Path to Health Final Evaluation

2019-2023

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Path to Health

Final Evaluation Report
to the County Medical Services Program Governing Board

(2019 – 2023)

Path to Health Final Report 2019-2023

Table of Contents

Executive Summary

Background. Path to Health (PTH) focused on improving access to primary care services to undocumented adults in California through partnerships with local clinic organizations. Medical services and procedures were provided at numerous clinic sites. As high-quality chronic disease management requires continuity of care, PTH aimed to improve access to both preventive and ongoing care. Thus, the goals of the program included providing primary care and preventive healthcare services to low-income undocumented residents residing in the 35 County Medical Services Program (CMSP) counties in California. PTH aimed to ultimately enroll 25,000 undocumented residents.

PTH launched in 2019 as a pilot program and was available to all 35 CMSP counties. The program enrolled members in a total of 29 CMSP counties through four expansion phases. In total, twenty clinic organizations partnered with CMSP for the program, covering 100 clinic sites overall. The program successfully reduced delays in care, hospitalization use, and emergency department use among members, while increasing healthcare access for undocumented residents in CMSP counties.

Evaluation Approach. The Path to Health pilot's evaluation consisted of a mixed-methods approach and design that utilized quantitative and qualitative sources of data. This final report includes data from across the program's duration: 2019-2023. UCLA utilized data from administrative enrollment transactions, enrollment surveys, service claims, and pharmacy claims to quantitatively assess first-time and cumulative enrollments, member demographics, changes in self-reported delays and usage of healthcare services, CMSP paid amounts per claim, pharmacy utilization, and member copays, among other metrics. Throughout the report, dates for claims refer to the date of service.

UCLA produced earlier reports to assess PTH during the initial phases of the program. Those reports included analyses of qualitative data from clinics and members collected via field interviews, site visits, and a randomly sampled telephone survey, which assessed member satisfaction and input with implementing the pilot program. In those reports, UCLA proposed recommendations, some of which the CMSP Board adopted, including flexible enrollment and telemedicine services during COVID-19 and expanding services to include mental health services. This final report refers to and assesses the overall impacts of PTH from 2019 to 2023.

Program Changes. When the program began, eligibility requirements included living in a CMSP county and being actively enrolled in restricted scope/emergency Medi-Cal. In 2021, the latter requirement was lifted, if the applicant could supply verification of their residency in a CMSP county and their income was above 138% of the federal poverty level (FPL) and no more than 300% of the FPL. However, we did not find any meaningful changes in enrollment patterns after this restriction was lifted.

Healthcare access was particularly critical during the COVID-19 public health emergency in California, which disproportionately affected undocumented persons. Path to Health covered telehealth services for members, and retroactive to March 4, 2020, providers were required to identify telehealth services distinctly. Whereas members were required to re-enroll in PTH every six months prior to the pandemic, CMSP changed the re-enrollment process to automatically re-enroll members during the public health emergency. Meanwhile, Medi-Cal coverage expanded beyond restricted scope/emergency coverage and granted full-scope coverage to older (over 50+) and younger (21-25 years old) low-income undocumented persons on May 1, 2022, and January 1, 2020, respectively. PTH ended on December 31, 2023 to coincide with Medi-Cal's expansion of full-scope coverage to the remaining age group of people 26-49 years on January 1, 2024. Additionally, public charge may have continued to reduce potential members' likeliness to enroll.

Limitations. In addition to the COVID-19 public health emergency, the social-political climate and dynamic policies specific to public charge, may have contributed to potential members' likeliness to enroll or re-enroll.

Coverage Expansion. In 2022, PTH expanded coverage to include COVID-19 vaccinations and boosters, mental health services, physical therapy, and substance use services. The full list of services included in this expansion are included in the "Service Claims: Expanded Services" section of this report.

Key Findings

1. The County Medical Services Program (CMSP) successfully partnered with twenty clinic organizations across 29 of the 35 CMSP counties that Path to Health was available to, with the majority of counties being in rural Northern California. Partner organizations strongly endorsed the pilot program as an essential resource to improving access to primary care, labs, basic on-site radiology, and prescription medications to eligible pilot participants.

2. Cumulative enrollments continued linearly throughout the duration of the PTH program, from 2019-2023. Path to Health successfully processed 32,606 enrollment transactions in total, including re-enrollments, and 19,415 first-time enrollments. Cumulative enrollments steadily increased throughout the duration of the program.

3. Members were 42 years old on average. Ninety-eight percent of members identified their race/ethnicity as Latino/Latina or Latino/Latina/White. About 40% of members had at least one pre-existing chronic condition. The most common chronic conditions were type 2 diabetes, hypertension, and cholesterol/hyperlipidemia. The pilot provided coverage for patients with chronic conditions that require an ongoing source of regular primary care.

4. More members self-reported improved health when comparing their first and final enrollment surveys. Fewer members self-reported worsened health.

5. A smaller proportion of people experienced delays in care, hospitalizations, and emergency department use later in the program compared to before they were Path to Health members. Analyses of enrollment surveys suggested statistically significant differences in these outcomes. Per these data, the pilot achieved important primary goals.

6. In 2021, Path to Health no longer required people to be on restricted scope/emergency Medi-Cal to be eligible for the program. We observed that cumulative enrollments (i.e., all first-time enrollments over time) continued to increase after this change, even as first-time enrollments decreased. This is because people continued to stay enrolled in the program without re-enrolling, and first-time enrollments were never at zero on a monthly basis. Community health centers continued to enroll new PTH members throughout the duration of the program.

7. The Path to Health pilot served as an important source of healthcare during the COVID-19 public health emergency that significantly impacted CMSP counties.

8. In 2022, Path to Health expanded the program to cover COVID-19 vaccinations and boosters, which provided critical services for members and were well-utilized. This was particularly important among this population, who may not have had access to COVID-19 vaccines were it not for PTH coverage. There were fewer places to easily access COVID-19 vaccines in rural areas; if people had coverage to get vaccinated at a clinic, that facilitated access for the vaccines in under-resourced areas. Community health centers in partnership with CMSP during Path to Health also could reach out to patients about vaccines.

9. In 2022, the pilot program also expanded covered benefits to include mental health, substance use, and physical therapy services. Members utilized mental health services once they were covered by the program, more than physical therapy and substance use services. Substance use services had low utilization overall.

10. Pharmacy benefits were mostly used by those with chronic conditions. The most pharmacy claims were processed in 2021, while the most clinical service claims were processed in 2022, but included retroactive coverage for COVID-19 vaccinations.

Conclusions. Results show that Path to Health achieved its primary goal of increasing healthcare access among low-income undocumented persons in rural CMSP counties. The program also allowed clinics to redirect resources, including to support healthcare of patients with no insurance coverage. Although the program reach may have been impacted because of Medi-Cal expansions and the COVID-19 public health emergency implementation challenges, primary care and preventive service use among members

remained consistent after program ramp-up. These important results will inform further programs and directives for CMSP, who will continue coverage programs for persons who remain ineligible for Medi-Cal or other coverage programs.

Background

California Immigrant Population Statistics

California is home to 23% of the United States' immigrant population (Cuellar Mejia et al., 2024). Per 2021 data, 80% are lawfully present in California, reflecting an increased proportion of legal (versus undocumented) immigrants in the state over recent decades. Eighteen percent of California immigrants – about 1.85 million people – remained undocumented in 2021. In California, the majority of immigrants come from Mexico, the Philippines, China, India and Vietnam (Cuellar Mejia et al., 2024). Per the 2021 American Community Survey, two-thirds of the immigrant population speak English – the rest speak either limited or no English (Cuellar Mejia et al., 2024).

Data on undocumented immigrant populations has been historically harder to come by than data on other populations because of risks of legal retaliation and fear of disclosing documentation status. In 2023, the Kaiser Family Foundation collaborated with the Los Angeles Times to conduct a probability-based representative survey of immigrants in the U.S. Results from that study show that among immigrant households making less than $40,000 annually, 31% report fair or poor health, and 19% report chronic conditions requiring ongoing care. Across the U.S., 79% of the overall immigrant population (i.e., of all income levels) report being in excellent or good health, but 14% overall have chronic conditions that require ongoing care (Pillai et al., 2023).

Across California, undocumented residents are about as likely to have at least one chronic condition as current Medi-Cal patients (Cha et al., 2023). Per 2023 research at the Public Policy Institute of California, chronic diseases affected 25.6% of low-income undocumented adults surveyed in 350 California community health centers. These statistics may underestimate proportions of immigrants experiencing chronic conditions, as some people may have yet to be diagnosed. Undocumented young adults tended to be healthier than young adults on Medi-Cal.

Healthcare Access and Coverage

Twenty-four percent of the immigrant households making less than $40,000 reported being uninsured in 2023 (Pillai et al., 2023). Among uninsured in some rural California communities, per 2023 survey data, 36% reported delaying or skipping care. Of those who skipped, 69% said they did so due to lack of healthcare coverage or prohibitive cost. These healthcare gaps among immigrant populations reflect lower rates of private healthcare insurance, which tends to be offered through salaried employment in the U.S., and proves continued need for coverage programs such as PTH that can make healthcare access less prohibitive (Pillai et al., 2023).

Undocumented immigrants were also more likely to experience difficulties finding culturally competent and respectful care than immigrants with documentation (34% vs. 29%) (Pillai et al., 2023). Undocumented persons may also avoid seeking care for fear of deportation, detention, or other retaliation; cultural and language barriers can also reduce care seeking (Pillai et al., 2023; Van Natta et al., 2023). Many mental healthcare services also fail to consistently offer culturally sensitive and language appropriate care.

California has relatively expansive healthcare insurance policies for immigrant populations compared to other U.S. states. To illustrate, the uninsured rate for immigrant adults in California is 8 percent, compared to 27 percent in Texas (Pillai et al., 2023). Coverage rates differ by county, however; favorable immigration policies influence county-based health care coverage (Van Natta et al., 2019). As California continues to expand Medi-Cal eligibility, learnings from prior Medi-Cal scaling include faster new enrollment among older adults compared to younger adults.

COVID-19 Public Health Emergency Impacts

As of September 2021, Latinx experienced over half of California's SARS-CoV-2 infections and almost half of the state's COVID-19 deaths (Young et al., 2022). Occupation was a strong predictor for COVID-19 among Latinx communities, which tend to be disproportionately younger and hold jobs as essential workers (Martínez et al., 2021).

The public health emergency affected health services and documentation processes for immigrants. Pandemic response safety nets were less comprehensive or entirely absent in rural communities. In interviews with first and second-generation Latinx immigrants in rural California between July 2020 and April 2021, researchers found that undocumented status likely exacerbated barriers due to provider shortages, exclusion from or underfunding of safety nets, and limited economic security. Specifically, undocumented populations were excluded from unemployment insurance, and pandemic relief programs frequently required a social security number to be eligible (Yount et al., 2022).

PTH covered a critical gap in CMSP counties during the COVID-19 public health emergency in California. Services expanded to include COVID-19 testing beginning in 2020, and then covering COVID-19 vaccinations and boosters once vaccines were approved in 2021. PTH members continuously took advantage of this coverage, making immunization appointments – which included COVID-19 immunizations – one of the most-used services during the PTH program.

Nationwide, the likelihood of getting a COVID-19 vaccine neither increased nor decreased in association with being undocumented.

Healthcare Utilization Among Immigrant Populations

Authors Cha et al. (2023) studied healthcare usage of low-income undocumented immigrants in 350 California community health centers (CHCs) from January 2018 to

November 2022. The majority of visits to CHCs were for preventive care. This utilization pattern aligns with PTH's coverage of preventive services. For example, one of the most common diagnoses in PTH service claims was pre-diabetes; increasing touchpoints with healthcare at this stage enables prevention efforts.

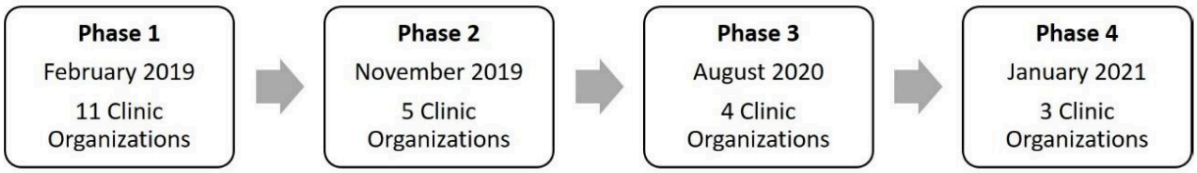
Among uninsured adults, 44% report they have no usual source of care outside of a hospital emergency room (Pillai et al., 2023). Across California, undocumented status was associated with being more likely to use behavioral health services.

Background on Path to Health

Path to Health (PTH) was a pilot healthcare coverage program for low-income undocumented adults in 35 County Medical Services Program (CMSP) California counties. A major goal of the program was to provide preventive and primary care to undocumented residents through partnerships with local clinic organizations. CMSP ran this pilot from 2019 through 2023. The pilot had four expansion phases and aimed to enroll up to 25,000 undocumented California residents with active restricted scope/emergency Medi-Cal.

