

HEALTH CARE ACCESS:

**Securing the Counties'
Health Care Safety Net
for All Residents**

TABLE OF CONTENTS

Executive Summary	2
Key Findings	4
Introduction	8
1. Race-based Disparities in Health Care Access	12
2. The County Safety Net: Moving the Dial on Health Equity	22
3. County Profiles	28
4. Building a State of Health Equity	46
Acknowledgments	52
Endnotes	54

EXECUTIVE SUMMARY

Living a long, healthy life depends on many things: diet, environment, exercise, access to health care, and more. One thing it should not depend on is race. Yet, race continues to be a major predictor of success and life chances for those in the Golden State. Indeed, California’s living legacy of racial injustice has led to shocking disparities in the health of its residents—even as the Affordable Care Act (ACA) and its various reforms worked to mitigate or reverse these disparities. As this report illustrates, disparities become even clearer at the county level.

This report is part of our RACE COUNTS initiative, which uses race as the primary lens for understanding disparities and focuses on systemic racism to identify barriers to and opportunities for improvement. Systemic racism is the way that racism has been embedded in our public political, economic, and social systems to subordinate people of color and Indigenous peoples. Through a comprehensive, cutting-edge tool that tracks three dimensions of racial equity—performance, racial disparity, and impact—we compare and rank California counties on how well they’re doing at providing health care access to residents. By taking a closer look at post-ACA changes and choices in three spotlight counties (Los Angeles, Riverside, and Merced), we identify lessons and opportunities to reduce these disparities.



Photos of RACE COUNTS convenings in Oakland and Los Angeles (Photos by Katie Smith).

KEY FINDINGS

The data presented here confirm that despite our significant history of health advocacy and progress, and despite the significant aggregate gains made since implementation of the Affordable Care Act, racial health disparity remains omnipresent in California. Whether it be an inability to obtain health insurance, qualify for Medi-Cal or other health safety net programs, find a nearby health care provider willing to see you promptly for primary care services in your preferred language, or even the basic challenge of getting time off from day-to-day responsibilities to tend to personal health, drivers of health disparity abound in and outside our health care system—undermining our state’s overall health every day.

RACE COUNTS illustrates that the most racially-disparate aspects of health care access statewide are preventable hospitalizations and health insurance coverage. These findings make plain that the very outcome and access disparities that the ACA honed in on – and made some headway on – nevertheless persist in California. Gaping disparities in *preventable* outcomes (such as usual access to primary care) continue to feed into California’s costly, downstream health disparities.

RACE COUNTS shows that while a few of the state’s mid-sized counties are comparatively-high performing and with below-average health disparities, they are exceptional. In other high-performing counties such as San Francisco and Marin, the strong performance on health care access is not shared by Indigenous residents or residents of color, driving large disparities. Meanwhile, for many counties

with below-average health care access disparities—including populous southern California ones like Los Angeles, Riverside, and San Bernardino, along with most of the Central Valley counties—those equity accomplishments are undercut by the poor overall levels of performance among all county residents.

In our spotlight counties, new community health centers and staff additions during the ACA era contributed to greater patient usage and preventive health visits – factors in drastically-reducing overall preventable hospitalizations. These gains are directly tied to community health centers’ (CHCs) improved finances—a product of increased federal funding as well as ACA-related coverage expansions that sharply reduced health centers’ share of uncompensated

patient care. Further improvements for CHC patients—predominantly low-income people of color—were hampered by access barriers in the form of continuing provider shortages, physical challenges in reaching existing CHCs, and restrictive eligibility standards for safety net assistance.

Our spotlight counties’ different responses embody the range of health safety net choices opened up by the ACA—and a shared struggle to improve poor health care access performance. While some counties, such as Los Angeles, used the ACA era as a catalyst to create innovative, comprehensive health programs for residents regardless of immigration status, other counties, such as Riverside, largely held to the status quo. Some, such as Merced, actually rolled back

health safety net services. Yet, despite these different tacks, RACE COUNTS shows that Los Angeles, Riverside, and Merced counties each ranks amongst the bottom 12 counties in the state when it comes to overall health care access performance. In each of these counties, advocates are pushing their elected officials to go further in directly tackling local health disparity drivers—whether by reinvigorating the health safety net in Merced, improving health care accessibility via public transit in Riverside, or broadening safety net eligibility standards in Los Angeles. These and similar campaigns across the state illustrate the concrete, meaningful role that counties and residents can take in creating a healthier, more equitable California for all.

Conclusions and Recommendations For Action

To ensure a healthy future for the state of California, first we need to make a commitment to ensuring every Californian's long-term health and well-being. The stakes have rarely been higher as regressive ideas on who has a right to health care, under what conditions, how it is paid for, and how it is delivered are rapidly being turned into policy, regulatory, and budgetary realities at the federal level.

Most of the health care access gains achieved to date are fragile and thus highly vulnerable to federal rollbacks and local disinterest. Community health centers' growth and counties' safety net innovations were primarily fueled by federal dollars—funds that are endangered for the foreseeable future, due to ongoing threats and actions by both Congress and the federal adminis-

tration to reverse coverage gains and reduce funding supports. Significant revenue disruption to CHCs or California's broader health safety net would be devastating for the health of low-income communities of color.

It is untenable for Californians to simply wait to see whether, or how much, federal policies will inflict harm on the health of communities of color. Califor-

nia today stands on the edge of opportunity, but the persistent disparities we have identified will not be erased without focused solutions tailored to the barriers that impact low-income communities of color. Officials should answer advocates' call and adopt state- and county-level reforms that can help to shore up a vulnerable safety net, and, once the federal danger passes, set the stage for a more equitable future for all. Our recommendations include the following:

1. Prioritize their health safety nets in terms of budgeting and broad goal-setting. Counties should make a concerted effort to make sure that their safety nets live up to their names. At a basic level, this will require additional resources—beyond looking to leverage state and federal funding and grant opportunities, counties should commit significant local resources to make this possible.
2. Set a framework to guarantee health care access for all. The state should create a baseline standard requiring that every Californian receive primary care, with a concomitant requirement that county programs extend eligibility regardless of immigration status and adopt uniform standards for data and reporting.
3. Create incentives to widen the health care workforce pipeline for areas in need. Build on the state's Future Health Workforce Commission and encourage local innovations that can identify the gaps in existing programs, such as the Teaching Health Center program and the National Health Services Corps, and identify potential solutions.
4. Refine health data-gathering to better assess and address the state's lingering health care disparities and find a better way to utilize its safety net in reducing them. Collect and make available data disaggregated by race, ethnicity, and national origin wherever possible, while prioritizing data collection efforts to ensure that there is comprehensive, accurate information about the state of health access in Indigenous and immigrant communities.

INTRODUCTION

Health is perhaps the most elemental of our needs. Living a long, healthy life depends on many things: diet, the environment, exercise, access to health care, and more. One thing it should not depend on is race. Yet California's history of racial injustice has led to shocking disparities in the health of its residents.

Through our RACE COUNTS initiative, we confirmed that race plays a significant role in determining who has access to quality health care and who can obtain positive health outcomes, in all 58 counties across the state. Identifying inequities, however, is

just the beginning—and because the experience of each county has been different, there are important lessons for organizers and officials working at the state and local levels about how to win health equity for all Californians.

These lessons are especially timely given the changes wrought by the Patient Protection and Affordable Care Act (ACA), and recent federal efforts to repeal and undermine it. Californians of color were the primary beneficiary of the ACA's coverage gains—it allowed more than five million residents to obtain insurance, dropping the state's overall uninsured rate to historic lows¹—but gaps, especially in immigrant communities, remained. Today, nearly three million Californians lack health coverage—with almost three quarters of these uninsured being people of color or Indigenous people.² And while a radical force for change in many respects, the ACA's reforms were primarily built atop our pre-existing health care system and inherited many of the same disparities that had existed previously. Californians of color are routinely denied basic health services due to cost, systemic neglect, lack of employment, or immigration status—each a barrier with its own long history of racial inequity.

WHAT IS RACE COUNTS?

In California, race continues to be a major predictor of success and life chances. This is not simply a question of history: race-based injustice is a daily presence in the lives of Californians of color and Native communities. The RACE COUNTS initiative is a platform supporting work to fight inequity at the local level, built around a comprehensive, cutting-edge tool tracking three dimensions of racial equity—performance, racial disparity, and impact—across the state in seven key issue areas: Democracy; Economic Opportunity; Crime and Justice; Health Care Access; Healthy Built Environment; Education; and Housing.

The tool, launched in November 2017 at racecounts.org, includes county-level data by race for 44 indicators within these issue areas, and a launch report with key initial findings. This report is one of a series that will follow up those initial findings by more closely analyzing disparities, in particular areas, to identify new approaches for achieving racial equity.

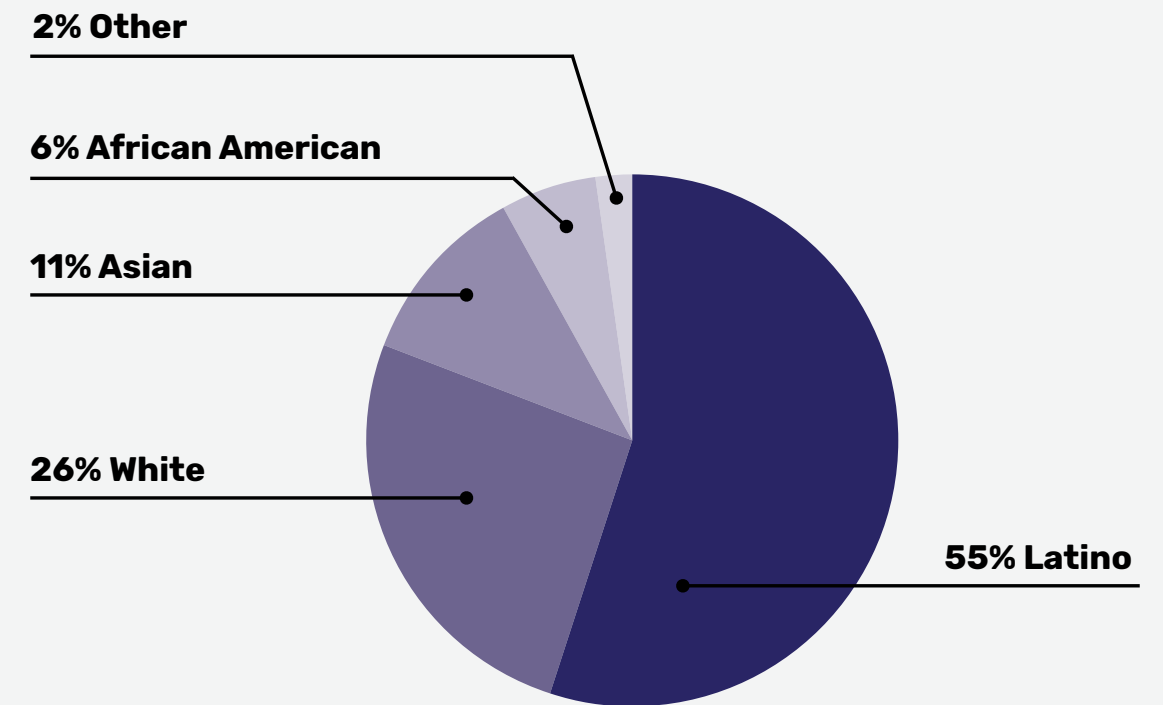
The RACE COUNTS Steering Committee is made up of Advancement Project California, California Calls, PICO California, and the University of Southern California's Program for Environmental and Regional Equity (PERE).

While many of California’s leaders have taken these limits of the ACA as an opportunity to innovate and advance further reforms, the current Congress and federal administration have instead waged a slash-and-burn campaign to roll back its achievements. Through executive orders, regulatory guidance, legislation, and the promise of more to come, they have threatened to cut funding for safety-net providers, drive premiums up, and erect new barriers to care that will disproportionately harm low-income Californians of color.

As California’s advocates and leaders weigh how to respond to this assault while continuing to push for proactive solutions, it’s more important than ever to understand how to move the dial on health equity. In Part I of this report, we use RACE COUNTS data to assess the key race-based health disparities that currently exist across California, and analyze how they differ by race, by county, and by specific health indicators. In Part II, we examine

the role of the county safety net in addressing these disparities, and how the ACA strengthened it. In Part III, we present deep-dive profiles of three counties—Los Angeles, Riverside, and Merced—to explore how they responded to the opportunities presented by the ACA and highlight both victories and remaining challenges. Finally, in Part IV, we offer overall conclusions and provide recommendations.

