized the implementation in their mission (Pourat et al. 2012).

The ACA's real-time verification system, which will be developed by the federal government through a "data hub" in order to expedite and streamline eligibility and enrollment in coverage, will be an important

step to improving efficiency in clinics. Some providers, however, feared that if there are heavy paperwork requirements, immigrant and low-income populations may have difficulty pulling together tax and wage documentation. Perhaps more importantly, asking patients for paperwork or inquiring about immigration status represents a major, and unpopular, shift in the way some safety net clinics currently conduct their business. Some providers are worried that implementing "new" procedures will drive current users, including unauthorized immigrants, away. Promoting better understanding and information about how the federal verification system may or may not change current enrollment and verification practices in local safety net systems may be warranted, given these concerns, some of which may reflect historic enrollment practices rather than those envisioned under the ACA.

Need for Improving Access

State experts reported that especially in rural communities, clinics and hospitals are not located near where the uninsured reside. Furthermore, access to clinics and hospitals is hampered by whether individuals have access to automobiles and by the strength of the public transportation system. Even in urban areas, such as L.A., traveling to clinics can take considerable time, even with an appointment. Transportation was also highlighted as a concern in Monterey, both in Salinas and in the southern part of the county, where there are no clinics. Round-trips to clinics of 100 miles were described, the bus system is not extensive (much like in L.A.), and immigrants are less likely to have vehicles than the native-born in both of these counties.

Although safety net providers may strive to provide linguistic and culturally appropriate services, language is still an issue, particularly for certain types of specialty care. Moreover, some California communities are seeing increases in numbers of indigenous-language speakers from Mexico who do not speak either English or Spanish. In both L.A. and Monterey, providers noted that they are not prepared to translate for these groups. Even when mandated to provide language assistance, as is the case for Medi-Cal managed-care plans, advocates hear "horror" stories of children having to serve as interpreters for their parents. Despite the importance of medical literature translations (e.g., pamphlets), one L.A. physician noted that half her patients are illiterate. In Monterey, over half of the foreign born have not graduated from high school. In both counties, the foreign born are less likely to speak English "very well" compared to the statewide average.

Regardless of immigration status, providers underscored the challenges in providing appropriate care to poor and low-income patients. Their incomes may be volatile, their housing transient or overcrowded, their education low, and their employment circumstances not conducive to receiving follow-up care during "regular" business hours. Physicians noted that it is difficult to get patients with chronic conditions to return for needed follow-up care appointments. Particularly in Monterey, because so much of the work of unauthorized immigrants is in agriculture, some of the reported health-related concerns for immigrants are different than other safety net users. These include pesticide exposure, water contamination, lead poisoning, stress on the job related to the pace of work and the mechanization of labor, and employer abuse and intimidation. Providers also highlighted that because many immigrants lack dental coverage, they often end up with the less-expensive but more serious treatment for dental problems—for example, an extraction rather than a root canal. In L.A., diabetes care was noted as one of the most common chronic conditions treated by clinic providers. Many clinicians note that without funding for insulin testing and monitoring, as well as consistent follow through by patients, the disease progresses rapidly among their clinic patients. Efforts in coordination of care among health institutions may not be enough to improve population health in these circumstances, but integrating and coordinating care beyond health care needs may be critical.

State experts also report that much of the time unauthorized immigrants do not know what health care services they can use or are entitled to, such as emergency room care. For those that do understand, they are often fearful of using such services because of concerns it might impact future chances of obtaining legal status. Large numbers of children who are eligible for coverage through Medi-Cal or Healthy Families but are not enrolled is a big concern (Huang et al. 2006) and exemplifies why some Californians who are newly eligible for coverage may not participate. Outreach to mixed-status families (with a citizen child and unauthorized adult) has not been able to overcome these barriers thus far.

Future Funding from State and County Health Programs

In the context of the ACA's expansion of affordable coverage to millions of uninsured Californians, the fate of some of the state's limited-benefits health care programs remains to be seen. The decision of policymakers to maintain or cut smaller, state-funded programs has direct implications for access to care for many of California's noncitizen immigrants, as most if not all programs help subsidize care for poor LPRs and unauthorized immigrants. Unauthorized immigrants pay clinics' sliding scale fees, and use the few state programs that support the uninsured regardless of immigration status, or they may go without care entirely. Key state programs include the Child Health and Disability Prevention's Gateway program, which allows uninsured children with family incomes below 200 percent of the FPL to get a free well-child exam once a year and follow-up treatment. Family PACT provides family planning services for everyone below 200 percent FPL, regardless of immigration status, and represents a small percentage (about 8% in L.A.) of clinic revenue. Immigrant rights groups expressed a great deal of concern about the future political viability of these and other screening programs (such as breast cancer screening and treatment programs)[29], particularly in light of budget deficits, and they are working at the state level to ensure the continuation of these programs.