PTH medical services and procedures were provided at numerous clinic sites to improve management of chronic diseases through continuity of care. As proper chronic disease management requires continuity of care, PTH aimed to improve access to both preventive and ongoing care. Other goals of the program included redirecting resources at the clinic organization level by enabling clinics to use funds covered by PTH to care for people without any coverage, and avoiding non-critical use of emergency services by members.

Figure 1. Expansion Phases



To be enrolled in PTH, for the majority of the program's duration, it was necessary to:

- Live in one of the 35 CMSP counties;
- Be actively enrolled in restricted scope/emergency Medi-Cal;
- Enroll in PTH at a contracted community health clinic, and;
- Be between the ages of 26 and 49 years old.

Originally, members were required to be over the age of 21 up to 64 years old. In September 2019, adults over the age of 65 were added to the PTH pilot. However, the age criteria for the program changed in January 2020, when adults aged 21-25 were granted full-scope Medi-Cal and thus excluded from the PTH pilot. Then, in May 2022, Medi-Cal expanded again to provide full-scope coverage to those age 50 and older regardless of immigration status. Enrollment criteria also changed in June 2021 when members were no longer required to be on restricted scope Medi-Cal, as long as applicants could verify their identity, residency in a CMSP county, and income documentation.

Table 1. Path to Health Original and Expanded Benefits and Services

	2019 – 2023	2022 – 2023
Services	• Office visit with primary care provider or on-site specialist • Preventive screenings • Adult immunizations • Screening for depression, alcohol misuse, obesity counseling • Screening for HIV, HPV, Hepatitis B/C, and STI screening • Tobacco use counseling and intervention (performed by a physician)	• Physical therapy • Substance use individual and group counseling • Mental health therapy • Neuropsychology assessments • COVID-19 vaccinations and boosters
Procedures	In-office minor medical procedures	Physical therapy procedures
Pharmaceuticals	Prescription medications with $5 copay and $1,500 limit for CMSP paid amount	
Labs	• Routine lab tests • Viral screening	

In 2022, the program expanded to cover physical therapy, mental health, and substance use services. PTH also covered COVID-19 vaccinations and boosters at that time; this coverage retroactively included vaccinations that happened in 2021, when vaccines became widely available.

Originally, PTH covered members for six months, after which members re-enrolled to continue coverage. However, during the COVID-19 public health emergency, re-enrollment was suspended until the end of the public health emergency in California on March 15, 2023. This meant that members remained in the program automatically.

Twenty clinic organizations ultimately participated in the PTH program. Half (10) of the clinic organizations had five or more clinic sites. In total, 100 clinic sites participated in the program. Of the 35 CMSP counties, 29 counties had at least one clinic enroll participants. Clinic organizations had varying numbers of associated clinical sites, or facilities. About one-fifth of the clinic sites were a part of the Ampla Health clinic organization.

Below is a breakdown of the number of clinic sites per clinic organization. Ampla Health had 12 clinic sites participate in the program. 56.6% of facilities were a part of five clinic organizations (Ampla Health, OLE Health, Marin Community Clinics, Open Door Community Health Centers, and Santa Rosa Community Health Center).

Table 2. Clinic Sites per Clinic Organization

Clinic Organization	N = 65[1]
Ampla Health	12 (18%)
OLE Health	7 (11%)
Marin Community Clinics	6 (9.2%)
Open Door Community Health Centers	6 (9.2%)
Santa Rosa Community Health Center	6 (9.2%)
La Clinica De La Raza	4 (6.2%)
CommuniCare Health Centers	3 (4.6%)
Community Medical Centers	3 (4.6%)
Mendocino Community Health Clinic	3 (4.6%)
Petaluma Health Center	3 (4.6%)
El Dorado Community Health Centers	2 (3.1%)
Madera Community Hospital	2 (3.1%)
Coastal Health Alliance, Inc.	1 (1.5%)
Innercare	1 (1.5%)
Peach Tree Healthcare	1 (1.5%)
Ritter Center	1 (1.5%)
San Benito Health Foundation	1 (1.5%)
Shasta Community Health Center	1 (1.5%)
Tehama County Health Services	1 (1.5%)
Winters Healthcare Foundation	1 (1.5%)

[1] n (%)

Evaluation Approach

The evaluation of the Path to Health pilot program utilized a mixed-methods approach, integrating various sources of data. Both qualitative and quantitative data were analyzed to assess the pilot program's impact from 2019 - 2023. There were two phases to the evaluation, Phase 1 from 2019 to 2021 and Phase 2 from 2021 – 2023. Data utilized from 2019 to 2023 for the evaluation consisted of 1) enrollment surveys, 2) semi-structured interviews of key stakeholders in partner Clinic Organization sites, 3) patient open-ended interviews, 4) patient experience telephone surveys, 5) administrative enrollment program data, and 6) program and pharmacy claims data. The enrollment survey included self-reported patient outcomes for access to office visits, delays in care, emergency department (ED) and hospital use, and participant characteristics such as general health status, year in the US, and co-morbidities.

Table 3. Quantitative and Qualitative Evaluation Components 2019 - 2023

Path to Health Pilot Program Evaluation Components 2019 - 2023	
Qualitative	Quantitative
Clinic site visits	Enrollment survey (8 questions)
Clinic key stakeholder interviews	Administrative program data
Patient open-ended interviews	Utilization claims
	Patient experience telephone survey

Phase 1 of the evaluation consisted of 3 annual reports. The first two reports (2020 and 2021) reported preliminary results and implementation progress to date on 1) partner community health center site visits, 2) provider/stakeholder interviews, 3) enrollments to date, and 4) descriptive pre- post- analyses of enrollment survey data to date. The third report (2021) included results from analyses of utilization claims data, updated enrollment surveys, and a patient experience telephone survey sampled at random. UCLA also provided recommendations for implementation which CMSP incorporated, including flexible enrollment and telemedicine services during COVID-19 and expanding services to include mental health services.

Phase 2 of the evaluation encompasses this final report (2019 –2023), which presents analyses results from enrollment administrative data, enrollment survey responses, and services utilization claims. This report also provides results of expanded benefits utilization, additional stratifications by clinic organizations, and analyses of eligibility changes. The report includes a pre- post- analysis of all pilot program data from 2019 to 2023 for the enrollment survey.

Analyses methods. Qualitative interviews conducted during the evaluation period (2019 – 2023) were transcribed, translated, and coded for themes by two independent coders using Dedoose software. We identified significant themes for the interviews. The first two

reports (2020 and 2021) provide a detailed summary of the qualitative interviews and site visit results. For all quantitative analyses, we used SAS statistical software (version 9.4) to conduct all quantitative data analysis. Data sources were combined for the analysis, including those that needed calculation of pre- post- changes. We calculated descriptive statistics, including means, standard deviations, and ranges for all variables. A flag was created for each member observation to indicate if a member enrollment period overlapped with the COVID-19 public health emergency. A flag was also created to identify enrollment criteria changes. Chi-squared tests and t-tests were used to calculate p-values for categorical and continuous variable comparisons. The Phase 2 final evaluation similarly used Pearson's chi-squared tests to calculate p-values, and looked at year-over-year changes for enrollment data and service claims. Since the eligibility requirements and policy changes shifted the member population during the program, Phase 2 also considers differences in demographics and benefits utilization across these populations.

Limitations. There are limitations to the evaluation. Policy and ecological events may have impacted the implementation, enrollment, and utilization of services in the Path to Health pilot program. Among the most notable are the COVID-19 public health emergency, changes in Med-Cal enrollment criteria, and the public's understanding of Public Charge in the early phases of the pilot program. Other limitations include the possible existence of unmeasured confounders in administrative data used for the analyses, such as member income data and complete medical histories. We also did not have a comparison group to look at differences in outcomes in a comparable population.

Path to Health Member Demographics

Path to Health processed 32,606 enrollment applications in total, including those for re-enrollments. The pilot program processed 19,415 first-time enrollment applications, which we use for the following summary statistics.

Demographic characteristics for pilot members, including gender, age, race, spoken language, and marital status are shown in Table 4 below. Demographics were collected through surveys that members filled out during enrollment. Since members that filled out more than one enrollment survey tended to keep their responses to demographic questions the same, we used the first enrollment survey available for each member. The total number of members per demographic characteristic changes based on whether a member answered a question.

The median age of members across 2019-2023 was 42, with 25% of members age 36 and lower, and 25% of members over age 48.

Most (79%) of the PTH member population identify as Latino/Latina or Latino/Latina/White (Table 4). About one fifth of respondents declined to answer their race/ethnicity or left that question blank. Nearly 15% of people identified as Latinx and at least one other race/ethnicity (mixed race Latino/Latina). Correlating with race/ethnicity statistics, 92% of members speak Spanish.

Table 4. Path to Health Member Demographics, N= 19,415

Characteristic	N	
Gender, n (%)	19,415	
Female		12,630 (65%)
Male		6,783 (35%)
Non-Binary		2 (<0.1%)
Age, (mean, min and max)	19,415	42 (36, 48)
Race/Ethnicity, n (%)	15,096	
Latino/Latina		11,862 (79%)
Latino/Latina, White		2,943 (19%)
Asian		118 (0.8%)
White		102 (0.7%)
Other		38 (0.3%)
African American		18 (0.1%)
Native Hawaiian		15 (<0.1%)
Spoken Language, n (%)	6,866	
Spanish		6,310 (92%)
English		493 (7.2%)
Other Non-English		57 (0.8%)
Portuguese		5 (<0.1%)
Mandarin		1 (<0.1%)
Marital Status, n (%)	2,949	
Single		1,455 (49%)
Married		1,248 (42%)
Registered Domestic Partner		82 (2.8%)
Separated		73 (2.5%)
Divorced		56 (1.9%)
Widowed		21 (0.7%)
Married (Spouse Not in Household)		14 (0.5%)

As shown below, the ages of members ranged, with the majority of members (75%) in the 31-50 years old range. This is expected given the changes in enrollment eligibility throughout the PTH program.

Table 5. Member Age Groups, N = 19,415

Age Group	N (%)
21-30	1,366 (7.0%)
31-40	7,033 (36%)
41-50	7,348 (38%)
51-60	2,577 (13%)
61-70	817 (4.2%)
71-80	224 (1.2%)
81-90	44 (0.2%)
91-100	6 (<0.1%)

Demographics Across Program Duration

Throughout the PTH program, there were changes in the California policy landscape and to the PTH eligibility requirements. Table 6 below stratifies the member population by eligibility time frame, based on when California Medi-Cal began full-scope coverage for people ages 25 and younger, then ages 50 and up; and when CMSP lifted the requirement to be on emergency/restricted Medi-Cal. The dates of these eligibility time frames are as follows:

- Start of program: Coverage start between February 1, 2019 to December 31, 2019
- 26 Years and Older: January 1, 2020 to May 31, 2021
- No Emergency/Restricted Medi-Cal Requirement: June 1, 2021 to May 31, 2022
- 26 to 49 Years Old, No Emergency Medi-Cal Requirement: May 1, 2022 to December 31, 2023

The total N of each column in Table 6 below represents the number of first-time enrollments in each group. The four eligibility time frames are grouped based on dates of eligibility changes, not whether or not members had emergency/restricted Medi-Cal or were a certain age. After the enrollment requirement to have emergency/restricted scope Medi-Cal was lifted in June 2021, about 300 people did not have emergency/restricted scope Medi-Cal when they enrolled in Path to Health (not identified in table).

Table 6 focuses on eligibility time frames. Since each column reflects a different amount of time (11 months, 17 months, 12 months, and 20 months, respectively), it is helpful to compare proportions of different demographic groups over time instead of the number of people in each group.

Table 6. Demographics Across Eligibility Changes

	February 1, 2019 to December 31, 2019 N = 5,142	January 1, 2020 to May 31, 2021 N = 7,404	June 1, 2021 to May 31, 2022 N = 3,774	May 1, 2022 to December 31, 2023 N = 3,095
Gender, n (%)				
Female	3,544 (69%)	5,004 (68%)	2,303 (61%)	1,779 (57%)
Male	1,598 (31%)	2,400 (32%)	1,471 (39%)	1,314 (42%)
Non-Binary				2 (<0.1%)
Age, mean (min, max)	42 (36, 49)	41 (36, 48)	44 (38, 52)	41 (36, 46)
Race/Ethnicity, n (%)				
Latino/Latina	3,665 (73%)	5,511 (77%)	842 (91%)	1,844 (93%)
Latino/Latina, White	1,249 (25%)	1,529 (21%)	65 (7.0%)	100 (5.0%)
Asian	51 (1.0%)	50 (0.7%)	7 (0.8%)	10 (0.5%)
White	32 (0.6%)	49 (0.7%)	4 (0.4%)	17 (0.9%)
Other	17 (0.3%)	5 (<0.1%)	4 (0.4%)	12 (0.6%)
Native Hawaiian	8 (0.2%)	5 (<0.1%)		2 (0.1%)
African American	6 (0.1%)	7 (<0.1%)	1 (0.1%)	4 (0.2%)

The proportion of female members decreased over time, while the proportion of male members increased. The median age decreased from 44 to 41 when older adults (age 50+) gained access to full-scope Medi-Cal. The proportions of Latino/Latina members increased over time and always constituted a majority in the program.