California’s Remaining Uninsured by Race



Paul Fronstin, *California’s Uninsured: As Coverage Grows, Millions Go Without*, California Health Care Foundation, (2016 with 2017 update).

1. RACE-BASED DISPARITIES IN HEALTH CARE ACCESS

In the RACE COUNTS framework, health care access means the ability of Californians to obtain affordable care from high-quality providers and achieve positive health outcomes. We measure disparities in health care access through six indicators that span the entire care continuum; from insurance coverage to access and proximity, from geographical access to actual utilization, from utilization to key health outcomes, and from outcomes to overall life expectancy. They are:³

1. Life Expectancy: the number of years a newborn would be expected to live based on current mortality rates (California Department of Public Health and Department of Finance data, mortality rates calculated 2007–2011, population data from 2006–2010);
2. Health Insurance: the percentage of the civilian, noninstitutionalized population without health insurance (American Community Survey, 2010–2014);
3. Preventable Hospitalizations: the rate per 100,000 population of hospitalization for conditions that would not have required hospitalization in properly treated, including diabetes, asthma, and hypertension (Office of Statewide Health Planning and Development, 2010–2014);
4. Low Birthweight: the percentage of infants born with a weight below about five pounds eight ounces (2.5 kg) (California Department of Public Health, 2013);
5. Usual Source of Care: the percentage of people whose usual source of health care is a doctor's office or a clinic, as opposed to an emergency room or not having a usual provider (California Health Interview Survey, 2011–2014); and
6. Access to Federally-Qualified Health Centers (FQHCs): the number of geographically-accessible FQHCs and look-alikes (commonly referred to together as Community Health Centers, or CHCs) per 100,000 population, with access determined by residence in the same census tract where a clinic is located (U.S. Department of Health and Human Services and American Community Survey data, clinic data from 2016, population data from 2010–2014).⁴

As discussed above, there are many determinants of health that do not fall into this comparatively narrow definition, such as access to healthy food, exposure to environmental hazards, or economic class. RACE COUNTS includes many indicators that address these factors in other issue areas, especially in our Economic Opportunity and Healthy Built Environment issue areas, but advocates and policymakers assessing the findings discussed below should keep this context in mind when weighing possible solutions—health disparities are not always about disparities solely within health systems.

Findings

RACE COUNTS tracks county-level racial equity in three dimensions: performance, racial disparity, and impact. Performance is assessed by how well or poorly a county's overall population scores on a particular indicator. Racial disparity is measured by how far each group is from the group with the best performance. Impact is indicated by the size of the county's population.

We visualize these three dimensions through scatterplots with disparity displayed on the hor-

izontal axis (higher disparity to the right, lower disparity to the left) and with performance displayed on the vertical axis (higher performance to the top, lower performance to the bottom). To assess the level of impact, the size of each county's circle on the scatterplot corresponds to its relative population size (Los Angeles County, for instance, with a markedly larger circle than the rest, represents its outsize population relative to all other counties).

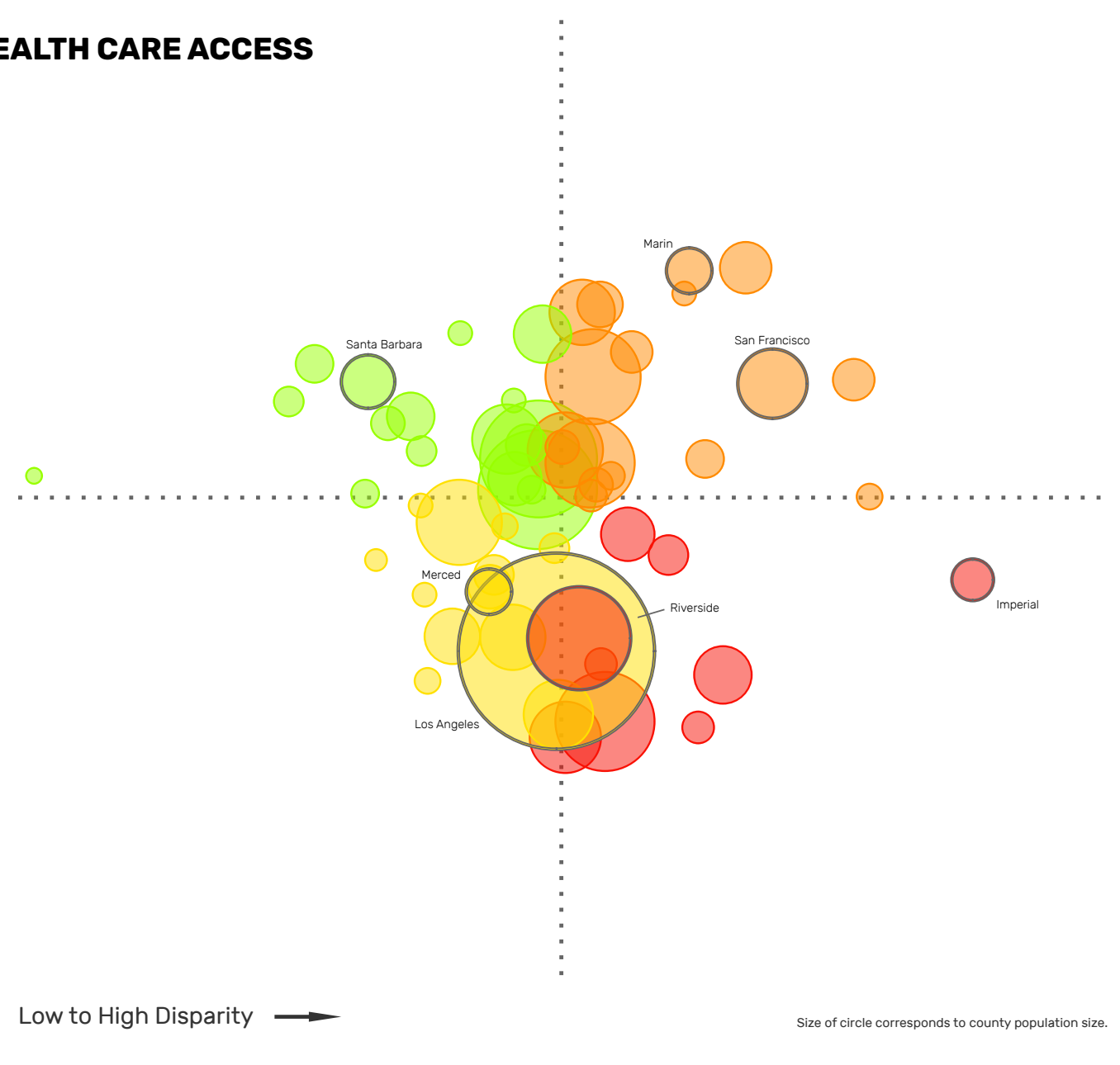
The scatterplot is divided into four color-coded quadrants, each indicating a separate typology. The color coding illustrates the relationship between performance and disparity for each county. Counties colored green are those with "Gains at Risk"; they have above average performance and below average disparity metrics—indicating progress in some areas that may be under threat

by changing economic or demographic trends. Counties colored orange, meanwhile, are those with "Prosperity for the Few," with high overall performance but relatively-higher race-based disparities. Yellow counties are "Struggling to Prosper," as they have relatively-lower disparities, but combined with overall lower performance, indicates deprivation affecting all county residents. Finally, red counties are "Stuck and Unequal," with low performance and high disparities presenting barriers to residents' progress.

The remainder of this section dives into our findings by first looking at disparities experienced by different communities of color in California; then by addressing trends at work in different counties; and finally by examining how the pattern of disparity is different for each of the six indicators.

HEALTH CARE ACCESS

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Low to High Performance



RaceCounts.org Primary Care Clinic Utilization Data, 2011 and 2015

FINDINGS BY RACE

In California, two groups emerge as carrying a particularly heavy burden of health care access disparities: statewide, in five out of the six health care access indicators, California's lowest performing group is either Latinos or Blacks. Asian Americans, as an aggregate, often appear to experience relatively lower disparities, but this masks the wide variation in the experience of members of different ethnicities and nationalities fitted within that broad "Asian American" category. Finally, Indigenous communities also experience significant health-related barriers.

Black Californians are the most heavily impacted by disparities across the entire set of 44 RACE COUNTS indicators, and the high disparities they experience in health care access reflect these intersecting burdens. On most outcome indicators, they

have the worst rates: 11.7 percent of Black babies have low birth weights, for example, as compared to a 6 percent rate for Whites, while the next-highest rate is only 7.7 percent, for Asian Americans. Blacks in California are more than twice as likely to be hospitalized for a preventable cause or condition and their life-expectancy is almost seven years lower than for Whites. Despite these high disparities on outcomes, however, Blacks' disparities on access, while still real, are more modest: their health insurance rates are worse than Whites' are, but are noticeably better than those of Indigenous people and Latinos. This suggests that for many Black Californians, health disparities are driven as much by economic, environmental, and social disparities as by those within the health care system.

Latinos, by contrast, face an inverse situation: they tend to do worst on access indicators, with the highest uninsured rate of any single racial group (25.6 percent, more than twice the rate [12.6 percent] for whites),⁵ and they likewise are the least likely to have a usual source of care. On outcome indicators, however, the disparities are smaller. They have the second-best low birthweight rate and have fewer preventable hospitalizations than Whites do. The data may not be telling the full story, though, and these two trends may be related, because a combination of documentation-status barriers (a major issue even within "mixed" families where some members are U.S. citizens and others are not) and language or cultural barriers tend to disproportionately exclude them from the health care system.⁶ Thus, the same factors that make it less likely for Latinos to have an

insurance card may make it less likely for them to visit doctors or hospitals, even in emergencies.

On many health care access indicators, Asian Americans appear to be doing well. However, data disaggregated by ethnic groups consistently shows significant social and economic diversity among Asian Americans. Census data on insurance rates illustrates this dynamic: while the percentage of Japanese Americans in California who are uninsured (7 percent) is lower than the percentage for Whites (8 percent), the share of Korean Americans without health insurance (20 percent) exceeds that of Blacks (12 percent) and approaches that of Latinos (23 percent). Further analysis of disaggregated data is needed to understand the ways that disparities impact Asian American communities.

Finally, understanding the disparities affecting Indigenous communities is especially challenging. In California, such communities are often geographically concentrated and have relatively small populations, which often makes data inadequate to convey their experiences grappling with persistent injustice and disparities. Their policy context is also unique: while the federal government is legally obligated to provide health care for Native Americans through the Indian Health Service (IHS), IHS is not an insurance program, is woefully underfunded, has eligibility gaps depending on enrollment in a tribe or other factors, and cannot provide the minimum essential health benefits outlined in the ACA. Similar to Latinos, they face cultural and linguistic barriers, and they were not subject to the ACA's recent-

ly-repealed individual mandate, which may have reduced their coverage rates. Indeed, within our data, Indigenous communities have high uninsured rates (over 23 percent), and life expectancies four years lower than that of Whites.

FINDINGS BY COUNTY

Looking at individual counties, we can better appreciate the wide health care access variations across the state. The best-performing counties (Sierra, Placer, Marin, Mono, and Santa Cruz) tend to be along the Central Coast or the Sierras. Meanwhile, Inland Empire and Central Valley counties (Fresno, Lake, San Bernardino, Kern, and Glenn) predominate amongst the poorest performing ones in the state.

Counties' disparities in health care access gives a different perspective. We see that remote, sparsely-populated counties such as Imperial, Del Norte, El Dorado, and Placer have the most disparate health care access in the entire state. The least disparate counties (Alpine, Tuolumne, Napa, Amador, and Santa Barbara), by contrast, are an assortment without any clear regional, demographic, or policy commonalities (though

the relatively lower populations of both the highest- and lowest-disparity counties may be a factor, since lower populations can lead to higher variability in the data). When we plot performance alongside these county-by-county disparities, we get a truly multi-dimensional understanding of health care access in California.

In short, while a few of the state's mid-sized counties are comparatively-high performing and with below-average health disparities, in the "Gains at Risk" quadrant, they are exceptional. In other high-performing counties, such as San Francisco and Marin, high access performance is not shared by Indigenous residents or residents of color—driving large disparities and illustrating the "Prosperity for the Few" dynamic. Meanwhile, for many counties with below-average health care access disparities, including pop-

ulous southern California ones like Los Angeles, Riverside, and San Bernardino along with most of the Central Valley counties including Merced, those equity accomplishments are paired with poor overall levels of performance. In such cases, county residents of many races may confront common challenges, such as a stagnant economy or a lack of health care infrastructure—exhibiting the "Struggling to Prosper" scenario.