[29] Some state programs provide/subsidize breast and cervical cancer screening for low-income women (Every Woman Counts), and prostate cancer for men (IMPACT). These services should be included in Medi-Cal and exchange health plans.

Conclusion

The health care safety net system, upon which millions of the most disadvantaged Californians rely, has been described as one that is both "fragile" and "resilient" (Siegel et al. 2004). In many ways, as demonstrated in our case studies, it delivers care that many other providers do not or cannot—care that is appropriate and culturally respectful of some of the most difficult-to-serve and vulnerable populations, whether due to illiteracy, poverty, multiple health concerns, or immigration status. The reforms embodied in the ACA will have important impacts on the future of local safety net systems, some positive and some negative. The large-scale expansions to increase access to affordable health care coverage, the primary goal of the ACA, may relieve some pressures on the safety net, through bringing in new and higher payment revenues. However, the reality of the ACA is that not everyone will be covered, most notably in states such as California, with large unauthorized immigrant populations. And many providers are already struggling with workforce and capacity concerns.

The safety net in California will be required to play various roles in the post-ACA landscape: to be providers of choice, partners of choice, and to maintain their long-standing mission to be the provider of last resort. On one measure that is critical to fulfill each of these roles—accessible location to high-need populations—our spatial analysis reveals that for the most part safety net providers are meeting this goal.

At the same time, it is also important to consider how to target resources to areas most in need of further safety net investment and expansion, and our spatial analysis also revealed the need for improvement in this area. We identified areas with low clinic access and high demand, which are more vulnerable because they are more likely to have a high concentration of unauthorized immigrants or remaining uninsured. These areas include parts of L.A. County (Lancaster/Palmdale region, parts of the San Gabriel Valley, and communities near the Port of L.A.) and parts of Orange, Riverside, and San Bernardino counties. Areas in the Central Valley (Fresno and Kern) and in Monterey County, where large unauthorized populations reside, appear to have both low ED and clinic access. If clinics squeeze out the remaining uninsured and unauthorized immigrants, as some advocates fear, there will be fewer choices for these residents, and it is likely that they will rely more heavily on the "safety net for the safety net"—hospital EDs—for care.

To assist safety net facilities in their mission to remain the provider of last resort under the ACA, state policymakers and local health departments will need to consider what level of investment will be required to maintain access to care for those who remain uninsured after health care reform, including the unauthorized population. Decisionmakers will also have to reconsider the continued need for current state and county programs that serve underserved and disadvantaged populations, and how to target remaining resources and revise current allocation schemes (i.e., DSH formulations) toward areas with greatest need—which are likely to be home to many of the state's remaining uninsured population.

To be the provider of choice in the post-reform world, safety net providers will also have to improve patient experience, provide a range of services that patients can access in a timely manner, and serve as a reliable and trusted medical home. Moreover, to become the partner of choice for Medi-Cal and the health plans offered through the Exchange, providers must redesign their care delivery processes to provide more integrated, patient-centered care that demonstrates to health plans and purchasers improvements in quality of care and cost-effectiveness. Our case studies of L.A. and Monterey reveal that some safety net institutions are well positioned to do just that. We heard of frontline providers' efforts to modernize, to update infrastructure and technology, and to focus on customer service. Innovative peer-based education and

outreach models, such as the promotora model, have been well received in immigrant communities. We also heard of the unique role that safety net providers play in serving as community centers, in addition to medical homes, and their sensitivity to providing culturally and linguistically appropriate care. In these ways, local safety net systems can maintain their credibility among the patient populations they currently serve, and also become the provider of choice for many newly insured.

However, there is also concern among FQHC providers over proposals to change their current reimbursement structure. Doing so may increase their ability to become partners with the Exchange as qualified health plan members, but unknowns regarding which people will newly take-up insurance coverage and which will remain uninsured post-ACA drive anxieties over reimbursement restructuring. Coverage expansions are a year and a half away from full implementation under the ACA. State policymakers will need to design and execute a widespread, community-based outreach and education model to inform low-income populations of their new options, while the state's local safety net providers will need to adopt the strategies identified above to position themselves as providers of choice. Promoting an improved application and "no wrong door" determination system, as envisioned by both state and federal leaders, may go some way in ensuring high participation, given the current (and sometimes burdensome and slow) application and processing systems. Safety net providers can be meaningful partners in these efforts. For instance, the promotora model may be a promising approach to share information on coverage opportunities and address common misperceptions about the broader goals of the ACA.

For policymakers and planners, safety net providers may serve as important and useful "navigators" in expanding enrollment in both Medi-Cal and the Exchange in 2014. Carefully monitoring progress of both clinics and public hospitals in the waiver demonstrations can further identify areas across the state where facilities are in need of improvement and resources, whether through better health IT infrastructure or reorganization of team-based delivery models to improve coordination of care. Doing so can help position safety net clinics to both maintain their mission as providers of last resort and become partners of choice for the state's major health programs and markets as expansion efforts get under way.

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