In the earlier PTH evaluation reports, results showed that people learned about the program through word of mouth; as more clinic organizations were enrolled earlier in the program (through 2021), first-time enrollments increased. However, first-time enrollments continued to happen even after clinic organizations were added, and eligibility requirements changed.

Considering the split in PTH members before and after the requirement to be on emergency/restricted Medi-Cal to enroll in PTH (before/after June 1, 2021, about halfway through the program, as in the table below), differences in self-reported health status, delays in care due to cost, primary care office visits in the past six months, and preexisting chronic conditions across these two groups were statistically significant. A p-value of less than 0.05 means that there is a 5% chance, or less, that the results we observe are due to chance alone; thus, a p-value of 0.05 or less suggests a statistically significant difference. Differences across groups may be related to an overall younger member population later in the program, since the age range became 26-49 years old, or due to established patients

utilizing coverage over time. However, we cannot point to definitive reasons through these methods.

Table 7. Enrollment Survey Response Differences Before and After Path to Health Emergency/Restricted Scope Medi-Cal Eligibility Requirement Lifted[1]

	Enrollment before eligibility requirement change, N = 12,546	Enrollment after eligibility requirement change, N = 6,869	p-value
Self-reported health status, n (%)			<0.001
Excellent	473 (5.3%)	265 (6.0%)	
Very good	773 (8.6%)	498 (11%)	
Good	6,761 (75%)	3,133 (71%)	
Poor	994 (11%)	536 (12%)	
Delays in care due to cost, n (%)			<0.001
No	7,405 (62%)	4,217 (65%)	
Yes	4,403 (37%)	2,169 (34%)	
Don't know	100 (0.8%)	83 (1.3%)	
Emergency department use, n (%)			0.72
0	8,847 (74%)	4,761 (74%)	
1-2	2,726 (23%)	1,519 (24%)	
3-4	264 (2.2%)	135 (2.1%)	
5 or more	62 (0.5%)	31 (0.5%)	
Hospitalizations, n (%)			0.17
0	10,838 (91%)	5,874 (91%)	
1-2	862 (7.3%)	445 (6.9%)	
3-4	108 (0.9%)	74 (1.1%)	
5 or more	68 (0.6%)	48 (0.7%)	
Primary care office visit in the last 6 months, n (%)			<0.001

[1] Approximately 300 people enrolled without emergency/restricted scope Medi-Cal.

	Enrollment before eligibility requirement change, N = 12,546	Enrollment after eligibility requirement change, N = 6,869	p-value
0	3,632 (31%)	2,369 (37%)	
1-2	4,524 (38%)	2,649 (41%)	
3-4	2,122 (18%)	891 (14%)	
5 or more	1,617 (14%)	545 (8.4%)	
Self-reported chronic conditions, n (%)			<0.001
No	6,491 (57%)	3,923 (65%)	
Yes 1-2	4,238 (37%)	1,885 (31%)	
Yes 3 or more	695 (6.1%)	225 (3.7%)	

The table below includes members who enrolled before March 2020, after which continuous enrollment began. It considers those who only enrolled once (right column), and those who enrolled more than once (left column). Although there were more people who only enrolled once than who re-enrolled before March 2020, we do not observe statistically significant differences in demographics across these populations.

Table 8. Demographics Among Those with and Without Re-Enrollments

	More Than One Enrollment, N = 2,177	Only One Enrollment, N = 4,039
Gender, n (%)		
Female	1,503 (69%)	2,797 (69%)
Male	674 (31%)	1,242 (31%)
Age	43 (37, 50)	42 (36, 49)
Race/Ethnicity, n (%)		
Latino/Latina	1,528 (71%)	2,878 (74%)
Latino/Latina, White	580 (27%)	931 (24%)
Asian	21 (1.0%)	37 (0.9%)
White	11 (0.5%)	38 (1.0%)
Other	8 (0.4%)	9 (0.2%)
Native Hawaiian	1 (<0.1%)	9 (0.2%)
African American	2 (<0.1%)	7 (0.2%)

Enrollment Survey Data

The tables below include survey responses associated with members' first and final enrollments in the PTH program, and include members who took at least two enrollment surveys (a first enrollment survey, and a final re-enrollment survey). The percentages below compare the proportions of each response in the earlier and later groups of surveys. Each row percent adds up to 100%. A p-value of less than 0.001 suggests a statistically significant difference, in responses of each survey question, between groups (groups of first versus final surveys).

Overall, of those members who took at least two enrollment surveys, 68% reported that their health was "good," "very good," or "excellent" in their last surveys, compared to 63% of members in their first enrollment surveys. The proportion of members reporting "poor" health decreased from 58% to 42%. More respondents reported having at least one chronic disease during their last enrollment survey (3,165 versus 3,048 members); this could be due to more people being diagnosed as a result of having better healthcare access and more frequent primary care visits.

There was a marked increase in the proportion of members that did not avoid medical care because they could not afford it (60% vs. 73%). This suggests that the PTH health coverage achieved one of its primary goals of making care more accessible, thus reducing delays in care. The survey question about delays in medication due to prohibitive cost was added later in the program, so the table below only shows participants' answers for their last enrollment surveys. We were not able to determine a meaningful comparison between enrollments with regards to medication cost barriers, since that survey question was added later in the program.

Table 9. First and Last Enrollment Survey Responses

	Overall, N = 15,356[1]	First Enrollment, N = 7,678[1]	Last Enrollment, N = 7,678[1]	p-value[2]
Self-reported health status				<0.001
Good	8,410 (100%)	4,038 (48%)	4,372 (52%)	
Very good	1,033 (100%)	494 (48%)	539 (52%)	
Poor	995 (100%)	576 (58%)	419 (42%)	
Excellent	594 (100%)	279 (47%)	315 (53%)	
Primary care office visit in the last 6 months				0.45
1-2	5,729 (100%)	2,860 (50%)	2,869 (50%)	
0	4,237 (100%)	2,078 (49%)	2,159 (51%)	
3-4	2,756 (100%)	1,387 (50%)	1,369 (50%)	
5 or more	2,076 (100%)	1,061 (51%)	1,015 (49%)	

	Overall, N = 15,356[1]	First Enrollment, N = 7,678[1]	Last Enrollment, N = 7,678[1]	p-value[2]
Pre-existing chronic conditions				0.088
No	8,093 (100%)	4,084 (50%)	4,009 (50%)	
Yes 1-2	5,428 (100%)	2,644 (49%)	2,784 (51%)	
Yes 3 or more	785 (100%)	404 (51%)	381 (49%)	

	Overall, N = 15,356[1]	First Enrollment, N = 7,678[1]	Last Enrollment, N = 7,678[1]	p-value[2]
Delays in care due to cost				<0.001
No	10,213 (100%)	4,611 (45%)	5,602 (55%)	
Yes	4,517 (100%)	2,729 (60%)	1,788 (40%)	
Don't know	85 (100%)	51 (60%)	34 (40%)	
Delays in medication due to cost				0.76

No	2,432 (100%)	4 (0.2%)	2,428 (100%)	
Yes	310 (100%)	0 (0%)	310 (100%)	
Don't know	16 (100%)	0 (0%)	16 (100%)	
How did you first hear about Path to Health				0.80
Clinic or hospital employee	14,627 (100%)	7,316 (50%)	7,311 (50%)	
Friend or family member	461 (100%)	228 (49%)	233 (51%)	
Printed materials or flyer	46 (100%)	21 (46%)	25 (54%)	
Radio or TV	28 (100%)	13 (46%)	15 (54%)	
Social Media or online	23 (100%)	14 (61%)	9 (39%)	

[1] n (row%)
[2] Pearson's Chi-squared test

As shown in Table 10 below, the number of times a member went to the emergency room was different among the last enrollment survey group. Smaller proportions went to the emergency room one or more times, and a larger proportion never used an emergency department in the prior six months.

Similarly, fewer proportions of the last enrollment survey group were hospitalized in the past six months. This was consistent across all categories of counts of hospitalizations.

Table 10. Changes in Self-Reported Emergency Department Use and Hospitalizations

	Overall, N = 15,356[1]	First Enrollment, N = 7,678[1]	Last Enrollment, N = 7,678[1]	
Emergency department use in the last 6 months				<0.001
0	11,534 (100%)	5,554 (48%)	5,980 (52%)	
1-2	2,946 (100%)	1,640 (56%)	1,306 (44%)	
3-4	245 (100%)	150 (61%)	95 (39%)	
5 or more	61 (100%)	36 (59%)	25 (41%)	
Hospitalizations use in the last 6 months				<0.001
0	13,839 (100%)	6,809 (49%)	7,030 (51%)	
1-2	773 (100%)	473 (61%)	300 (39%)	
3-4	101 (100%)	55 (54%)	46 (46%)	
5 or more	58 (100%)	36 (62%)	22 (38%)	

Differences in the first- and last- groups, specifically the differences in the distributions of responses among response options, were statistically significant among the following characteristics: self-reported health status, delays in care due to cost, emergency department use in the last 6 months, and hospitalization use in the last 6 months.

Enrollment Data

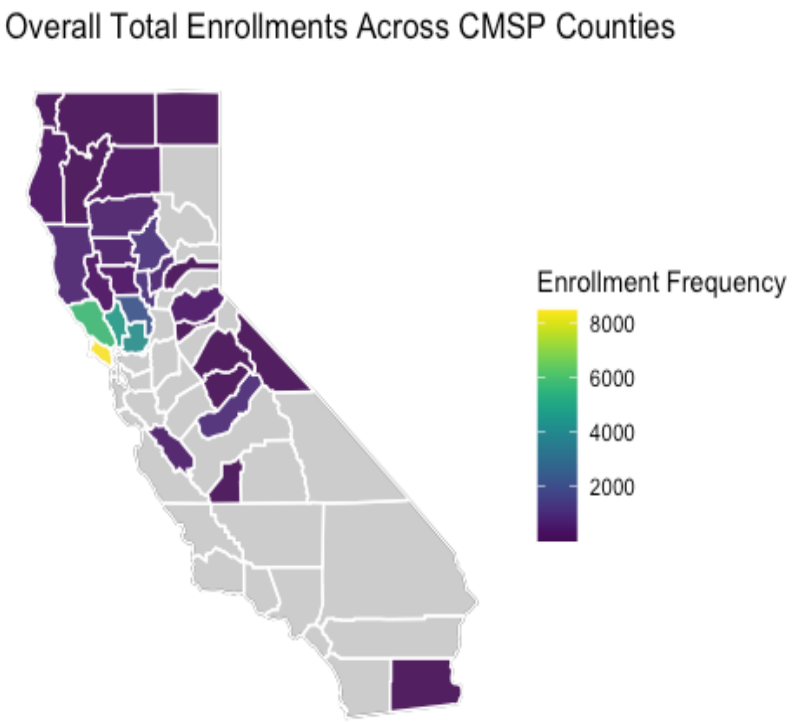
The table below shows the number of first-time enrollments per clinic organization, and total enrollments per clinic organization. Total enrollments include re-enrollments of individuals who re-enrolled in PTH. We also see enrollments by county.

Table 11. First-time Enrollments Across Clinic Organizations, N=19,415

	N per Clinic Organization
Member Organizational Facility	
Marin Community Clinics	4,803 (25%)
OLE Health	2,490 (13%)
Santa Rosa Community Health Center	2,357 (12%)
Ampla Health	2,323 (12%)
CommuniCare Health Centers	1,486 (7.7%)
Petaluma Health Center	1,328 (6.8%)
La Clinica De La Raza	1,213 (6.2%)
Madera Community Hospital	843 (4.3%)
Mendocino Community Health Clinic	805 (4.1%)
Community Medical Centers	639 (3.3%)
San Benito Health Foundation	332 (1.7%)
Open Door Community Health Centers	255 (1.3%)
El Dorado Community Health Centers	253 (1.3%)
Coastal Health Alliance, Inc.	100 (0.5%)
Winters Healthcare Foundation	97 (0.5%)
Shasta Community Health Center	54 (0.3%)

	N per Clinic Organization
Ritter Center	28 (0.1%)
Peach Tree Healthcare	5 (<0.1%)
Innercare	3 (<0.1%)
Tehama County Health Services	1 (<0.1%)