The multidimensional scatterplot illustrates a similar profile shared among this report's three spotlight counties. Each of them can lay claim to having either average (Los Angeles and Riverside) or slightly better-than-average (Merced) levels of general health care access disparities. This minor success is hollow, however, offset by their poor overall performance. In fact, they are

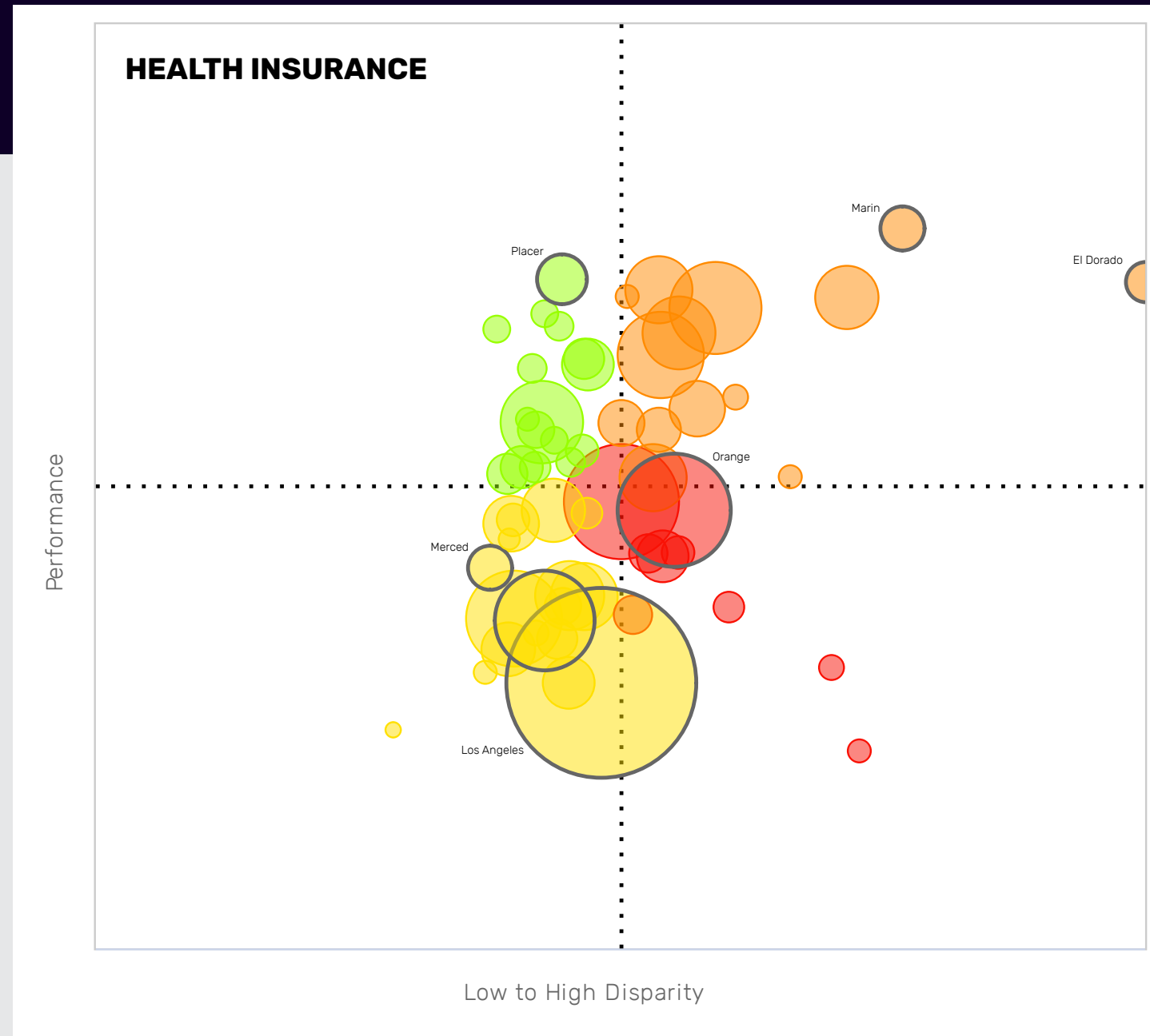
each tightly bunched toward the bottom of the state in health care access performance—among the worst—with Merced highest among the three, ranking 46th out of California's 58 counties. So while residents in these counties, broadly speaking, share similar levels of health care access, they are sharing in a poor state of overall access—an undesirable outcome for all.

FINDINGS BY INDICATOR

Honing in on RACE COUNTS indicators adds nuance to the story of separate and unequal health care access. Individual indicators give an appreciation for what aspects of health care access are the most problematic in California. For instance, the most racially-disparate health care access indicator statewide is preventable hospitalizations. We see this disparity most pronounced in the opposing, thinly-populated corners of our state—in Del Norte and Imperial Counties—but it is also quite stark in the heavily-populated Inland Empire counties of Riverside and San Bernardino. Large disparities in these *preventable* events suggest how upstream inequities (such as usual access to primary care) feed into costly, disparate health outcomes downstream.⁷ They also illustrate that the causal link between health and economic factors can work both ways: in

addition to the underlying health issues, hospital visits tend to drive down long-term household income and drive up families' risk of financial catastrophe.⁸ In this one highly-disparate indicator, then, we see racial, geographic, health, and wealth disparities intersecting and perpetuating in our state.

The second most-disparate health care access indicator statewide is health insurance coverage. This partially reflects the fact that the timeframe for our data includes several years before the ACA's coverage expansion went into effect: if these policies are sustained, therefore, we expect to see the level of disparity on this indicator decrease somewhat. Even if federal attacks do not meaningfully reverse the ACA's progress, however, California's people of color continue to face alarming coverage disparities.



RaceCounts.org Primary Care Clinic Utilization Data, 2011 and 2015

This includes a high proportion of its estimated 2.5 million undocumented immigrants who remain formally excluded from the ACA’s benefits.⁹ There is significant regional variation as well, indicating that different counties will need to explore different solutions: southern California counties with high immigrant populations, for instance, can point to below-average disparities when it comes to health insurance, but match it with poor performance. This wide sharing of pain across a county is, obviously, not the desired scenario. By contrast, many populous Bay Area counties (such as Marin, San Mateo, and Santa Clara) appear to perform very well on overall insurance levels, but high disparities make that success hollow.

In general, provider access indicators are less disparate, or may have disparities that show Blacks, Latinos, and Indigenous communities doing better than White populations, as is the case with access to community health

centers. This is an important finding, though even health care access indicators that look relatively equitable on a statewide level tell a different story in individual counties: many residents of the state’s non-coastal counties, for instance, have difficulty in simply finding a care provider. Counties such as Merced, Fresno, Stanislaus, and Madera have especially low provider access—a provider deficit that hits low-income Indigenous people and residents of color particularly hard. And the inverted disparities on the clinic access indicator is a reflection of federal requirements that they be located in high-need communities, which are disproportionately communities of color.

Even with these caveats, this comparatively brighter picture on provider access indicators, and especially on access to community health centers, is good news and points the way toward opportunities to reduce all health disparities. Because the safety net

of CHCs operates at the county level, and serves a patient population that is primarily people of color, much depends on how county leaders and advocates working for health equity reform their safety net in the wake of the ACA’s passage and the current threats. The next sections go into more detail on these opportunities and provide case studies of the choices made in three critical counties.

2. THE COUNTY SAFETY NET: MOVING THE DIAL ON HEALTH EQUITY

Mandated by law, and intended to catch those excluded from the market-based system, California’s so-called health “safety net” obligates all counties to provide care and support for their poorest residents. Via assorted programs and providers of last resort, counties offer some medical services to those unable to fully pay for their health needs, and who are not covered by other programs such as Medi-Cal.

This common obligation to serve the needy, unfortunately, has not translated into a common, statewide approach.¹⁰ Instead, counties rely upon a range of ways to serve their neediest residents—some providing direct services via community health centers and/or county-run hospitals (including Los Angeles and Riverside Counties); some contracting out with private providers such as CHCs and hospitals (such as Merced County); and others joining a consortium providing basic coverage across 35 counties. Just 10 of the state’s 58 counties provide more

than mere emergency health care to undocumented immigrants—including Los Angeles and Riverside counties.¹¹ Each county has a different definition of who qualifies for services and what those services entail, and each funds their programs and infrastructure differently.

The safety net—and the hundreds of community health centers at its core—has become the *de facto* health care system for California’s low-income Indigenous people and communities of color. In fact, together, these communities make up almost 80 percent of all CHC patients statewide and over 95 percent of those enrolled in Los Angeles County’s safety net program.¹²

As discussed above, at least when it comes to geography, community health centers are primarily located in the communities of color that they service. This is, however, only one facet of accessibility: if you have no means to get there, if the clinic has no available appointments, if you

lack the ability to pay, or if no staff there speaks your language, access is a mirage. Nonetheless, studies have long found that CHCs improve health and lower care costs for both their patients and the overall health care system.¹³ Despite serving patients that are more likely to suffer from chronic health conditions and have other socioeconomic challenges, CHCs’ health outcome performance compares favorably to other primary care providers.¹⁴ Many have argued that centers are uniquely suited to reduce or eliminate disparities in health care outcomes.¹⁵ These safety-net providers and the county programs that help support them are thus a key resource in the struggle for health equity.

Health centers are not only an essential component of California’s primary and safety net health care systems, but their governing structure and decisions are shaped by the residents they serve (all CHCs, for instance, must have governing boards with

majority client representation, patient representatives that reflect the demographics of those served by the center).¹⁶ Despite predictions that the ACA coverage expansion would lead the newly-insured away from CHCs and toward private health care, this has not proven true here.¹⁷ In 2010, less than three million Californians used community health centers in the state.¹⁸ Today, more than four million Californians—96 percent of whom are low-income—use our state’s CHCs.¹⁹

How the ACA Changed the Safety Net

The Affordable Care Act (ACA) was passed at a time when the safety net was struggling, as the Great Recession drove the number of uninsured to record levels and community health centers faced significant financial challenges as they tried to serve the needs of their patients.²⁰ The ACA championed community health centers as cost-effective vehicles for improving health access, outcomes, and equity. It included billions of dollars in direct funding streams for CHCs—and its coverage expansions—by making millions of Californians newly eligible for Medi-Cal and helping thousands of others afford private health insurance via subsidized Covered California plans, which gave many of their previously-uncovered patients insurance.²¹

As more state residents gained coverage via the Medi-Cal expansion, those providing their care were now reimbursed for the service rather than absorbing the cost as uncompensated care. Although Medi-Cal's reimbursement rates remain problematically low, they nonetheless far exceed what an uninsured patient has the capacity to pay out of pocket. Not coincidentally, California residents during this period dramatically reduced their number of hospital visits for treatable conditions – though preventable hospitalizations remains one of the state's most pernicious health disparities. Likewise, the coverage expansion helped stabilize community health center finances, fueling growth in centers' infrastructure and allowing more patients the opportunity to access comprehensive care. CHC patients,

for example, increasingly used preventive care—reducing disparities and improving long-term health. Increased funding enabled hundreds of new health centers to open in California, thousands of health professional hires at these centers, an increased focus on innovative managed care models, and expanded access to specialty (oral and mental) health services. Improved finances and incentives also encouraged CHCs to zero in on long-neglected groups such as the homeless or the formerly incarcerated via outreach and tailored programs.

Among all these benefits, the ACA also created new challenges. Despite increases in staffing and clinic hours, the huge increase in patients meant that wait times typically increased as well.²² And while the Medi-Cal expansion was overwhelmingly financed

with federal dollars, the state was required to provide some matching funds. Correctly anticipating that the expansion would lead to a drastic reduction in the number of Californians reliant on county safety net programs, the state passed legislation—2013's Assembly Bill 85—that redirected about \$900 million in annual state funding for county health programs to pay for the state's share of the expansion, with some counties retaining more funding than others.²³ Each county was forced to reckon with this revenue challenge and make critical policy and budgeting choices. Some counties created new programs to adapt to the new landscape. Others chose to simply spend less on indigent care, or even effectively shut down their safety net services.