Figure 2. Enrollment Frequency Across Counties

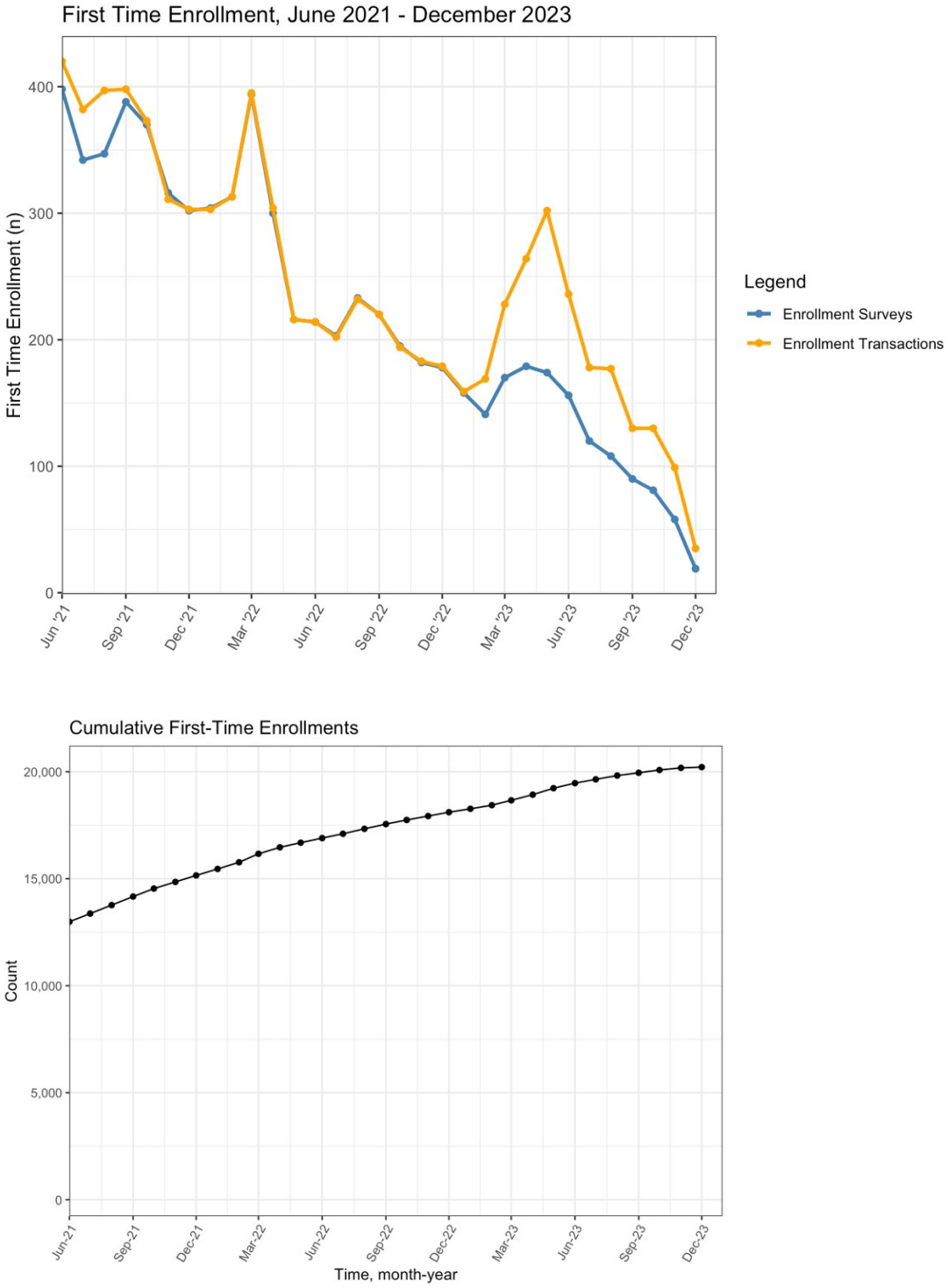


Marin Community Clinics organization in Marin County accounted for 25% of first-time enrollments. Although the Ampla Health and OLE Health clinic organizations had the most participating clinic sites, the Marin Community Clinics' clinic sites enrolled more PTH members. Clinic organizations in Sonoma, Solano, Napa, and Yolo counties accounted for another 49.1% of first-time enrollments.

The graphs below show changes in cumulative enrollment and first-time enrollment over time. Since CMSP changed PTH eligibility requirements in 2021, removing the need to be on restricted/emergency Medi-Cal, data shown below consider enrollment after June 2021, when the change went into effect. The graphs do not show any noticeable increase in first-time enrollment as a result of that change. However, first-time enrollments did

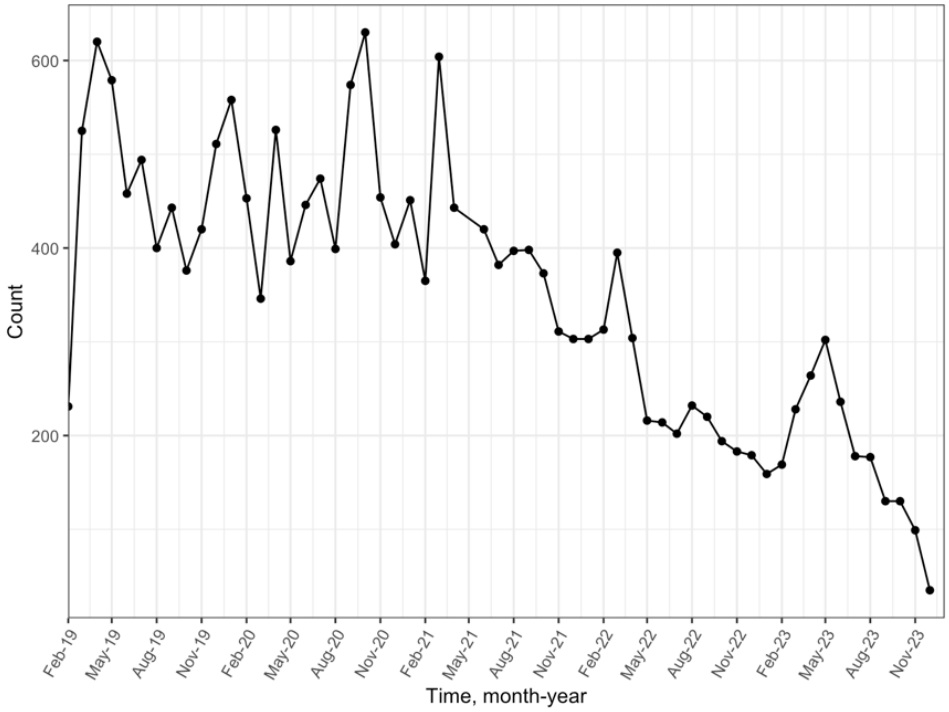
continue throughout the program's full duration, showing a near-linear increase in cumulative first-time enrollments (i.e., aggregate first-time enrollments, summed over time).

Figure 3. First Time and Cumulative First-time Enrollments, June 2021 – December 2023



Below, we show first-time enrollments over the full program duration. The most recent data is from December 2023. We used first-time enrollment survey data for these graphs, since we had enrollment surveys from the full duration of the program (i.e., no gaps in enrollment survey data).

Figure 4. First-Time Enrollments, 2019-2023



Service Claims

Service claims data included header (HDR) claims and detail claims. Each HDR represents one PTH member's contact with a clinic, but may include more than one service if a member received multiple services or procedures. In the data set, there is one HDR claim per service visit. Each different procedure or service is counted as a separate detail (DTL) claim. We used header claims to count total service claims submitted and primary diagnoses associated with claims. We used detail claims to investigate categories of procedures and services that members used.

On average, PTH members had 2 procedures/services per HDR service claim, or clinic encounter. The total N in the table below is the number of HDR claims in the dataset.

We analyzed 101,494 total unique HDR claims. On average, PTH members had 2 procedures/services per HDR service claim, with a standard deviation of 1.

Table 12. Number of Detailed Services per Claim

DTL Lines per Paid HDR Service Claim	N = 101,494
Mean (SD)	2 (1)
Median (Range)	1 (1, 33)

Primary Diagnoses

Primary diagnoses associated with service claims were consistent across the study period. Type 2 diabetes and hypertension constituted the majority of the primary reasons for service claims. Immunizations, including COVID-19 immunizations, followed in frequency. COVID-19 viral detection was less frequent across members than consistent visits for cholesterol, dysuria, prediabetes, and general and focused adult exams.

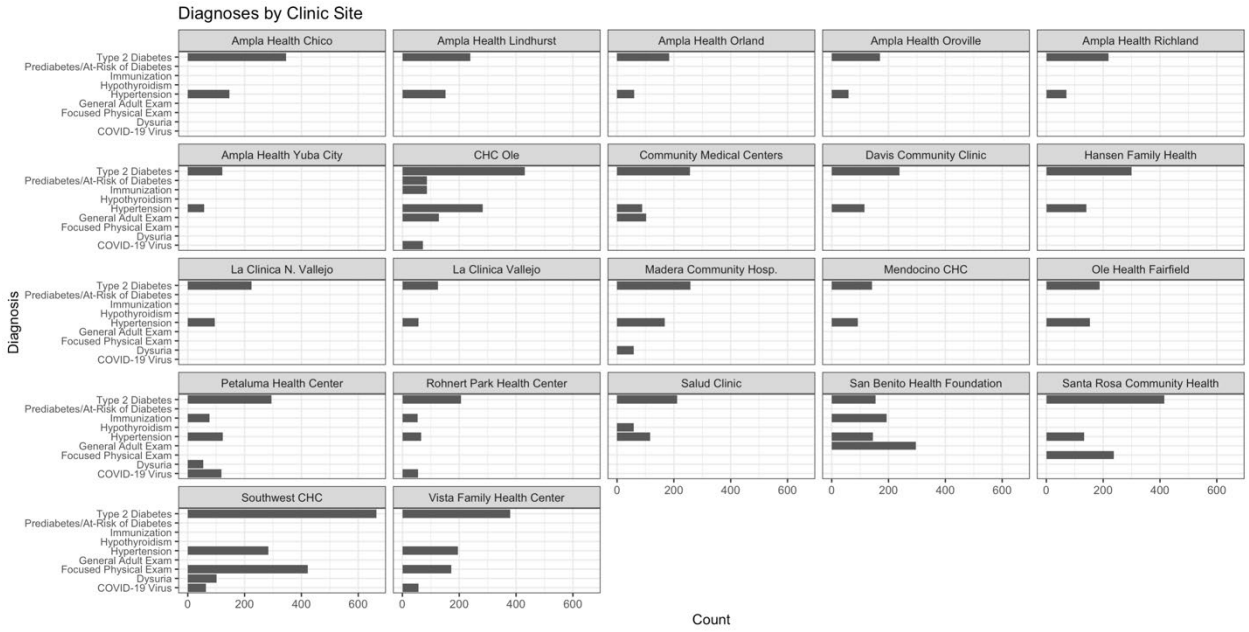
Table 13. Primary Diagnoses for Service Claims

Count	%	Principal Diagnosis
9076	8.90	Type 2 Diabetes
4425	4.40	Hypertension
3419	3.40	Immunization
2323	2.30	Cholesterol/Hyperlipidemia
1386	1.40	Dysuria
1347	1.30	Focused Physical Exam
1322	1.30	General Adult Exam
1310	1.30	Prediabetes/At-Risk of Diabetes

Count	%	Principal Diagnosis
1131	1.10	COVID-19 Virus
994	0.98	Hypothyroidism

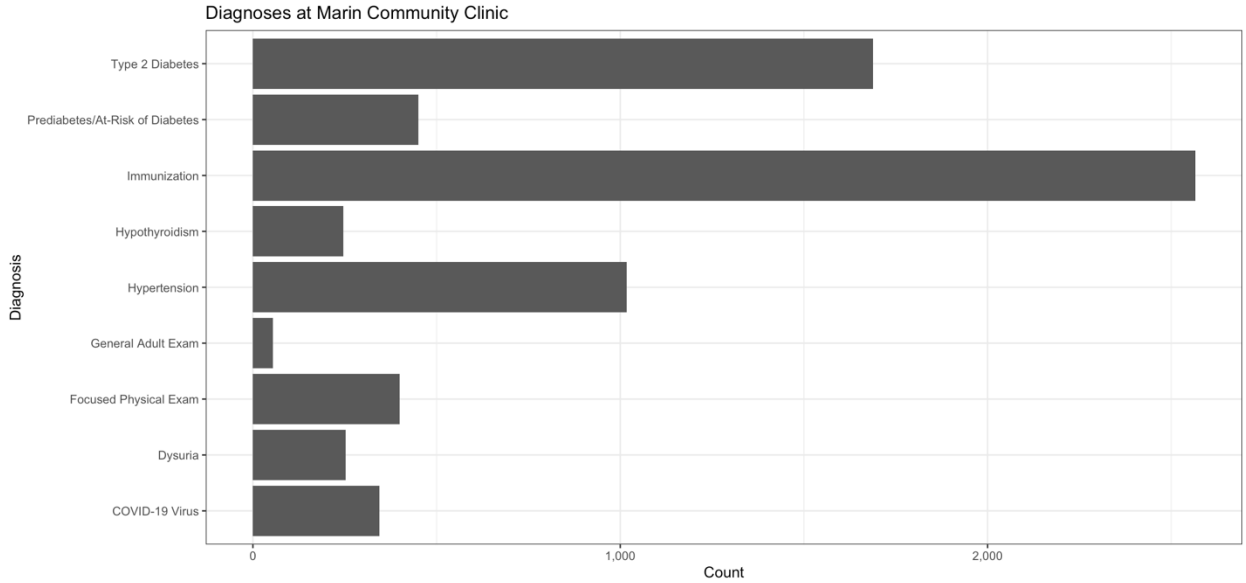
The frequency of each of these top ten diagnoses varied across clinics. Below, we filtered for clinics that had claims for at least fifty counts of one of diagnoses above. We also filtered out Marin Community Clinic and examined diagnoses at that site specifically below, because the frequency of diagnoses there was higher than at the other sites included below.

Figure 5. Principal Diagnoses Across Clinic Sites



In the service claims data set, all of the Marin Community Clinic sites (eight total) were listed under the same clinic name ("Marin Community Clinic"), which might explain why there are many more diagnoses there compared to the other organizations with individually identified clinic sites. Also, as mentioned, Marin Community Clinics also enrolled more members compared to other clinic sites.

Figure 6. Diagnoses at Marin Community Clinic Organization



COVID-19 Diagnoses

Annual COVID-19 diagnoses (ICD-10 diagnostic codes U07.1, B342, and Z20828) across clinic sites show most sites detected the most COVID-19 viruses in 2020.

Table 14. Annual and Cumulative COVID-19 Diagnoses Across Sites

Clinic Name	2020	2021	2022	2023	Total COVID-19 Diagnoses
MARIN COMMUNITY CLINIC	196	77	118	23	414
PETALUMA HEALTH CENTER	91	43	41	1	176
COMMUNITY HEALTH CLINIC OLE	46	31	23	5	105
ROHNERT PARK HEALTH CENTER	36	21	18	5	80
SOUTHWEST COMMUNITY HEALTH CENTER	24	2	44	3	73
VISTA FAMILY HEALTH CENTER	19	13	31	2	65
AMPLA HEALTH CHICO MEDICAL	14	23	24	1	62
COMMUNITY MEDICAL CENTERS	31	13	11	5	60

Clinic Name	2020	2021	2022	2023	Total COVID-19 Diagnoses
AMPLA HEALTH LINDHURST MEDICAL	19	20	17	2	58
LA CLINICA NORTH VALLEJO	24	8	19	5	56
DAVIS COMMUNITY CLINIC	26	14	6	1	47
SALUD CLINIC	22	11	11	2	46
HANSEN FAMILY HEALTH CENTER	13	4	23	2	42
AMPLA HEALTH RICHLAND MEDICAL	20	9	9	0	38
AMPLA HEALTH ORLAND MEDICAL	13	15	6	1	35
OLE HEALTH FAIRFIELD	8	8	9	8	33
SANTA ROSA COMMUNITY HEALTH	15	1	14	0	30
LA CLINICA VALLEJO	13	4	6	2	25
AMPLA HEALTH ARBUCKLE MEDICAL	1	3	18	1	23
AMPLA HEALTH YUBA CITY MEDICAL	5	1	13	1	20
AMPLA HEALTH HAMILTON CITY MEDICAL	7	3	2	0	12
AMPLA HEALTH COLUSA MEDICAL	0	6	5	0	11
FORTUNA COMMUNITY HEALTH CENTER	0	9	2	0	11
MADERA COMMUNITY HOSPITAL	1	4	6	0	11
AMPLA HEALTH LOS MOLINOS MEDICAL	5	2	3	0	10
AMPLA HEALTH OROVILLE MEDICAL	2	5	3	0	10
PLACERVILLE CENTER	3	4	1	2	10
WINTERS HEALTHCARE CLINIC	5	3	1	1	10
COMMUNITY HEALTH CLINIC	1	0	8	0	9
POINT REYES MEDICAL CLINIC	2	0	6	0	8
SAN BENITO HEALTH FOUNDATION	3	2	0	3	8
AMPLA HEALTH GRIDLEY MEDICAL	2	0	4	1	7
OLE HEALTH ST HELENA	0	1	5	0	6
MENDOCINO COMMUNITY HEALTH CLINIC	0	0	3	1	4
ANDERSON FAMILY HEALTH AND DENTAL CENTER	1	0	1	0	2
COMMUNITY MEDICAL CENTER	0	0	2	0	2

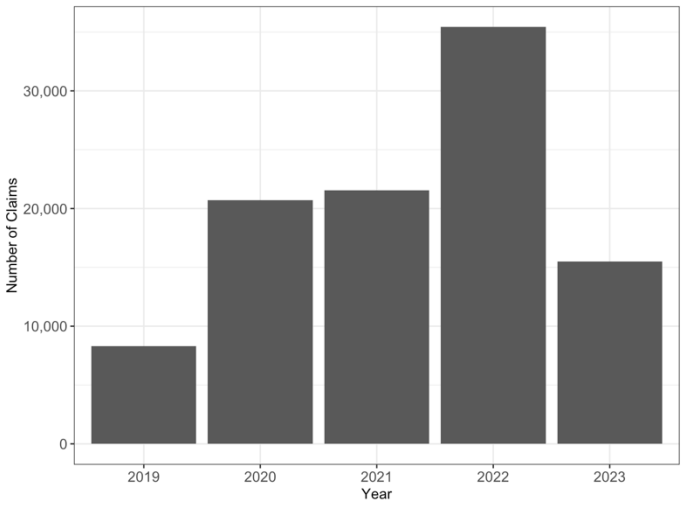
Clinic Name	2020	2021	2022	2023	Total COVID-19 Diagnoses
EUREKA COMMUNITY HEALTH CENTER	0	1	1	0	2
HUMBOLDT OPEN DOOR CLINIC	0	0	1	0	1
LAKESIDE HEALTH CENTER	0	0	1	0	1
OLE HEALTH EAST FAIRFIELD	1	0	0	0	1
PEACH TREE CLINIC	0	0	0	1	1
SHASTA COMMUNITY MATERNITY CENTER	0	0	1	0	1

Most sites also show comparable numbers of COVID-19 detections in 2021 and 2022, which aligns with national and regional COVID-19 viral trends. As the virus mutated, different variants continued to infect populations across clinics, though at a smaller scale than in 2020.

CMSP Paid Claims

Service claims included labs, procedures, office visits, and primary care services, as described in the next section below. The majority of service claims had dates of service in 2022. During this year, enrollment was continuous, so members did not need to re-enroll in the PTH program to continue their coverage. Members also continued to receive COVID-19 vaccinations and boosters during this time.

Figure 7. Annual Approved and Paid Service Claims



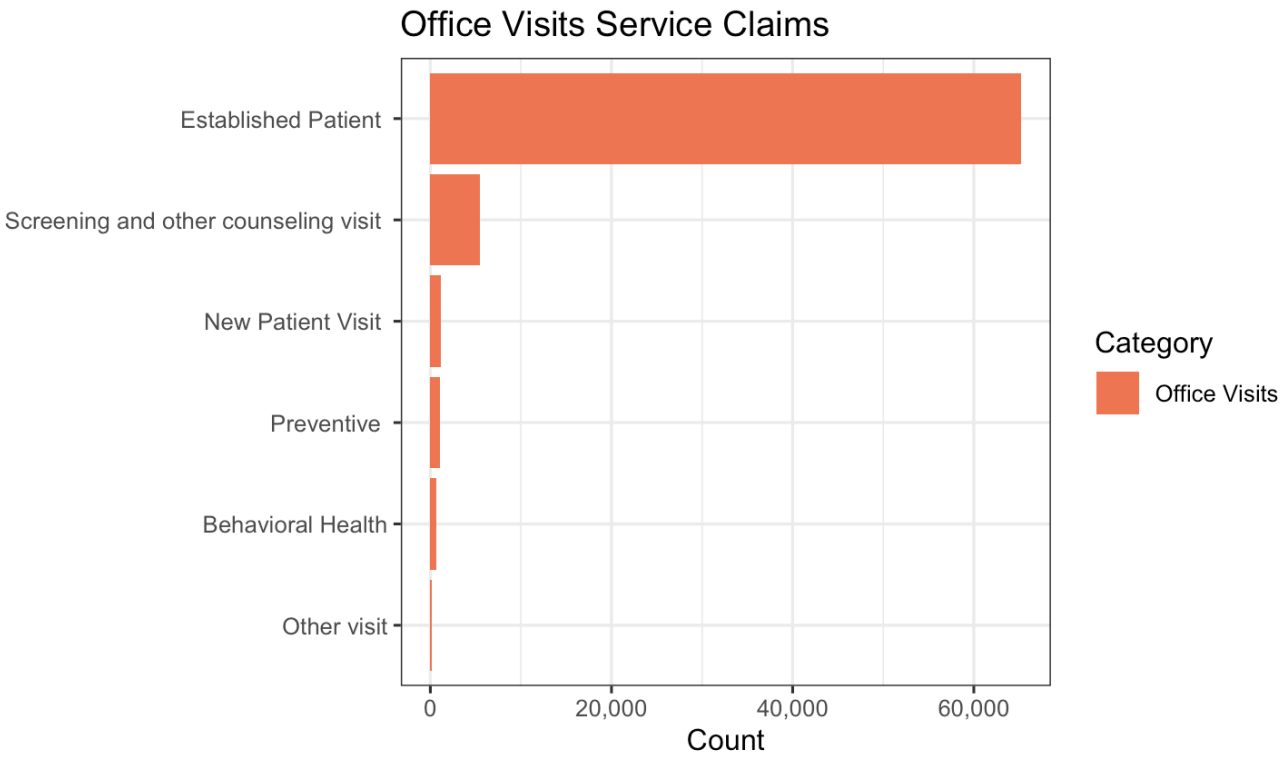
Current Procedural Terminology (CPT) Codes: Categories of Service Claims

Categorizations in the figure below are consistent with how claims were organized in prior evaluation reports. CPT codes associated with detail claims showed that the majority of visits were office visits, followed by lab services, immunizations, and primary care services.

Ninety percent of office visits were with established patients (N = 86,253). These included outpatient clinic visits. The graph below shows the number of office visits that were actually telehealth visits, since Path to Health began covering telehealth during the COVID-19 public health emergency. Thus, the second most frequent visit type was for screening purposes, as shown in the graph and table below.

We broke out "Behavioral Health" and "Screening and other counseling visit" as separate from new and established patient visits because of the clinical context of behavioral health and screening appointments. Thus, we distinguished between routine primary care visits (established patients), first-time visits (new patients), behavioral health appointments, and screening appointments. We could not identify which behavioral services were from new versus established patients because of how visits were coded by physicians.

Figure 8. Office Visits Categories



Office Visits	N = 95,686[1]
Behavioral Health	701 (0.7%)
Established Patient Visit	65,251 (68%)
New Patient Visit	1,129 (1.2%)
Other Visit	134 (0.1%)
Preventive	1,080 (1.1%)
Screening and other counseling visit	5,476 (5.7%)

[1] n (%)

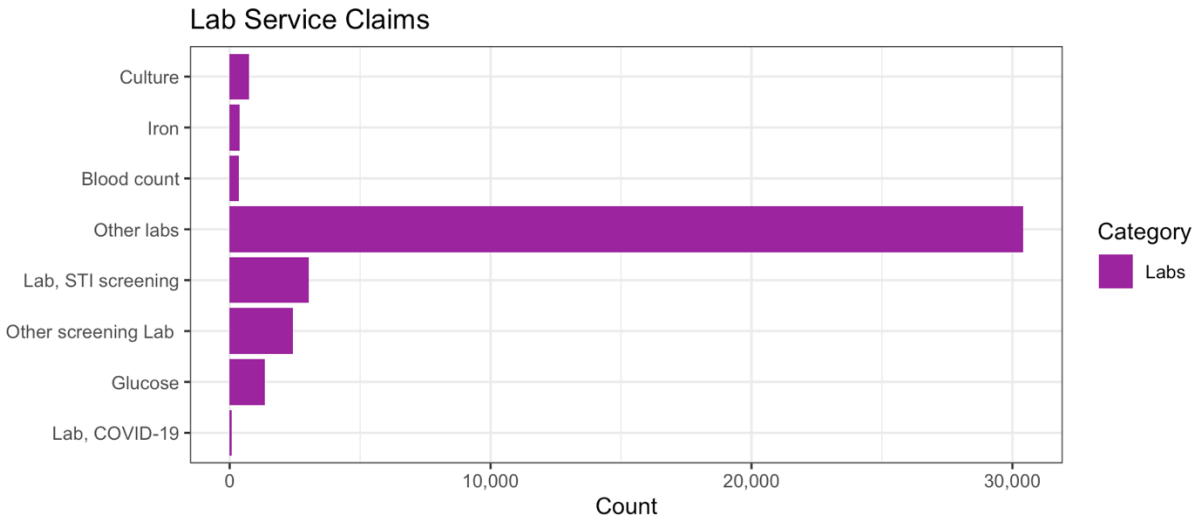
Of the office visits in Figure 8, 21,915 visits (23% of office visits) were telehealth visits. The table below shows how many of each office visit type were conducted virtually via telehealth. Nearly 90% of behavioral health visits were via telehealth. Over 30% of established patient visits for routine care were telehealth visits.

Table 15. Types of Telehealth Visits

Visit Type	Telehealth Visits	Total Visits	% of Total Visits that were Telehealth
Established Patient Visit	21,002	65,251	32%
Behavioral Health	627	701	89%
Screening and other counseling visit	177	5,476	3%
New Patient Visit	92	1,129	8%
Telehealth (CPT G0071)	12	12	100%
Preventive	3	1,080	0.2%
Other visit	2	134	1.5%

Lab service claims are displayed graphically and in table format below in Figure 9. Labs for the screening or diagnosis of sexually transmitted infections (STI) were a major category. Labs in the "other" category below included, among others: lab draws, pap smears, and microscopy.