Then there are the problems that the ACA did not solve. Stakeholder conversations showed us how racially-disparate barriers continue to subvert access to care throughout California. Eligibility

restrictions keep the state's undocumented adults largely locked out of coverage and many safety net programs, though state legislation to extend Medi-Cal coverage to children and young adults regardless of immigration status has improved things for them. Many residents, with or without insurance, also face barriers because they simply cannot get to a provider or because there are not enough primary care providers to serve low-income residents.²⁴ For patients of color, Indigenous peoples, and immigrants, the inability of some health care providers to respectfully serve patients' cultural and linguistic needs can lead to distrust or fear of using health services.²⁵ And perhaps most fundamentally, the state's high costs of living and housing compound all other barriers—a burden falling hardest on the state's low-income communities of color and Indigenous residents.

Health care advocates across California have highlighted the monumental improvements that

the ACA brought to health care access in the state and the need to vigilantly protect them. As threats to the ACA have emerged, they have banded together via advocacy coalitions such as Fight4OurHealth to collectively fight back. But alongside the important gains, advocates also recognize that the ACA alone could not bring true health equity in our state. So they're boldly pushing California's leaders to embrace broader health care goals and align their allocation commitments accordingly. The Health4All campaign, for instance, has organized local advocates across the state to push their communities to go beyond the ACA – to expand health coverage benefits to all residents, regardless of immigration status. This work has paid incremental dividends as the state of California has expanded Medi-Cal eligibility to all residents under the age of 19.

Dozens of local campaigns have taken on this struggle to improve health care access and make it more equitable in their own communities. Responding to this advocacy, some individual counties (such as Monterey and Contra Costa) have begun expanding their safety net programs to serve all residents, regardless of immigration status. Together, these statewide and community-oriented efforts are recasting the many individual health care access issues as part of a larger, collective fight for health justice. By showing how this broad fight for equitable access is inextricably bound to California's long-range prosperity, they are making it everyone's concern.

County Choices

These statewide trends have not played out uniformly across California: individual county decisions are crucial, as counties play an oversize role in determining which low-income residents will get health care and what kind of care they will get. To unearth regional dynamics, we explored the experience of three key counties—Riverside, Merced, and Los Angeles—that all have high Medi-Cal participation rates, significant immigrant populations, and persistent disparities. Despite these similarities, they are of vastly different scales and have taken divergent approaches to health safety net spending and services.

To assess the choices each county made, and the implications of those choices for low-income people of color, we examined Office of Statewide Health Planning and Development data on CHC funding, staffing, and service provision.²⁶ To assess the impact of the ACA's changes, we compared 2015 data (the most recent year available) to a 2011 baseline. And to complement this health-center-level data, we also looked at each county's most recent adopted budgets to understand how state and local funding of safety net programs shifted over time.

Our data alone, of course, cannot definitively tell us whether these community health centers and the broader safety net are paving a path to improved health for the communities of color and Indigenous people they serve. In analyzing the shifting relation-

ship between funding, access, and outcomes within California's safety net, we relied on insights gleaned from interviews with health center administrators, public health officials, and community health advocates.

Taken together, these three county profiles highlight trends facing California when it comes to protecting the health of its communities of color and Indigenous people. In highlighting the safety net's challenges and identifying its opportunities in this moment of change, we hope to help point the way toward a healthier, more equitable future for our state.

3. COUNTY PROFILES

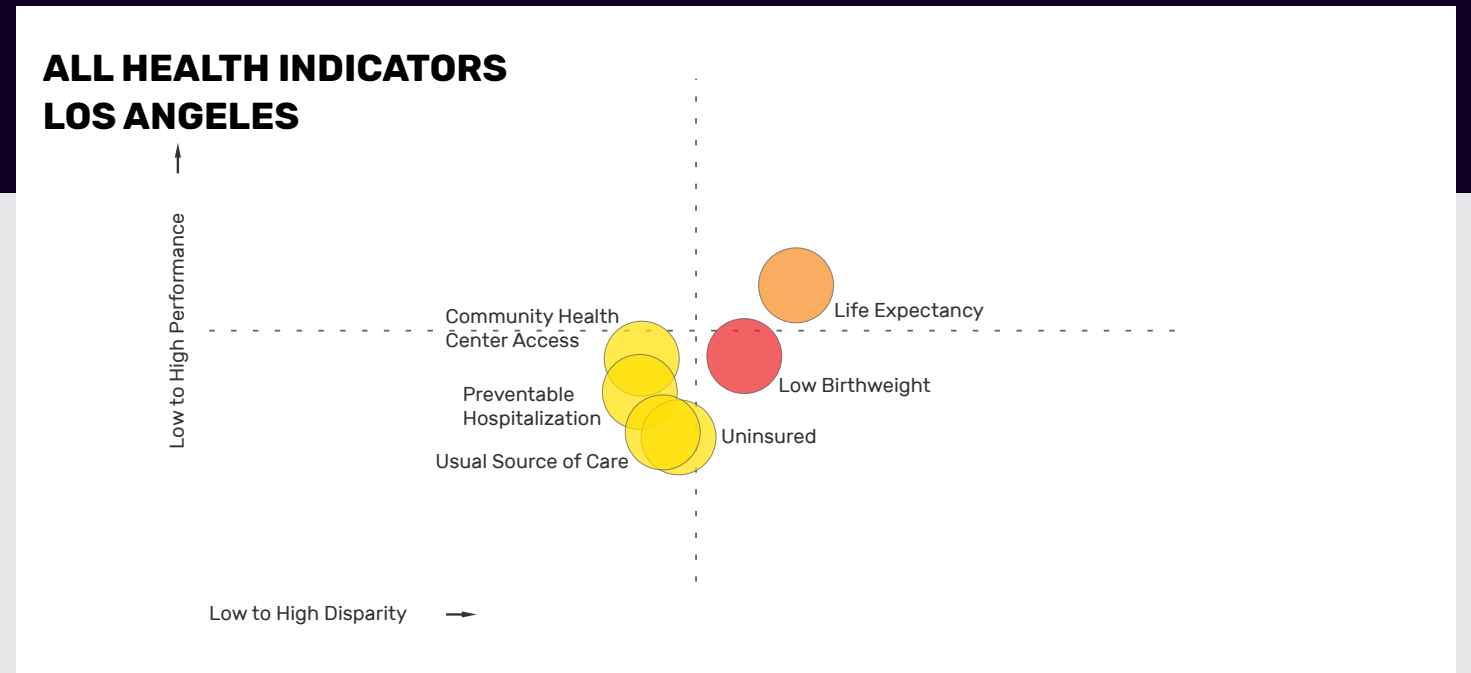
Profile - Los Angeles County

As California’s biggest county, the experience of Los Angeles County is essential to understanding health disparities in California. While Los Angeles County benefitted more than many counties from the passage of the ACA—due to its size and high level of need—it continues to face many challenges. Los Angeles County’s rate of uninsured adults and children dropped to historic lows during the ACA years, and 39 percent of its population was covered by Medi-Cal as of late 2017.²⁷ Fortunately, county leaders and advocates have seized opportunities to address these head on.

Community health centers serve a huge proportion of county residents—a pattern that accelerated with a 21 percent increase during the ACA years. The more than 1.5 million CHC patients county-wide are, disproportionately,

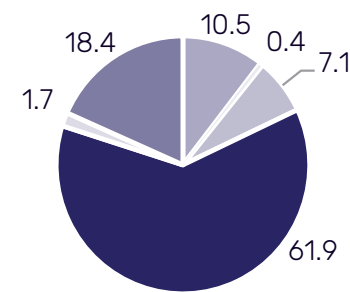
Indigenous people and people of color, with 62 percent identifying as Latino (of any race), 10 percent as Black, 7 percent as Asian/Pacific Islander.

While Los Angeles County’s health care access disparities are similar to those in the state as a whole, its performance on most indicators is poor—with especially poor access to a usual source of care. On the one measure where the county can boast good performance (life expectancy), that success is offset by substantial disparities. Indicators such as uninsurance rate and rate of preventable hospitalizations highlight that Los Angeles County residents’ race matters a great deal when it comes to their health care access and outcomes.



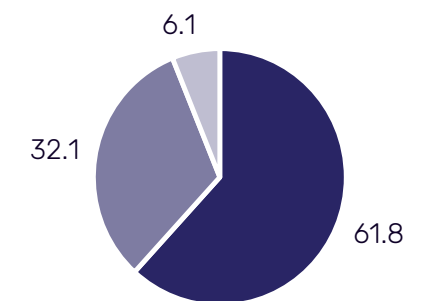
Advancement Project California; RACE COUNTS, racecounts.org, 2017

Los Angeles: CHC Patients by Race (%), 2015



- Black
- Asian / Pacific Islander
- Two or More
- Native American
- White
- Other/Unknown

Los Angeles: CHC Patients by Ethnicity (%), 2015



- Latino/a
- Non-Latino/a
- Unknown

RaceCounts.org Primary Care Clinic Utilization Data, 2015

CHANGES TO HEALTH CENTER CAPACITY AND SERVICES

Los Angeles County had a significant increase of community health center sites during the ACA years, going from 248 sites to 341—a 38 percent increase. During this same period, local health centers welcomed an additional 267,000 patients.²⁸ Meeting these patients' needs required more than just more new buildings—it required health professionals to deliver that care. Accordingly, we see large staffing expansions across the County's health centers during the ACA years, with some administrators noting a rapid doubling of their staff.

Staffing levels did not increase across the board. While the number of higher-paid professionals (such as physicians and psychologists) went up, that increase was dwarfed by the addition of providers such as nurses and social workers. This trend highlights CHCs' uneven staffing growth—a pattern that likely reflects evol-

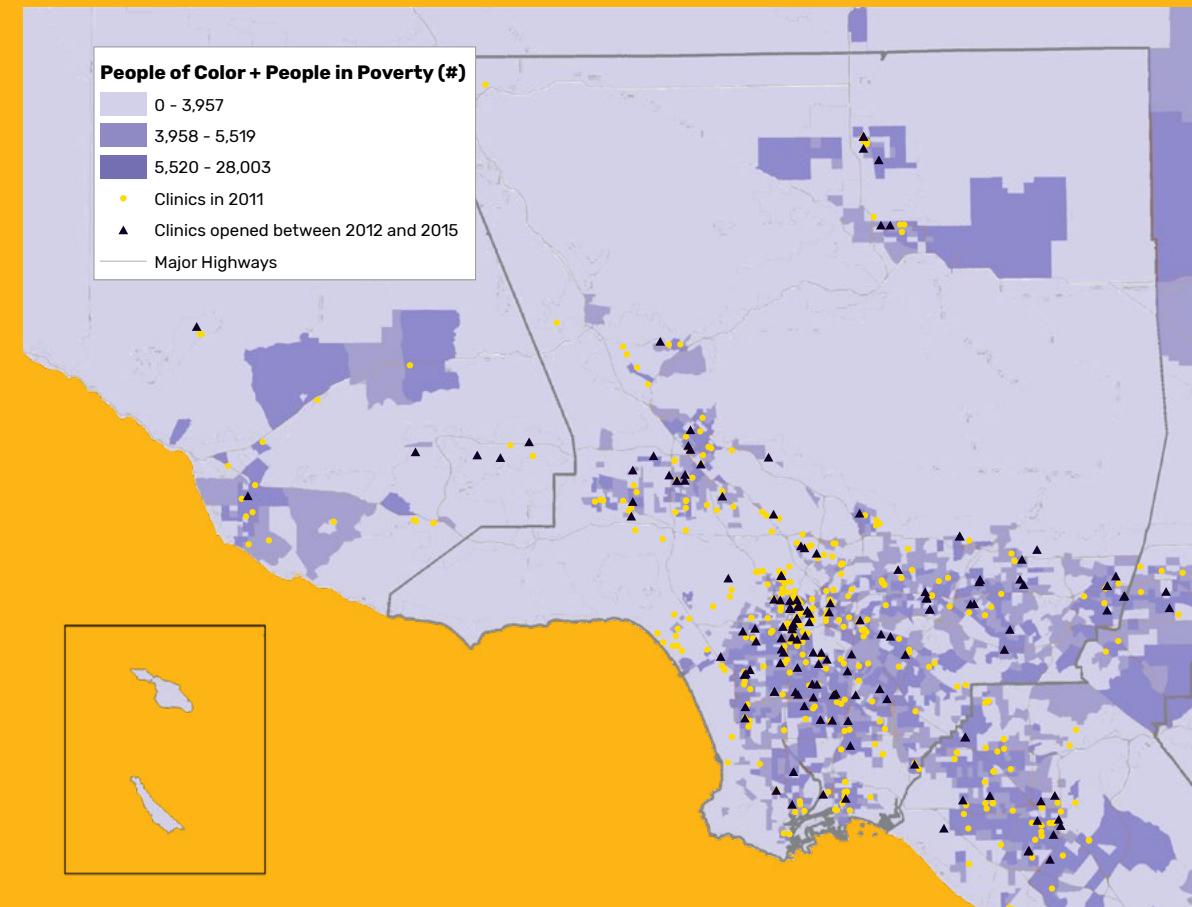
ing care practices and the continuing struggle to attract and retain top-level care providers in a high-cost county while competing with private practices.²⁹

Hiring more staff allowed CHCs to reform the way they serve their patients by shifting to managed care models. Health

centers increasingly focused on their patients' full range of needs, navigating patients through the potentially-confusing landscape of different health services and programs, while also, for example, helping them access public benefits beyond the safety net system.³⁰ The ACA era "changed the way we do business," one CHC director said, paving the way for more strategic planning, outreach to marginalized communities, and data collection and analysis—as well as new approaches to improving patients' care and provision of additional services such as mental and oral health.