Figure 9. Lab Services Categories

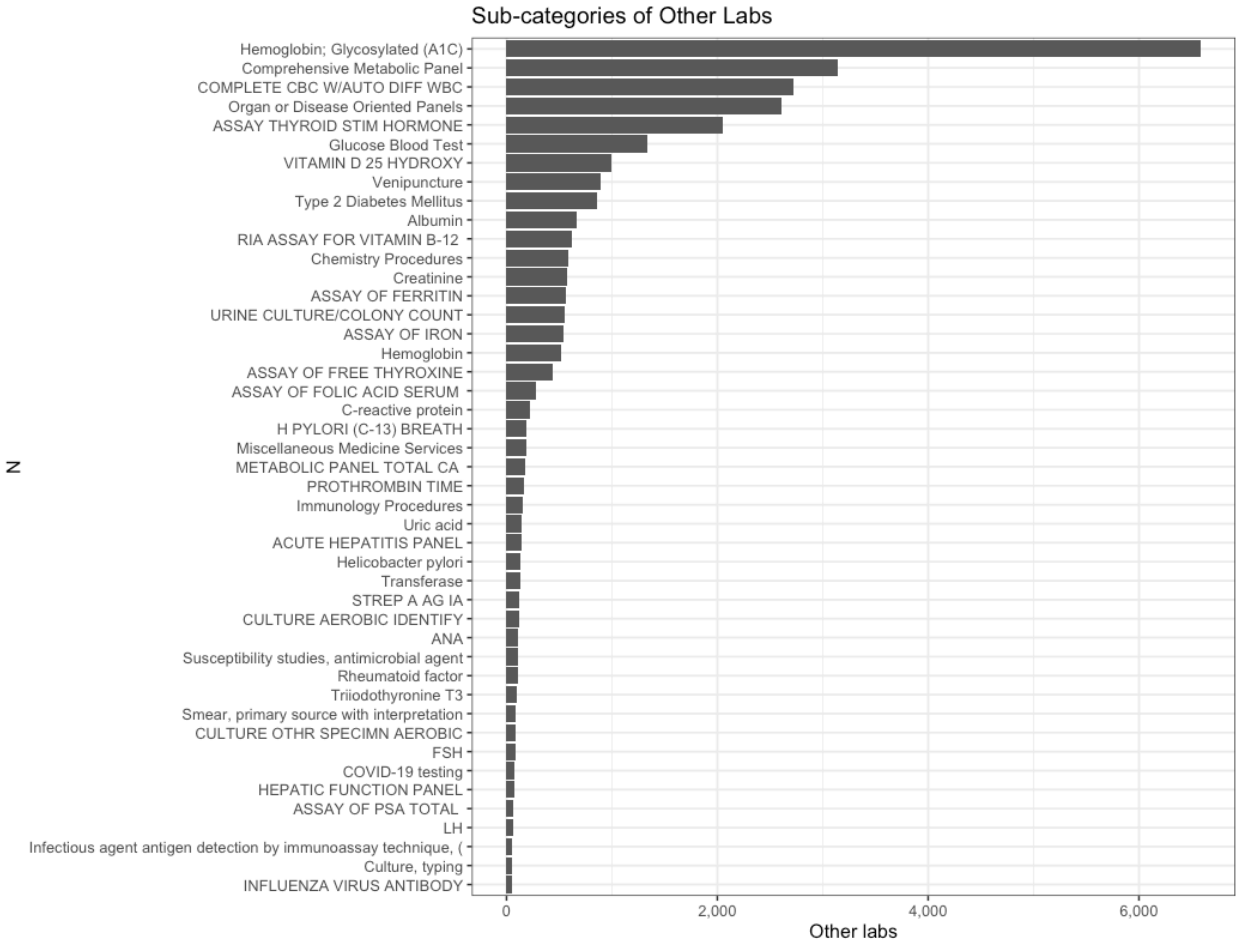


Labs	N = 38,770[1]
Glucose/Diabetes	1,340 (3.46%)
Lab, COVID-19	80 (0.21%)
Lab, STI screening	3,045 (7.85%)
Other labs	30,409 (78.43%)
Other screening Lab	2,437 (6.28%)
Blood count	345 (0.89%)
Culture	748 (1.93%)
Iron	366 (0.94%)

[1] n (%)

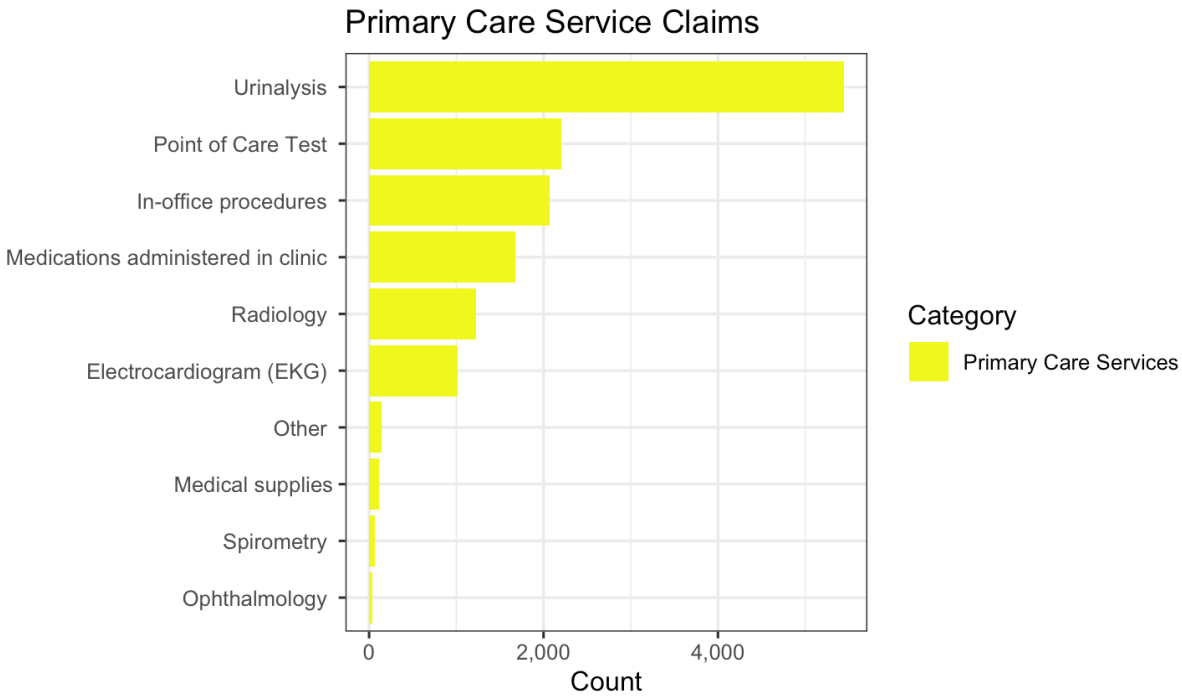
A breakdown of the "other labs" category shows that most lab claims (N = 6,586) were for hemoglobin measurement, followed by a comprehensive metabolic panel; these sub-categories of "other labs" are fully listed in below and also include primary care labs such as rheumatologic, gastrointestinal, kidney, and inflammatory markers.

Figure 10. Sub-categories of Other Labs



Most primary care point of service tests were for urinalysis, as shown below. Point of care tests include hemoglobin and blood glucose tests that occurred at the point of care in the clinics. In-office procedures include procedures like in office removal of small lesions or joint injections.

Figure 11. Primary Care Service Claims

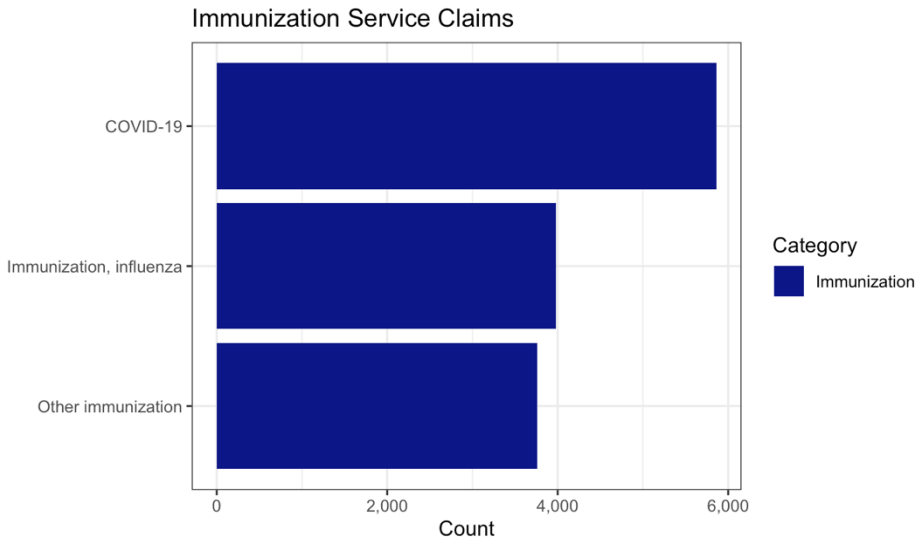


Primary Care Services	N = 13,988[1]
Electrocardiogram (EKG)	1,012 (7.2%)
In-office procedures	2,071 (15%)
Medical supplies	110 (0.8%)
Medications administered in clinic	1,676 (12%)
Ophthalmology	34 (0.2%)
Other	141 (1.0%)
Point of Care Test	2,207 (16%)
Radiology	1,229 (8.8%)
Spirometry	66 (0.5%)
Urinalysis	5,442 (39%)

[1] n (%)

As shown below in Figure 12, most immunizations were for COVID-19. Other immunizations include Hepatitis B immunizations and unspecified adult immunizations.

Figure 12. Most Common Immunizations Service Claims Categories

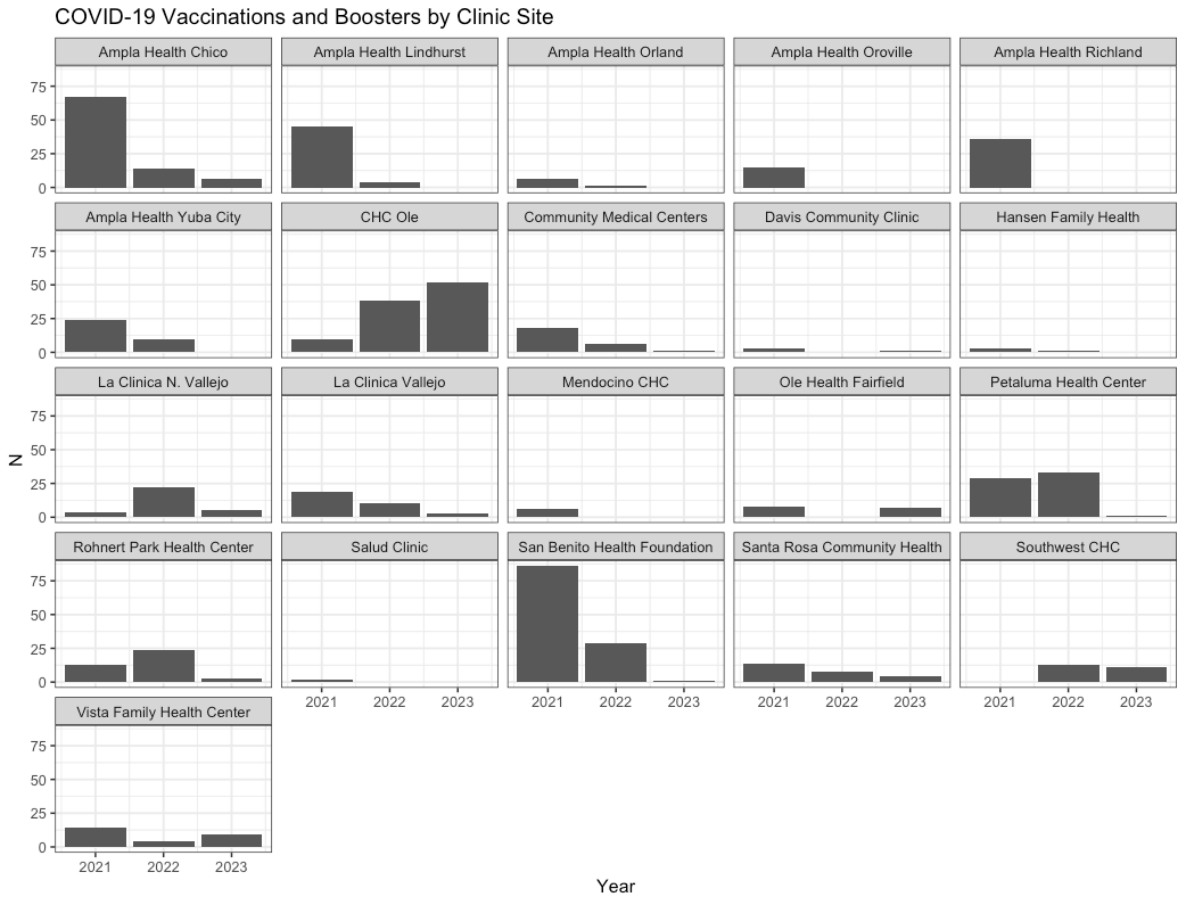


Immunizations	N = 13,598
COVID-19	5,863 (43%)
Immunization, influenza	3,978 (29%)
Other immunization	3,757 (28%)

COVID-19 Vaccinations

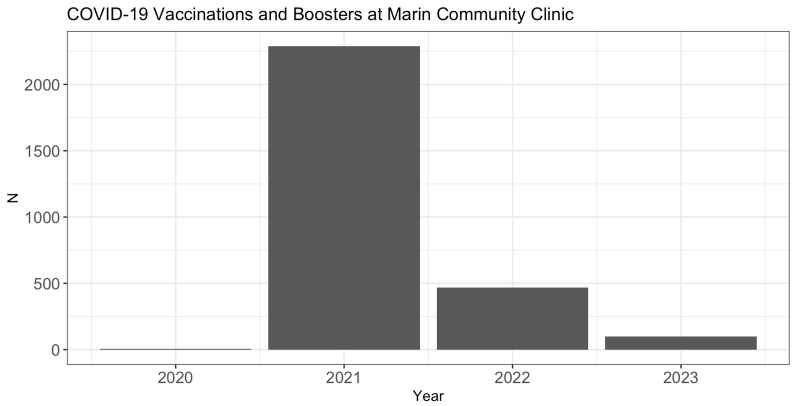
Members took advantage of COVID-19 vaccination coverage across clinics. Most COVID-19 vaccinations took place at Marin Community Clinics. Ampla Health Chico, Ampla Health Lindhurst Medical, Ampla Health Richland Medical, Ampla Health Richland Medical, Petaluma Health Center and San Benito Health Foundation all provided at least twenty vaccinations in one year. Most clinics vaccinated more members in 2021 than in later years, but most clinics also continued to provide vaccinations and boosters throughout 2023.