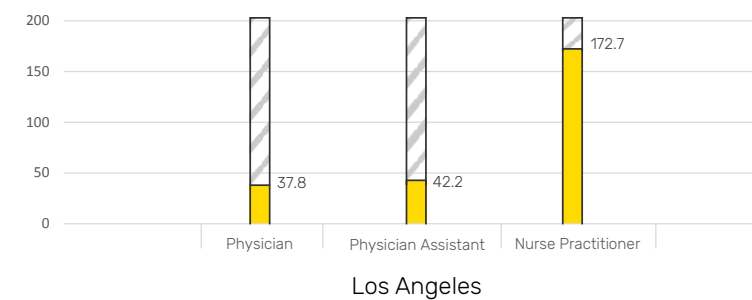
These cumulative changes contributed to improved health outcomes. For instance, CHC patients got more preventive care in 2015 than they had four years earlier. Not only were there considerably more prevention visits (a 63 per-

LOS ANGELES COUNTY Clinics with People of Color + People in Poverty (#)

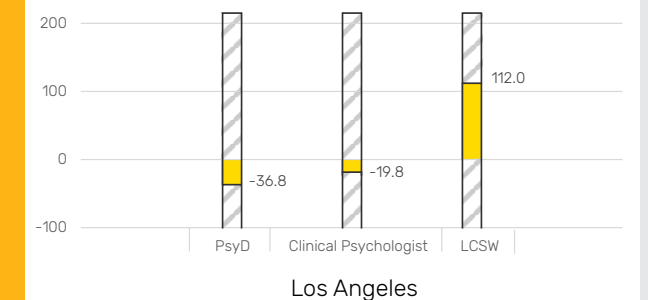


Office of Statewide Health Planning and Development (OSHPD) Primary Care Clinic Utilization Data, 2011 and 2015. ACS 2012-2016 5-Year Estimates, Tables S1701 and DP05.

Change in Primary Care FTE (%), 2011 v 2015

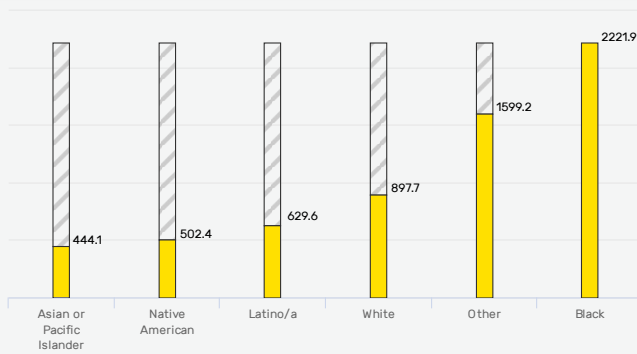


Change in Mental Health FTE (%), 2011 v 2015

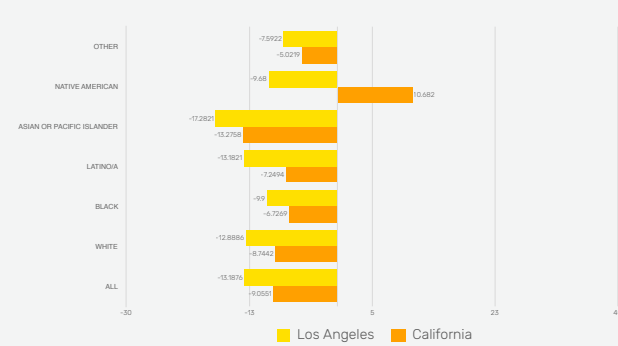


Office of Statewide Health Planning and Development (OSHPD) Primary Care Clinic Utilization Data, 2011 and 2015. FTE means the equivalent of one full-time staff member in a specific role

PREVENTABLE HOSPITALIZATIONS PER 100K PERSONS BY RACE LOS ANGELES COUNTY, 2010-2014



CHANGE IN PREVENTABLE HOSPITALIZATIONS PER 100K PERSONS BY RACE (%), 2011 v 2014



Advancement Project California; RACE COUNTS, racecounts.org, 2017

cent increase) countywide, they were making up a greater share (up to 7 percent of all visits in 2015 versus just 5.5 percent of visits in 2011) of all health center visits.

Even more impressive were the outcomes at the opposite end of the care spectrum, as Los Angeles County residents of all kinds had sharp declines in preventable hospitalization rates during this period – steeper declines than seen statewide. The comprehensive primary care approach embraced in local community health centers and in the My Health LA safety net program likely contributed to this improvement

among the county’s communities of color. This is a crucial victory, improving one of the county’s worst health measures. Yet, even these gains have not reversed the prevailing disparity. For instance, while Los Angeles County’s Black residents had the greatest absolute reduction in preventable hospitalizations between 2010 and 2014 among all racial/ethnic groups, their rate of reduction (9.9 percent) was in the middle of the pack – meaning that Black residents remained by far the most likely of all groups countywide to be hospitalized for a preventable cause.

CHANGES TO COUNTY FUNDING AND PROGRAMS

Many of these changes were underwritten by fundamental budgetary and revenue shifts, as who paid for Los Angeles County CHC patients’ care changed dramatically during the ACA years. There were challenges adapting to the new reality, as stakeholders highlighted a lag time in getting the county’s huge volume of newly-eligible residents transitioned into Medi-Cal that left many low-income residents paying out of pocket for community health center services while waiting for their paperwork to be sorted out. Nonetheless, driven by Medi-Cal expansion, patients transitioned away from forms of uncovered care (44 percent of all patients in 2011 versus 32 percent in 2015) toward Medi-Cal coverage (increasing from 32 percent of all patients in 2011 to 56 percent in 2015). The community health centers’ share of “free care” patients was accordingly cut in half in this period.

This funding shift was transformative. With more of their patients’ care reimbursed in 2015, CHCs countywide reduced the financial losses they absorbed from providing free or reduced-price care by 47 percent as compared to 2011. The overall patient revenue finding its way into Los Angeles County CHCs went up by nearly 60 percent.

Los Angeles County did not passively rely on the ACA’s coverage expansions to improve health equity in the county. Taking advantage of the fact that many of the people served by the previous safety net program, called Healthy Way LA, would now be covered through the ACA, advocates and county officials created a new county-run program, My Health LA, with \$57 million of seed money (\$6.5 million of which came from local revenues, while the remainder was paid for via state funding and

tobacco settlement dollars).³¹ This program serves county residents ineligible for Medi-Cal by assigning them to a local community health center for care, where they can access a range of primary care options free of cost. Critically, My Health LA is available to residents regardless of immigration status. By 2015, My Health LA was serving more than 140,000 county residents—a full 94 percent of whom identify as Latino.

To be sure, the program only serves about 16 percent of the county’s estimated undocumented population, has restrictive income-based eligibility standards (only those at 138 percent of the federal poverty level or below qualify), and offers fewer services and lower reimbursements than does full-scope Medi-Cal coverage. But it still serves as a model of creative thinking for how to address gaps in the ACA’s gains.

Barriers to equitable health care access remain. They include high housing costs driving residents to farther-flung, less-served parts of the county and state; the county's inadequately-accessible transit, which can make it difficult for low-income county residents to actually make use of available health services at a clinic site; and the difficulty health centers experience attracting and retaining high-level providers in a county with competition for staff from high-priced private practices.

Fortunately, local health advocates—acting in concerted coalitions such as LA Access to Health Coverage and as independent actors—have demonstrated the leadership to take on these challenges. They continue to push for easing the My Health LA program's current income eligibility standards so these innovative services will reach more residents. Countywide, a host of other health care access campaigns are bringing together philanthropies, service organi-

zations, health advocates, and leaders to work on issues ranging from expanding programs for justice-system-involved Angelenos to creating a new Center for Health Equity. All of this and more will be needed to improve Los Angeles County's significant health care access disparities.

Profile – Riverside County

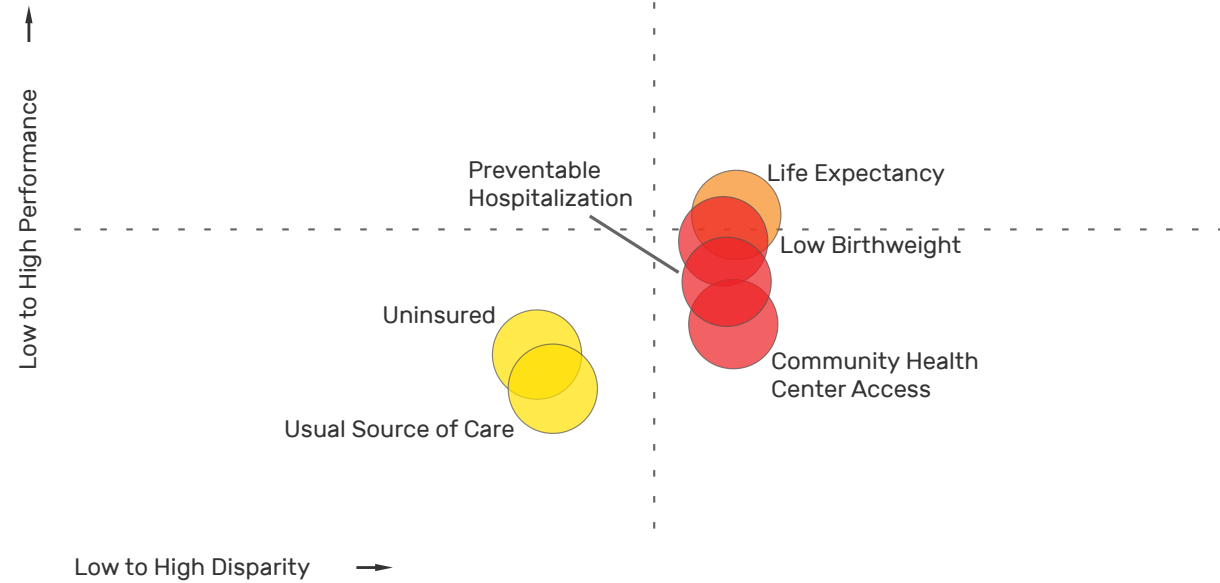
Riverside County's expansiveness can make accessing health care difficult—particularly for its low-income residents of color. Its safety net depends heavily on just a few dozen community health centers countywide, along with a limited emergency program to serve uninsured residents, regardless of immigration status. After the ACA's coverage expansions, 35 percent of the county population is covered by Medi-Cal.³²

One of the biggest local barriers to equitable access to health care is the lack of affordable, accessible transportation for low-income county residents. The uncoordinated, underfunded transit network—particularly in rural areas—leads to patients delaying needed care and waiting until emergencies to finally seek out costly transit to care sites.³³

Those using CHCs are much more likely to be people of color than the overall county population. In 2015, 58 percent of Riverside County CHC patients identified as Latino (of any race), 6 percent as Black, 3 percent as Native American, and 2 percent as Asian/Pacific Islander.

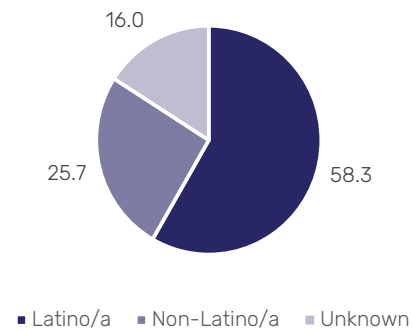
On our RACE COUNTS indicators, Riverside is generally lower-performing, and for some indicators, such as having a usual source of care, it is in the “Struggling to Prosper” low-disparity low-performance quadrant—indicating the difficulty many residents have finding an accessible provider. In fact, it had below-average performance in all but one RACE COUNTS Health Care Access indicator—and matched that low performance with high levels of disparity in three categories. Interestingly, while Latino residents struggle in a number of health care access indicators, they have outperformed many other racial and ethnic groups in the county when it comes to preventable hospitalizations—a trend deserving future exploration.

**ALL HEALTH INDICATORS
RIVERSIDE**



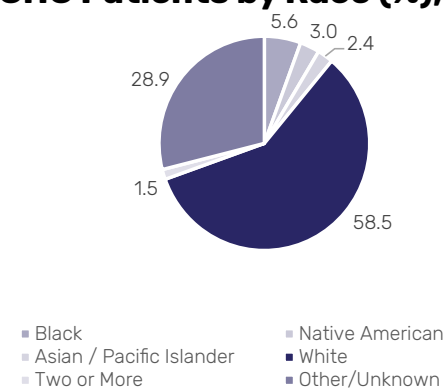
Advancement Project California; RACE COUNTS, racecounts.org, 2017

**Riverside:
CHC Patients by Ethnicity (%), 2015**

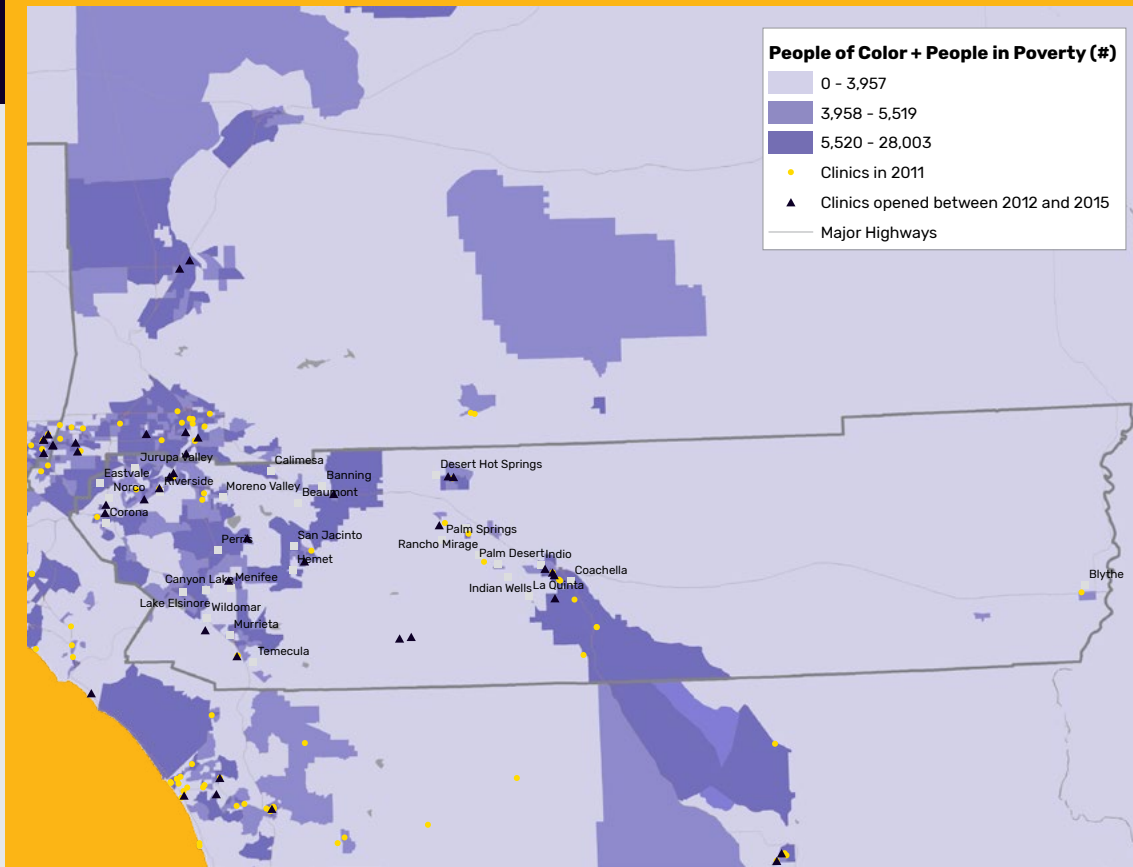


RaceCounts.org Primary Care Clinic Utilization Data, 2015

**Riverside:
CHC Patients by Race (%), 2015**



**RIVERSIDE COUNTY
Clinics with People of Color + People in Poverty (#)**



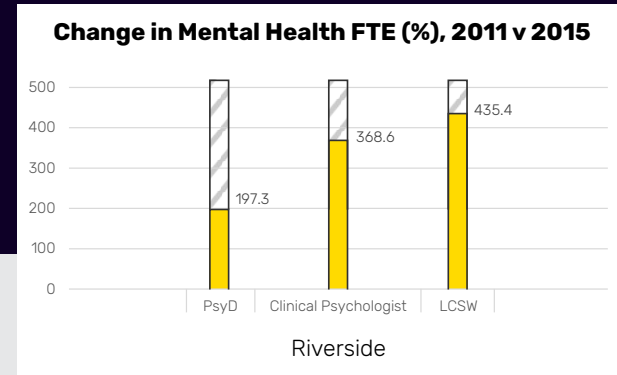
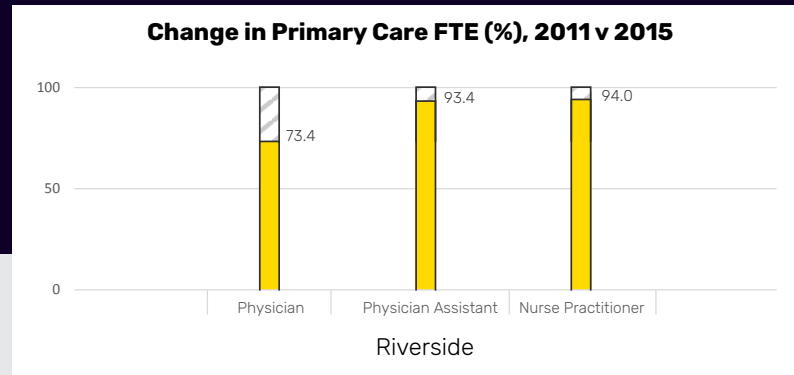
Office of Statewide Health Planning and Development (OSHPD) Primary Care Clinic Utilization Data, 2011 and 2015. ACS 2012-2016 5-Year Estimates, Tables S1701 and DP05.

CHANGES TO HEALTH CENTER CAPACITY AND SERVICES

Riverside County saw the largest percentage increase of CHC sites of any of our three counties with 15 new sites added during the ACA years, an increase of 71 percent. Yet, this fact reflects an inadequate starting point, as even with the new additions there are

still only 36 sites serving a county with more than 2.4 million residents. That is just one community health center per 65,000 residents, far below the statewide rate, which is one clinic per 30,000 residents.³⁴ From the map above, one can see that these

CHC sites are highly concentrated in the county—leaving large swaths with few or no health centers in close proximity. Nonetheless, CHCs in the county did show a significant (52 percent) leap in the number of patients served during these years.



Office of Statewide Health Planning and Development (OSHPD) Primary Care Clinic Utilization Data, 2011 and 2015
FTE means the equivalent of one full-time staff member in a specific role

To staff the new sites opening across the county, community health centers hired more health professionals of all kinds. The increase in physicians at Riverside County CHCs is a particular highlight, as it was easily the largest percentage gain in any of our three key counties.

Unfortunately, these capacity

increases weren't paired with significant improvements in the use of preventive care. While children at local CHCs did get more preventive care, (there were twice as many preventive visits in 2015 than in 2011), the share of adults at the centers getting preventive care was the same in 2015 as it was in 2011 (1.6 percent of all adult visits). Nonetheless, the

county's ability to reduce preventable hospitalizations for residents of color (but not, notably, for Native Americans) during these years was generally in line with the statewide trend. These reductions brought the number of such visits amongst residents of color to levels well below our other two counties, perhaps owing to the additional CHCs and providers.

CHANGES TO COUNTY FUNDING AND PROGRAMS

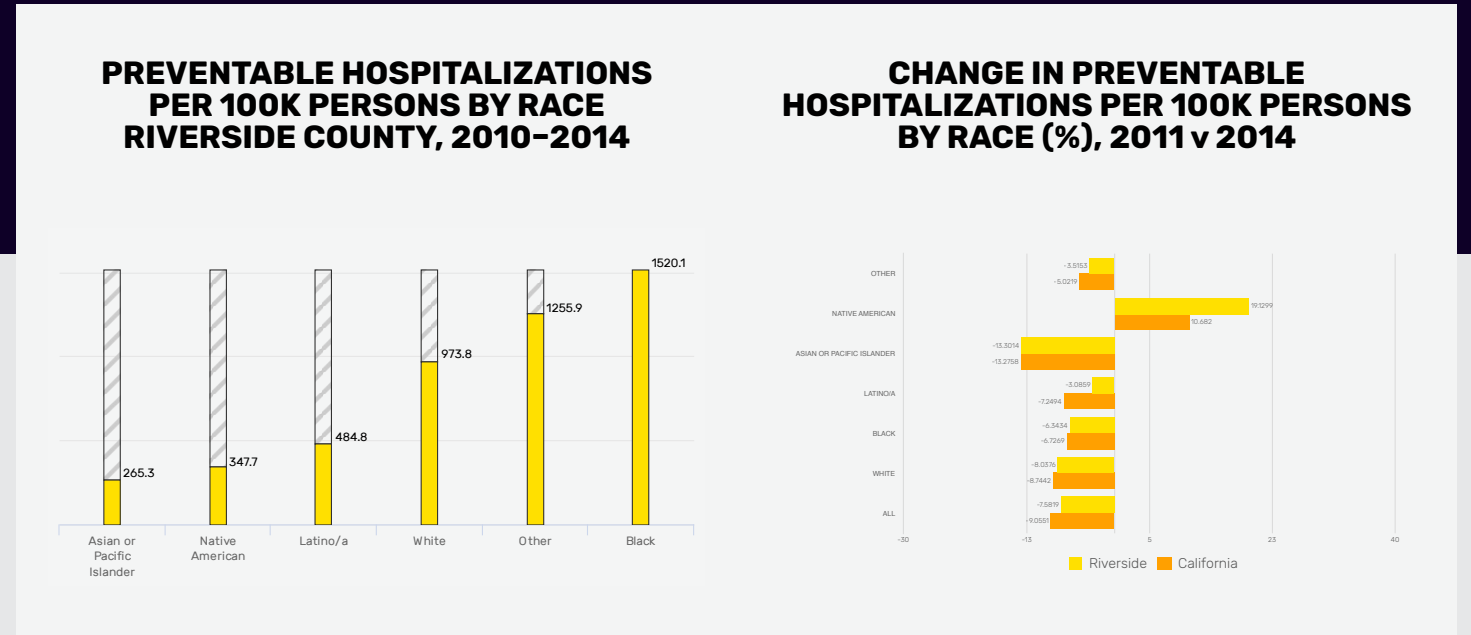
As was the case across the state, Riverside County CHC patients shifted considerably from receiving safety net, free, or sliding-scale care in 2011 toward Medi-Cal coverage in 2015. Overall patient revenue finding its way into Riverside County community health centers went up considerably (76 percent) between 2011 to 2015. As expected, federal contributions (primarily in the form of direct patient payments such

as Medicare and Medi-Cal) drove nearly all of the overall revenue increase. State contributions went down considerably as did county spending on patient costs.

Meanwhile, the county's safety net program is wide but shallow. While eligibility standards are relatively-generous (those with income up to 200 percent of federal poverty level qualify, including undocumented resi-

dents), it fails to cover upstream preventive/primary care. Those reliant on the safety net are thus eligible for only the costliest, downstream kind of care—emergency care delivered via its hospital network.

The county spent about \$8 million on patient care in fiscal year 2015, of which the county paid \$2.5 million from local tax revenues. That county contribution stayed



Advancement Project California; RACE COUNTS, racecounts.org, 2017

relatively stable over the course of the ACA years, while the state contribution dropped considerably, from \$9.5 million in fiscal year 2011 to \$5.4 million in fiscal year 2015, reflecting the reallocation of those resources to pay for the Medi-Cal expansion. As a result, the program's well-being depends more than ever on county financial support, but the Board of Supervisors has not yet taken action to ensure that these scarce resources are refocused on populations and services that can have the greatest impact on health.