Figure 13. COVID-19 Vaccinations Across Clinics



COVID-19 vaccinations and boosters at Marin Community Clinic are counted separately below. Separating out Marin Community Clinic allowed us to shorten the y-axis above, making the smaller numbers of vaccinations at each clinic site visible. As shown in Figure 14 below, Marin Community Clinic distributed over 2,000 COVID-19 immunizations and boosters in 2021.

Figure 14. COVID-19 Vaccinations and Boosters at Marin Community Clinic



Across the 2019-2023 years during which the PTH program ran, more members submitted service claims than pharmacy claims. Twenty-two percent of members submitted a pharmacy claim associated with a specific service claim; some submitted more than one pharmacy claim per service claim.

Expanded Services

In 2022, the PTH program covered expanded services for COVID-19 vaccinations and boosters, mental health, substance use, and physical therapy. The complete list of expanded services by category is listed below.

Table 16. Definitions of Expanded Services Categories

COVID-19 Vaccines	Mental Health	Substance Use	Physical Therapy
• COVID-19 vaccine administration code • Pfizer Vaccine Administration • Moderna Vaccine Administration • Janssen Vaccine Administration	• Neuropsychological testing evaluation services • Psychological or neuropsychological test administration and scoring • Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform with automated results only • Assessment of aphasia • Psychotherapy • Developmental screening, per standardized instrument • Developmental test administration • Neurobehavioral status exam • Psychological testing evaluation services • Psychotherapy for crises • Family Psychotherapy • Multiple-family group therapy • Group Psychotherapy (other than of a multiple-family group) • Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service	• Individual Counseling • Group Counseling	• Single Modality to One Area • Single Procedure to One Area • Treatment Including a Combination of Any Modalities and Procedures (One or More Areas) • Hubbard Tank or Pool Therapy with Therapeutic Exercise • Any of the Tests and Measurements • Physical Therapy Preliminary Evaluation Rehabilitation Center

COVID-19 vaccinations constituted a majority of the expanded services that members used. However, no substance use claims were submitted. Members also used mental health services, which included neuropsychological evaluations, therapy sessions alone and with family, and crisis counseling. Over the duration of the program, about 5% of total service claims were for the expanded services.

The percentages shown below reflect the proportions of total annual service claims that were included in the expanded services categories each year. Expanded services had the greatest utilization in 2021 because the coverage of COVID-19 vaccinations acted retroactively to when they were approved and distributed in 2021. The one claim in 2020 was for a developmental/behavioral screening, a mental health service that was covered retroactively.

Table 17. Expanded Services Claims Stratified by Pilot Program Year

	2019 N = 16,784	2020 N = 29,030	2021 N = 31,372	2022 N = 61,312	2023 N = 25,957
Expanded Service Claims	0 (0%)	1 (<0.1%)	3,516 (11%)	1,440 (2.3%)	822 (3.2%)

Members used expanded services less than the primary care and preventive services that were included from the beginning of the program, but there are fewer expanded services overall. Clinics likely differed in the resources they had for mental health services, substance use services, and physical therapy services; for example, only one clinic submitted claims for physical therapy.

Table 18. Expanded Services Claims Stratified by Categories

Expanded Service Category	COVID-19	Mental Health	Physical Therapy
Total N = 7,057	4,376 (62%)	2,633 (37%)	48 (0.7%)

Members at Marin Community Clinics, Community Health Clinic Ole, and Ole Health Fairfield used more of the expanded services than at other clinics. At Community Health Clinic Ole, Ole Health Fairfield, Mendocino Community Health Clinic, Southwest Community Health Center, Little Lake Health Center, Del Norte Community Health Center, Salud Clinic, and Bolinas Family Practice, more mental health service claims were submitted than COVID-19 vaccination claims. The rest of the clinic sites utilized COVID-19 vaccination coverage more than mental health services. The appendix includes a table of the specific procedures and services that were included in the COVID-19 and Mental Health categories.

Table 19. COVID-19 and Mental Health Service Utilization Across Sites

	Covid-19, N = 4,376[1]	Mental Health, N = 2,633[1]
Clinic Site		
MARIN COMMUNITY CLINIC	3,324 (76%)	1,085 (41%)
COMMUNITY HEALTH CLINIC OLE	102 (2.3%)	356 (14%)
OLE HEALTH FAIRFIELD	21 (0.5%)	270 (10%)
MENDOCINO COMMUNITY HEALTH CLINIC	6 (0.1%)	230 (8.7%)
SOUTHWEST COMMUNITY HEALTH CENTER	24 (0.5%)	161 (6.1%)
SAN BENITO HEALTH FOUNDATION	140 (3.2%)	0 (0%)
PETALUMA HEALTH CENTER	67 (1.5%)	71 (2.7%)
AMPLA HEALTH CHICO MEDICAL	110 (2.5%)	20 (0.8%)
ROHNERT PARK HEALTH CENTER	40 (0.9%)	53 (2.0%)
LITTLE LAKE HEALTH CENTER	0 (0%)	86 (3.3%)
AMPLA HEALTH LINDHURST MEDICAL	70 (1.6%)	8 (0.3%)
AMPLA HEALTH RICHLAND MEDICAL	58 (1.3%)	14 (0.5%)
LA CLINICA NORTH VALLEJO	31 (0.7%)	32 (1.2%)
COMMUNITY MEDICAL CENTERS	36 (0.8%)	25 (0.9%)
AMPLA HEALTH YUBA CITY MEDICAL	39 (0.9%)	14 (0.5%)
LA CLINICA VALLEJO	43 (1.0%)	6 (0.2%)
SANTA ROSA COMMUNITY HEALTH	26 (0.6%)	19 (0.7%)
VISTA FAMILY HEALTH CENTER	27 (0.6%)	18 (0.7%)
DEL NORTE COMMUNITY HEALTH CENTER	6 (0.1%)	35 (1.3%)
COMMUNITY HEALTH CLINIC	0 (0%)	38 (1.4%)
AMPLA HEALTH COLUSA MEDICAL	30 (0.7%)	0 (0%)
AMPLA HEALTH OROVILLE MEDICAL	20 (0.5%)	8 (0.3%)
AMPLA HEALTH ARBUCKLE MEDICAL	24 (0.5%)	0 (0%)
EUREKA COMMUNITY HEALTH CENTER	16 (0.4%)	5 (0.2%)
FORTUNA COMMUNITY HEALTH CENTER	20 (0.5%)	0 (0%)
AMPLA HEALTH GRIDLEY MEDICAL	19 (0.4%)	0 (0%)
DAVIS COMMUNITY CLINIC	4 (<0.1%)	14 (0.5%)
AMPLA HEALTH HAMILTON CITY MEDICAL	16 (0.4%)	0 (0%)
HANSEN FAMILY HEALTH CENTER	4 (<0.1%)	12 (0.5%)
LAKESIDE HEALTH CENTER	0 (0%)	16 (0.6%)
AMPLA HEALTH ORLAND MEDICAL	13 (0.3%)	0 (0%)
TELEHEALTH & VISITING SPECIALIST	11 (0.3%)	2 (<0.1%)
PLACERVILLE CENTER	0 (0%)	11 (0.4%)
NORTHCOUNTRY CLINIC	10 (0.2%)	0 (0%)
SALUD CLINIC	2 (<0.1%)	8 (0.3%)
DORA STREET HEALTH CENTER	2 (<0.1%)	4 (0.2%)
COMMUNITY MEDICAL CENTER	3 (<0.1%)	2 (<0.1%)

	Covid-19, N = 4,376[1]	Mental Health, N = 2,633[1]
BOLINAS FAMILY PRACTICE	1 (<0.1%)	2 (<0.1%)
REDWOOD COMMUNITY HEALTH CENTER	3 (<0.1%)	0 (0%)
RITTER CENTER	3 (<0.1%)	0 (0%)
AMPLA HEALTH LOS MOLINOS MEDICAL	2 (<0.1%)	0 (0%)
ANDERSON FAMILY HEALTH AND DENTAL CENTER	0 (0%)	2 (<0.1%)
HUMBOLDT OPEN DOOR CLINIC	2 (<0.1%)	0 (0%)
OLE HEALTH ST HELENA	0 (0%)	2 (<0.1%)
PEACH TREE CLINIC	0 (0%)	2 (<0.1%)
SHASTA COMMUNITY MATERNITY CENTER	0 (0%)	2 (<0.1%)

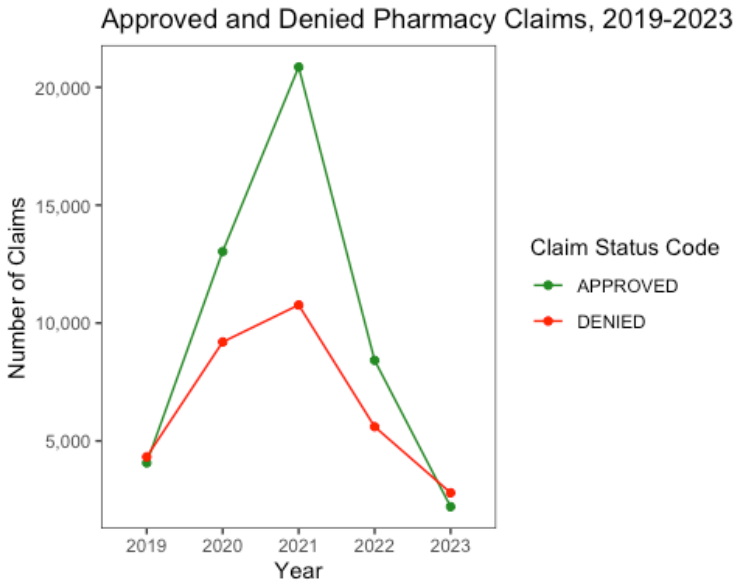
Pharmacy Claims

Pharmacy claims submitted for reimbursement through PTH include prescription medications prescribed at a participating clinic. The pharmacy claims dataset that we analyzed included 48,597 approved and 32,700 denied pharmacy claims. Overall, 3,705 pharmacies submitted pharmacy claims, with the most claims submitted in 2021. Pharmacy claims were denied if medications were not covered by the program, if members had reached the $1,500 PTH cap in 6 months, or if a refill was requested too quickly.

Total Pharmacy Claims and Members with Pharmacy Claims

The graph below shows that approved claims increased near linearly from 2019 through 2021, then decreased in 2022 and 2023. Denied claims followed a similar pattern, though less steeply.

Figure 15. Pharmacy Claims Over Time

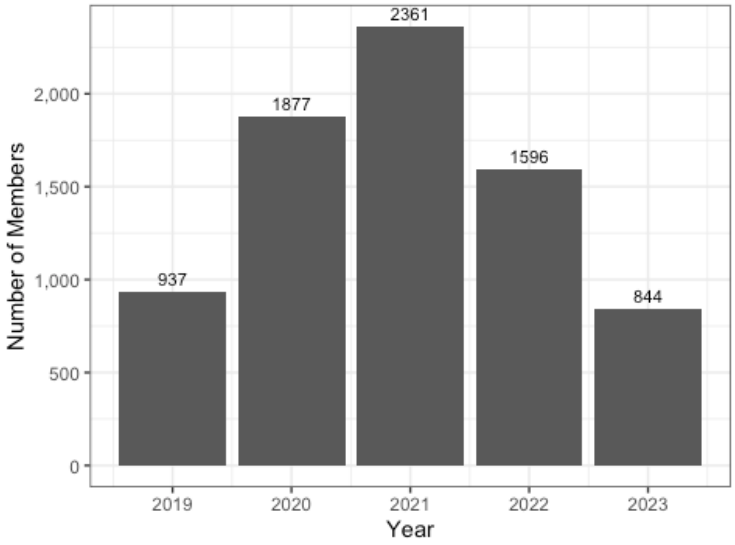


Both of these decreases mirror the smaller number of pharmacy claims in 2022 and 2023. Overall, this is related to the overall decrease in members (for example, members gaining Medi-Cal coverage and no longer needing PTH coverage). As shown in the graph below, the most pharmacy claims for PTH members were submitted in 2021. In 2021, the increasing number of pharmacy claims for members from 2019-2021 reflects the steady increase in membership throughout the program rollout. The most members had prescriptions filled in 2021, reflecting the larger member population during that year.