The sparseness of Riverside County's safety net provider network and the challenges in getting low-income residents to the services they need has spurred health advocates to band

together in recent years to press the County and local transit providers to better integrate transit lines with health care providers in far-flung parts of the Riverside County. Coalitions such as Inland Congregations United for Change have been instrumental in advocating for these changes.³⁵ Recognizing this important barrier to health care access in many parts of Riverside County, local CHCs have also begun innovative transportation programs to bring needy patients from remote areas to the care they need. These efforts serve as important steps in improving health care access for low-income communities of color in the county.

Profile – Merced County

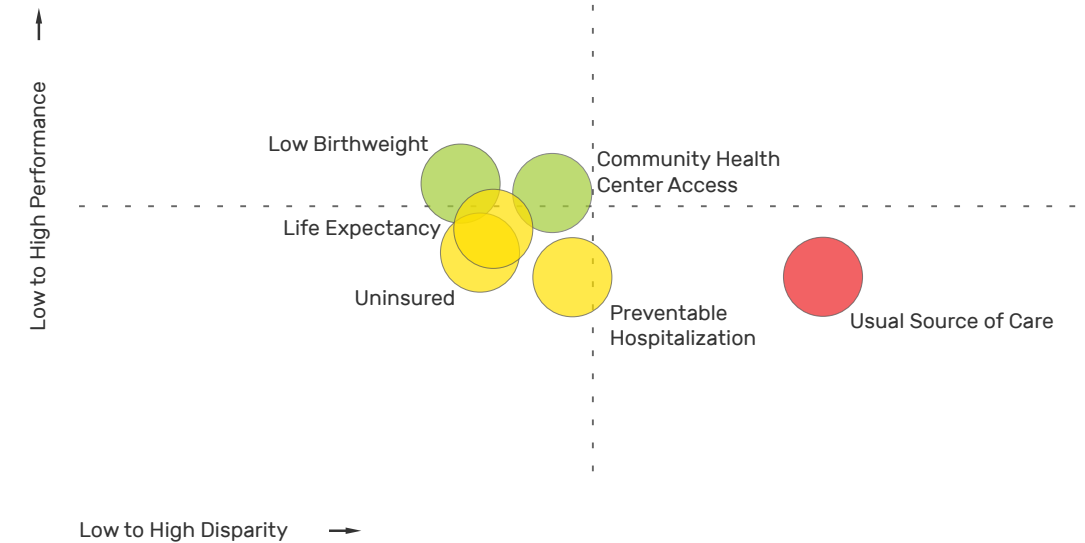
The Central Valley’s Merced County is marked by a high rate of poverty that translates into a high proportion of residents reliant on Medi-Cal: over half of all county residents qualify.³⁶ The Merced County health care safety net is made up almost entirely of a small number of community health centers that struggle to attract health professionals or offer the type of comprehensive care that one might find in wealthier, more densely-populated counties.

In 2015, those CHCs saw 109,000 patients—a rather incredible 40 percent of all county residents. The centers’ vital role as the county’s primary care providers predated the ACA years, however, and there was only an 11 percent increase in patients seen during this period. These community health centers disproportionately serve Merced’s people of color. In 2015, 72 percent of the county’s CHC patients identified as Latino (of any race), 4 percent as Asian/Pacific Islander, 3 percent as Black, and 1 percent as Native American.

Merced fits the profile of a “Struggling to Prosper” county on many RACE COUNTS issue areas, including health care access—generally low performance across the board means leading to disparities that in many cases are comparatively lower. There are exceptions, however: like many neighboring counties,

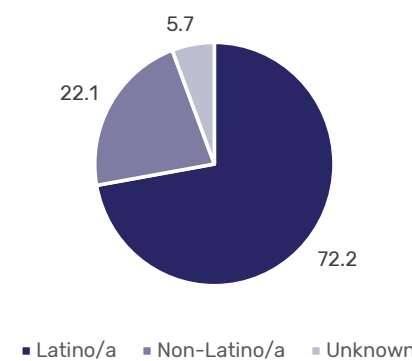
Merced has high disparities in having a usual source of care, for example, likely reflecting the fact that provider shortages disproportionately affect communities of color. On a more positive note, Merced’s uninsurance rate, while higher than the state average, is lower than the other two counties we profile in this report, as well as having lower disparities— though this may reflect that the generally lower income of the county, combined with the lower cost of living, makes more residents eligible for public programs. Taken together, these findings indicate that the county safety net clearly plays a very significant role for a large portion of Merced’s population.

ALL HEALTH INDICATORS MERCED

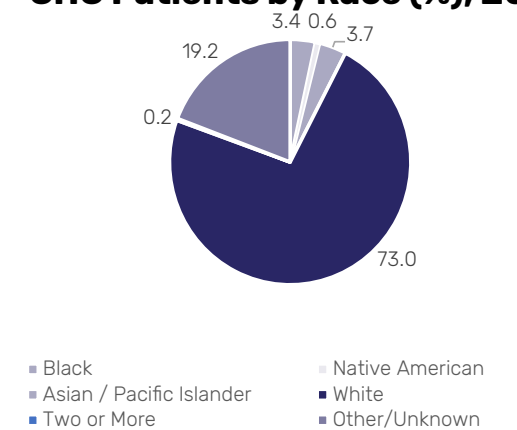


Advancement Project California; RACE COUNTS, racecounts.org, 2017

Merced: CHC Patients by Ethnicity (%), 2015

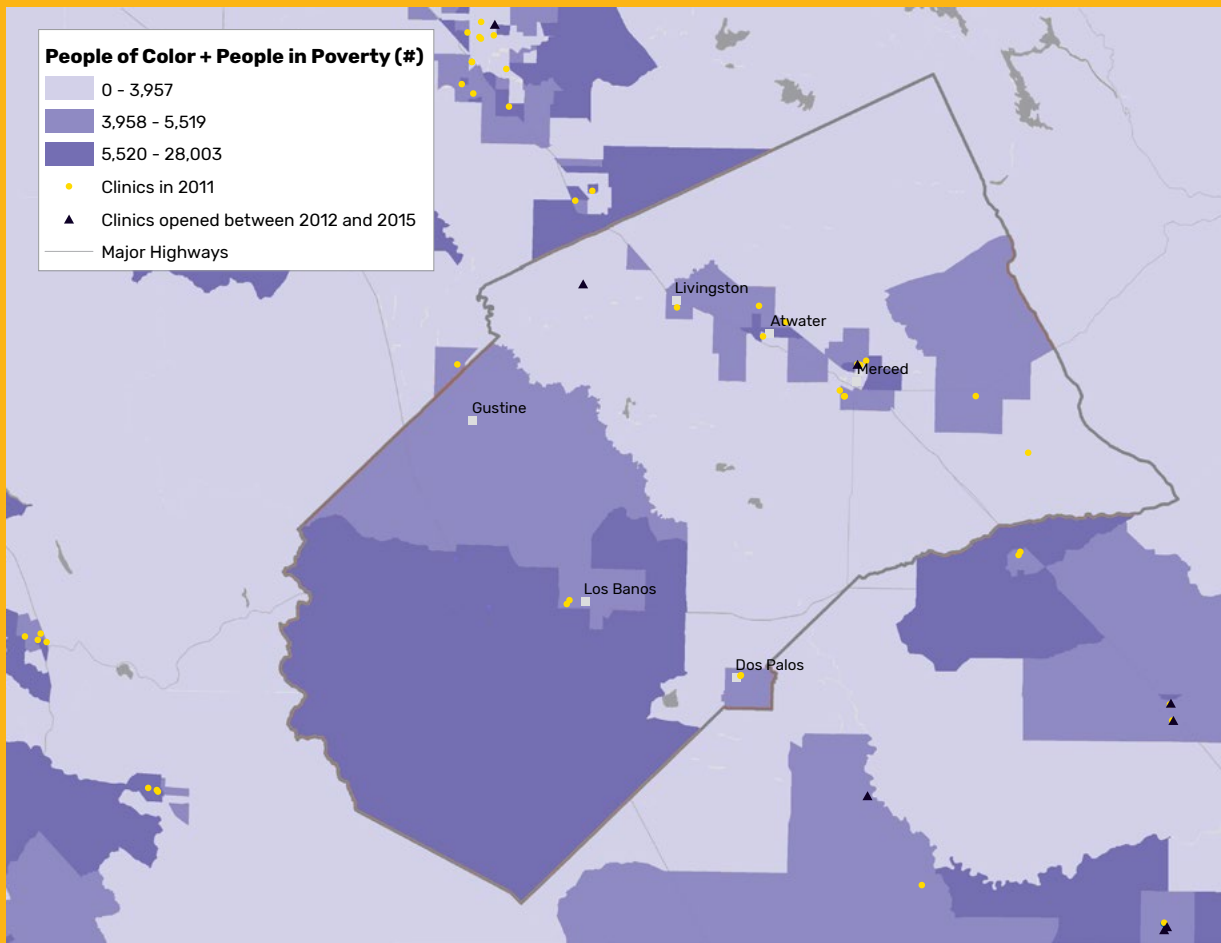


Merced: CHC Patients by Race (%), 2015



Office of Statewide Health Planning and Development (OSHPD) Primary Care Clinic Utilization Data, 2015

**MERCED COUNTY
Clinics with People of Color + People in Poverty (#)**



Office of Statewide Health Planning and Development (OSHPD) Primary Care Clinic Utilization Data, 2011 and 2015. ACS 2012-2016 5-Year Estimates, Tables S1701 and DP05.

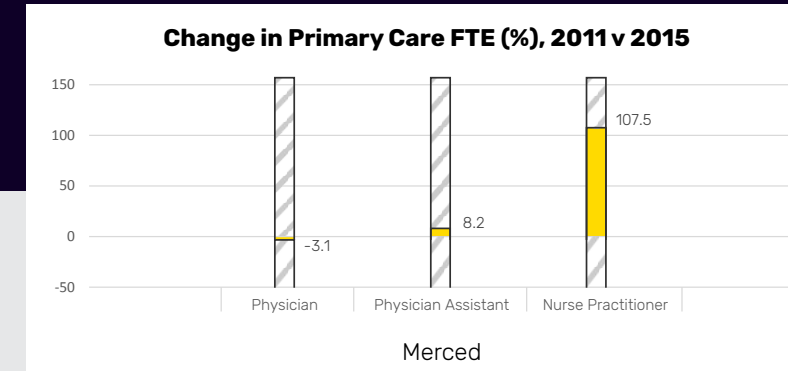
CHANGES TO HEALTH CENTER CAPACITY AND SERVICES

Merced County’s safety net capacity did not accelerate at the pace needed to keep up with the 34,000 residents who gained coverage via Medi-Cal expansion. In fact, Merced County only gained two community health centers during the ACA years—leaving the county with 18 sites as of 2015. As men-

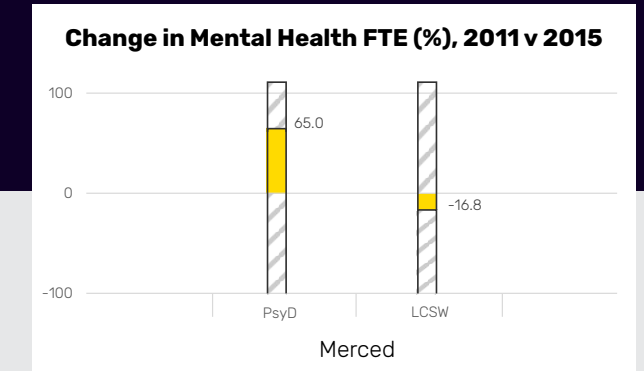
tioned above, patient visits only increased by 11 percent, far below the increase in the other counties we studied, which suggests that newly-covered Merced residents are forgoing care because they cannot access a provider.

Even more striking than the lack of new community health

centers, though, was the inability to increase the number of physicians working in the CHCs during the ACA years. Alarmingly, the county’s CHCs actually had fewer doctors in 2015 than they had four years earlier to meet low-income residents’ health needs—a trend complete-



Office of Statewide Health Planning and Development (OSHPD) Primary Care Clinic Utilization Data, 2011 and 2015. FTE means the equivalent of one full-time staff member in a specific role



ly out of step with the statewide one, and especially troubling given that Merced has only 45 physicians per 100,000 residents, well below the statewide average of 77.³⁷ While there was an increase in the number of nurses in these CHCs, advanced care was harder than ever to access and specialty care was almost non-existent—likely owing to the difficulty in attracting top-level providers to the county, a problem that is common to many of the state’s more rural counties.

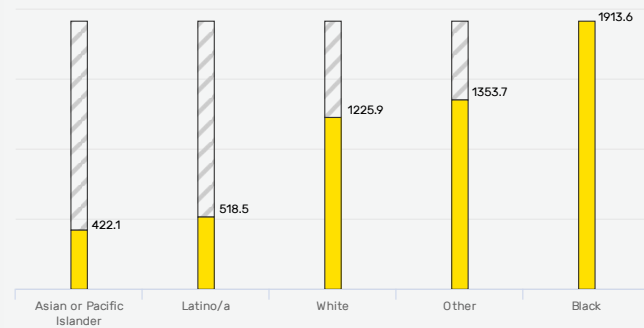
Although it is not yet reflected in our data, this situation was recently made worse by the bankruptcy and closing of Horizons Unlimited Healthcare, a nonprofit health center network serving thousands of residents across the region—including five clinics in Merced County. According to court documents, about 80 percent of Horizons’

patients were on Medi-Cal.³⁸ Since the closures, patients have been left to fend for themselves, flocking to the county’s three remaining community health center networks. According to the CEO of one such network, their patient load doubled after Horizons stopped operations. For many low-income people of color in Merced, this means in-network specialty care is unavailable, emergency care must be obtained out-of-county, and waiting times at the remaining clinics can be a disincentive to seeking out regular care.

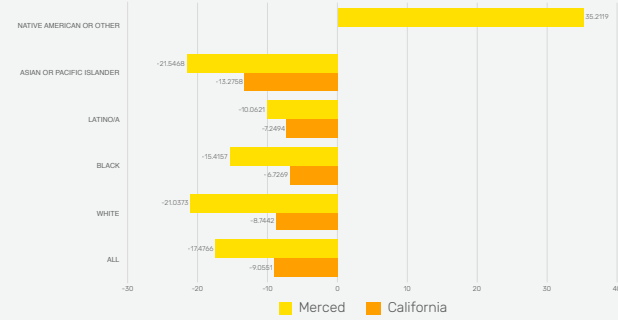
Despite the staffing challenges, Merced County CHC patients were much more likely to receive some preventive care treatment than they had been four years earlier. More than four times as many county children got preventive care in this setting in 2015 than had in 2011. Local

centers also made efforts to offer a broad range of dental, medical, and behavioral health services.³⁹ These changes in care along with the large number of Merced County residents newly eligible for Medi-Cal may have helped in significantly reducing the rate of preventable hospitalizations for most residents. In fact, on this measure Merced outpaced the state’s overall reduction and that in our other spotlight counties—though Latino residents made less progress than other groups and the county’s Native American residents did considerably worse over this timeframe.

PREVENTABLE HOSPITALIZATIONS PER 100K PERSONS BY RACE MERCED COUNTY, 2010-2014



CHANGE IN PREVENTABLE HOSPITALIZATIONS PER 100K PERSONS BY RACE (%), 2011 v 2014



Advancement Project California; RACE COUNTS, racecounts.org, 2017

CHANGES TO COUNTY FUNDING AND PROGRAMS

Relatively speaking, Merced County residents were more likely to gain Medi-Cal coverage due to the ACA-related expansion than our other two key counties. Not surprisingly then, county CHC patients overwhelmingly shifted from safety net, free, or sliding-scale care in 2011 toward Medi-Cal coverage in 2015, and the rate of “free care” patients was likewise reduced considerably due to these shifts in coverage.

Overall patient revenue finding its way into Merced County CHCs went up by 29 percent during the ACA years—a more modest rise than in other counties, again reflecting the supply-limited nature of the county’s safety net.

As more dollars from the combined state and federal Medi-Cal program has come in, however, the County effectively terminated its previously-existing safety

net health program in 2014, with no net spending on safety net health needs in fiscal years 2015 or 2016. State dollars primarily paid for the program that were largely reallocated for the Medi-Cal expansion, and the county simply decided to end the program when this funding stream dried up.⁴⁰ That means that for those ineligible for Medi-Cal or other coverage (such as undocumented adults), there is no real safety net—they must pay out of pocket or delay care until being hospitalized with an emergency. This blinkered approach may reduce the county’s outlays, but

at the cost of reducing access to care for undocumented residents—and perhaps contributing to Merced’s high and racially-disparate rate of preventable hospitalizations.

In 2017, the organizers and advocates who make up Merced’s Building Healthy Communities hub banded together with other local advocates and the Department of Public Health to press the Board of Supervisors to reinvest in a county safety net program—one that for the first time would serve all county residents, regardless of documentation status. While these Health4All

efforts were dealt a blow by a 3-2 Board of Supervisors’ vote in October 2017 defeating a motion to fund such a program, the efforts illustrate the growing need for those in the halls of power to understand that the lack of a safety net program is undermining Merced County’s health and prosperity.⁴¹

4. BUILDING A STATE OF HEALTH EQUITY

It is clear that the health care safety net helped reduce health inequities during the ACA era: across California, people of color and Indigenous people gained coverage, and benefitted from an increase in the number of community health centers and staff devoted to serving their needs. Many safety net providers also adopted new approaches to better meet the needs of their patients. At the same time, counties took noticeably different paths on their programs when confronted with the opportunities provided by the ACA's coverage expansions: in Los Angeles, advocates and leaders created a new program to better meet the emergent needs of vulnerable residents; Riverside leaders largely stayed the course, making few changes of their own in response; while Merced ended its program, potentially undermining the benefits of the ACA's reforms. Most other California counties appear to have followed one of these three paths, making them an illustrative set of examples.⁴²

Those hard-earned gains are fragile and under grave threat. Community health centers' growth and innovations were primarily fueled by federal dollars—funds that are endangered for the foreseeable future, due to ongoing threats and actions by both Congress and the federal administration to reverse coverage gains and reduce grants directly supporting CHCs.⁴³ Indeed, the recent repeal of the individual mandate, as part of the tax cut legislation, may begin driving up Covered California premiums and reducing the number of people covered through Medi-Cal, putting immediate strain on the safety net.

In interviews, CHC administrators warned that significant revenue disruption could devastate their operations. Administrators stressed that they would continue to prioritize patient care amid any potential revenue cuts, but conceded that hard choices might need to be made to stay fiscally viable.⁴⁴ Whether that means

reduction in staffing, scaling back investments in innovative programs such as managed care, or consolidation of health centers to absorb those who cannot sustain themselves financially, all would directly or indirectly effect health care access and outcomes for the communities of color they serve.

It is untenable for Californians to simply wait to see whether, or rather how much, harm the federal government will inflict on the health of communities of color. California today stands on the edge of opportunity. In recent years, community health advocates across California have been waging—and winning—important fights for true access, pushing some counties to expand their safety net to include undocumented immigrants, while others work to extend local transit and health access reforms for low-income residents. Meanwhile, statewide campaigns to extend full-scope Medi-Cal to more residents have won important gains.

Together, these efforts share a focus on inclusion, local assets, and a recognition that the fight for equitable health starts with true, equitable access for all Californians. It's critical to foreground racial equity in these conversations, as the persistent disparities we have identified will not be erased without focused solutions tailored to the particular barriers that impact low-income communities of color. Officials should answer advocates' call and adopt state- and county-level reforms that can help to shore up a vulnerable safety net, and, once the federal danger passes, set the stage for a more equitable future for all. Our recommendations include the following:

1. COUNTIES SHOULD PRIORITIZE THEIR HEALTH SAFETY NETS.

As our analysis has shown, in too many cases, counties have been content to coast, allowing state and federal programs (and dollars) to play the near-exclusive role in determining access for their residents. County leaders should listen to advocates' arguments that there is a local stake in health equity too. Counties across California are dealing with a host of challenges including the rise in homelessness, the challenge of meeting the needs of undocumented residents, and caring for justice-system-involved individuals. A lack of a strong safety net exacerbates and perpetuates all of these other problems, while denying our fellow Californians the care they need to thrive.

Recognizing this reality, counties should make a concerted effort to make sure that their safety nets live up to their names. At a basic

level, this will require additional resources—and beyond looking to leverage state and federal funding and grant opportunities, counties should commit significant local resources, including property tax revenues, which currently in most cases are disproportionately spent on policing and jails. Funds should be invested after a needs-assessment determines which investments would do most to ameliorate the specific racial disparities in each county. Those counties that have already created promising programs in this regard should loosen restrictive income eligibility standards to make those benefits more widely available to vulnerable residents. These efforts would likely include: reforming eligibility rules for safety net programs to extend access regardless of documentation status so that they can apply to all uninsured residents; expanding

language access; supporting both county-operated and private clinics with direct funding to build needed capacity and assist with ongoing operations; and adopting new models of care, such as medical homes, that can improve outcomes and quality for patients.

Counties also should think broadly about the social determinants of health, understanding that effective access has many prerequisites and that low-income communities of color often labor under the combined burden of disparities in many different areas. Recognizing that even effective federal incentives for locating new CHCs in communities of need cannot ensure a health center in close proximity to all, efforts must be made to creatively link those in need of medical services with providers. One model is to follow the path

Riverside County is beginning to create by working actively with public transit providers to better integrate transit lines with health safety net providers such as community health centers and hospitals. Counties can also boost mobile health services that can

meet patients where they are, such as expanding on existing community health worker (CHW) and *promotora* programs as well as improving upon home care models such as the PACE program.⁴⁵ Beyond physical access, counties can do more to align the

many public assistance and other benefit programs they administer to serve residents with health needs, and build racial equity into their zoning and land use decisions to ensure a healthy built environment for all.

2. SET A FRAMEWORK TO GUARANTEE HEALTH CARE ACCESS FOR ALL.

Counties will need support and partnership from Sacramento to achieve these goals. First, the state should set a floor by creating a baseline standard requiring that every Californian receive primary care, including behavioral and oral health. This would involve a concomitant requirement that county programs extend eligibility regardless of immigration status. It would also mean the adoption of uniform standards for data and reporting, for both demographic and outcome data, to enable regulators

and researchers to understand whether counties are meeting this requirement (better alignment of the various state and federal health data systems would be helpful as well).

To allow even resource-poor counties to meet the goal, the state should adopt new funding allocation metrics to ensure that dollars are following need in the new, post-ACA landscape. Ensuring adequacy of funding might require the state to revisit how its budgets allocate existing

health funding streams, such as the recently-passed Propositions 52 and 56, and explore new ones. Ultimately, the state should lead the way toward universal coverage. Determining the eventual contours of such a universal system will require study, but steps such as extending full-scope Medi-Cal coverage to all state residents, would go far toward reducing the disparities we have identified, and provide an important backstop to counties that lack the funding or political will to take on these challenges.

3. CREATE INCENTIVES TO WIDEN THE HEALTH CARE WORKFORCE PIPELINE FOR AREAS IN NEED.

The current workforce systems, in conjunction with local job market conditions across California, make it difficult for safety net providers in underserved areas in either rural or urban counties to attract and retain a sufficient number of trained, culturally-competent health professionals. It is low-income communities of color, especially those with language needs, who are locked out as a result. Educational training and incentives such as loan forgiveness can help open avenues for historically-disadvantaged populations

to enter a broad array of health professions, and permit them to work locally upon completing their degree. While federal action may ultimately be required and while waiting for more supportive federal partners, the state's new Future Health Workforce Commission can lead the way by studying the gaps in existing programs such as the Teaching Health Center program and the National Health Services Corps, and identifying potential state-level solutions.⁴⁶

4. IMPROVE DATA-GATHERING AND ANALYSIS.

Even though the data in RACE COUNTS provides a cutting-edge view of racial disparities in health care access across California, there are still important gaps in the available data that limit the ability of advocates and state and local leaders to improve our public systems. As part of our efforts to understand how disparities play out below the county level, this year we will gather and publish city-level indicator data. Beyond that, to help all stakeholders better understand the challenges and opportunities that confront them, we call on agencies that gather and make public health data to adopt the following best practices:

- Collect and make available data disaggregated by race, ethnicity, and national origin wherever possible, especially for the Asian American community;
- Prioritize data collection efforts to ensure that there is comprehensive, accurate information about the state of health access in Indigenous communities;
- Gather data about the experience, access, and outcomes of immigrants in our health systems, while being mindful of the potential for harm and distrust if questions are not asked in a culturally-competent way that eliminates risks for patients; and
- Institute uniform data collection and reporting protocols for each county's safety net program that abide by the above recommendations.

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ENDNOTES

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