Overall, 3,705 pharmacy claims for members were submitted. Each member on the y-axis below had at least one claim submitted. Of these, 73 members had at least one claim at

340B pharmacy. 340B pharmacies offer reduced prices for drugs through government contracts.

Figure 16. Member Utilization of Pharmacy Claims



The average and median number of claims per member, for 3,097 members across 2019-2023, are shown in the table below. In all columns, the total N represents the number of unique pharmacy claims submitted for members in each year. The median number of claims submitted per member during COVID-19 (March 2020 – March 2023) was 6, which was two times the median claims submitted per member before the pandemic. Some of this may be associated with claims related to COVID-19, but is also likely related to increase in the Path to Health program reach. Clinics were added in phases before and during the pandemic.

Table 20. Average and Median Pharmacy Claims per Member

	2019, N = 766	2020, N = 1,457	2021, N = 1,972	2022, N = 1,195	2023, N = 479
Pharmacy Claims					
Mean (SD)	5 (6)	9 (12)	11 (14)	7 (9)	5 (5)
Median (Range)	3 (1, 44)	5 (1, 112)	5 (1, 103)	4 (1, 66)	3 (1, 42)

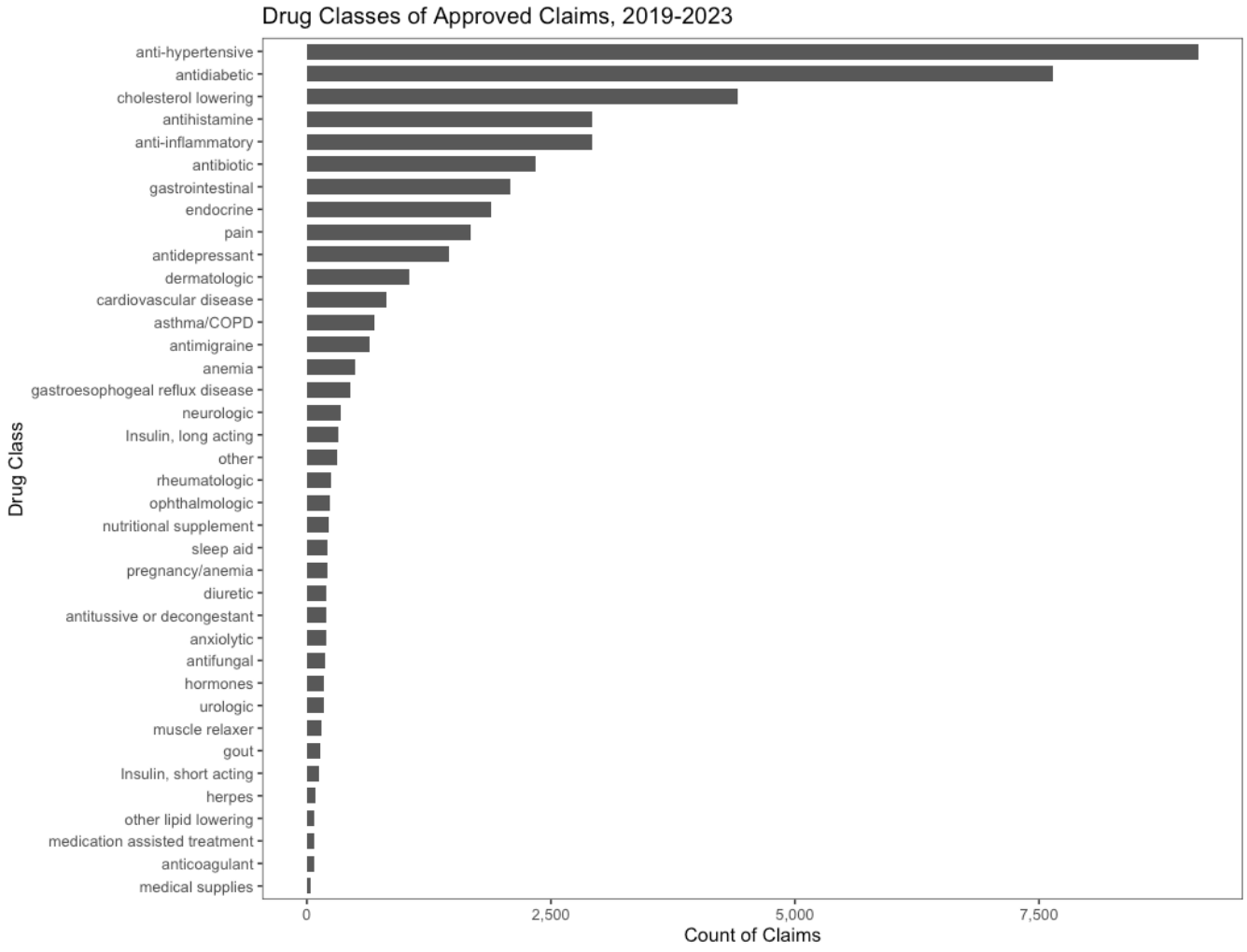
Drug Classes of Pharmacy Claims

To assess drug classes of pharmacy claims, we joined CMSP claims data with a UCLA-created resource with generic drug names, drug classes, and mechanisms. Of all pharmacy claims, 14,403 do not have a drug class label (i.e., the drug class was unlabeled; this could be due to the drug itself not being in the generic drug name list that was used to join drug classes to the drug name). Drug classes with fewer than 150 individual claims

were collapsed into an “other” category, which includes immunosuppressive, acne, weight loss, antipsychotic, and oncologic classes.

Anti-hypertensive, antidiabetic, and cholesterol lowering drug classes were the first, second, and third most frequent drug classes of approved claims across the program period. Members also submit nearly 3,000 claims for drugs of each of the antihistamine (N = 2,925) and anti-inflammatory (N = 2,917) classes. There were slightly more claims for cardiovascular disease drugs (N = 821) than asthma/COPD drugs (N = 693), and over 2,000 claims for antibiotic (N = 2,340) and gastrointestinal (N = 2,084) drug classes.

Figure 17. Drug Classes of Pharmacy Claims



Similarly to prior reports, at the pharmacy claim level (not the unique patient level), Metformin Hcl, Atorvastatin Calcium, and Lisinopril were the top three most common prescriptions across the program duration. Four drugs in the top ten most frequent prescriptions were anti-hypertensive. Two were antidiabetic.

Table 21. Most Frequent Prescriptions

Generic Name	Therapeutic Class	Count	Percent (%)
METFORMIN HCL	antidiabetic	4411	9.08
ATORVASTATIN CALCIUM	cholesterol lowering	3025	6.22
LISINOPRIL	anti-hypertensive	2942	6.05
LEVOTHYROXINE SODIUM	endocrine	1730	3.56
IBUPROFEN	anti-inflammatory	1413	2.91
GLIPIZIDE	antidiabetic	1222	2.51
OMEPRAZOLE	gastrointestinal	1171	2.41
LOSARTAN POTASSIUM	anti-hypertensive	1022	2.10
AMLODIPINE BESYLATE	anti-hypertensive	1000	2.06
HYDROCHLOROTHIAZIDE	anti-hypertensive	999	2.06

We observed differences in the types of drugs that members filled prescriptions for when the requirement to be enrolled in emergency/restricted scope Medi-Cal, in order to be a PTH member, was lifted on June 1, 2021. The latter time period also included when members over 50 years old were moved off of Path to Health and onto full-scope Medi-Cal, which may have also impacted the types of prescriptions members had filled, since only about 300 people enrolled in Path to Health without emergency/restricted scope Medi-Cal.

The table below shows that claims from the member population after the emergency/restricted scope Medi-Cal requirement was lifted filled higher proportions of anti-hypertensive, antidiabetic, and cholesterol lowering drugs. However, that population filled fewer prescriptions for long-acting Insulin (0.5% vs. 0.9%). Overall, members filled more prescriptions when PTH covered adults over 50, which corresponded with the time period after the requirement was lifted. The p-value of <0.001 suggests that there is a statistically significant difference between the drug classes overall of pharmacy claims from members before and after the emergency/restricted scope Medi-Cal eligibility requirement was lifted.

Table 22. Differences in Drug Classes for Prescriptions During and After Emergency/Restricted Scope Medi-Cal Requirement

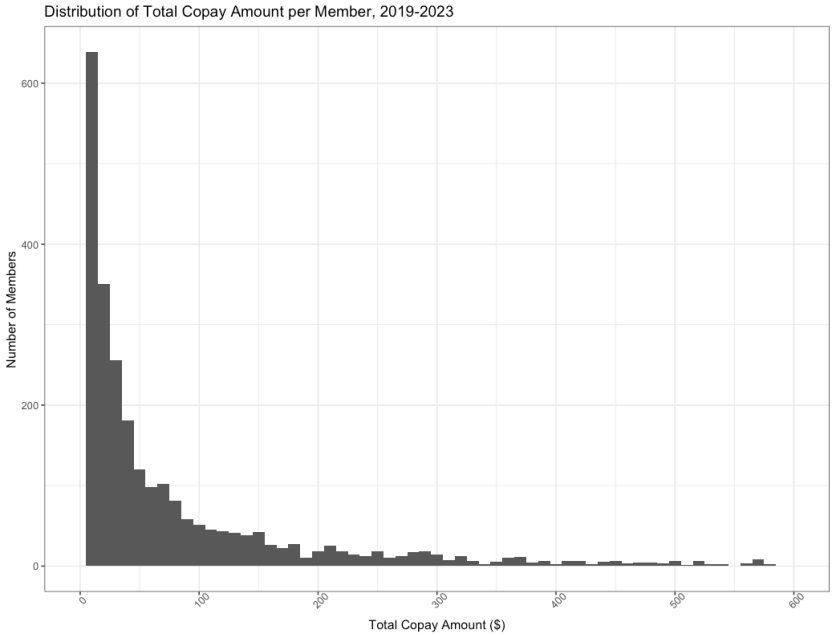
	Before Requirement Removed, N = 25,462	After Requirement Removed, N = 23,135	p-value
Drug Class			<0.001
anti-hypertensive	4,614 (20%)	4,519 (21%)	
antidiabetic	3,872 (16%)	3,775 (18%)	
cholesterol lowering	2,155 (9.2%)	2,253 (11%)	
antihistamine	1,668 (7.1%)	1,257 (6.0%)	
anti-inflammatory	1,594 (6.8%)	1,323 (6.3%)	
antibiotic	1,306 (5.6%)	1,034 (4.9%)	
gastrointestinal	1,159 (4.9%)	925 (4.4%)	
endocrine	878 (3.7%)	1,011 (4.8%)	
pain	916 (3.9%)	764 (3.6%)	
antidepressant	745 (3.2%)	710 (3.4%)	
dermatologic	628 (2.7%)	427 (2.0%)	
cardiovascular disease	484 (2.1%)	337 (1.6%)	
asthma/COPD	415 (1.8%)	278 (1.3%)	
antimigraine	371 (1.6%)	271 (1.3%)	
anemia	251 (1.1%)	240 (1.1%)	
gastroesophogeal reflux disease	140 (0.6%)	305 (1.4%)	
neurologic	207 (0.9%)	137 (0.6%)	
Insulin, long acting	210 (0.9%)	111 (0.5%)	
other	159 (0.7%)	152 (0.7%)	
rheumatologic	173 (0.7%)	81 (0.4%)	
ophthalmologic	164 (0.7%)	69 (0.3%)	
nutritional supplement	131 (0.6%)	94 (0.4%)	
sleep aid	122 (0.5%)	93 (0.4%)	
pregnancy/anemia	125 (0.5%)	83 (0.4%)	
diuretic	103 (0.4%)	100 (0.5%)	
antitussive or decongestant	120 (0.5%)	76 (0.4%)	
anxiolytic	125 (0.5%)	68 (0.3%)	
antifungal	90 (0.4%)	97 (0.5%)	
hormones	77 (0.3%)	97 (0.5%)	

	Before Requirement Removed, N = 25,462	After Requirement Removed, N = 23,135	p-value
urologic	86 (0.4%)	85 (0.4%)	
muscle relaxer	68 (0.3%)	76 (0.4%)	
gout	66 (0.3%)	65 (0.3%)	
insulin, short acting	62 (0.3%)	58 (0.3%)	
herpes	55 (0.2%)	36 (0.2%)	
other lipid lowering	42 (0.2%)	34 (0.2%)	
medication assisted treatment	35 (0.1%)	40 (0.2%)	
anticoagulant	44 (0.2%)	27 (0.1%)	
medical supplies	32 (0.1%)	12 (<0.1%)	

PTH Member Copay Amounts

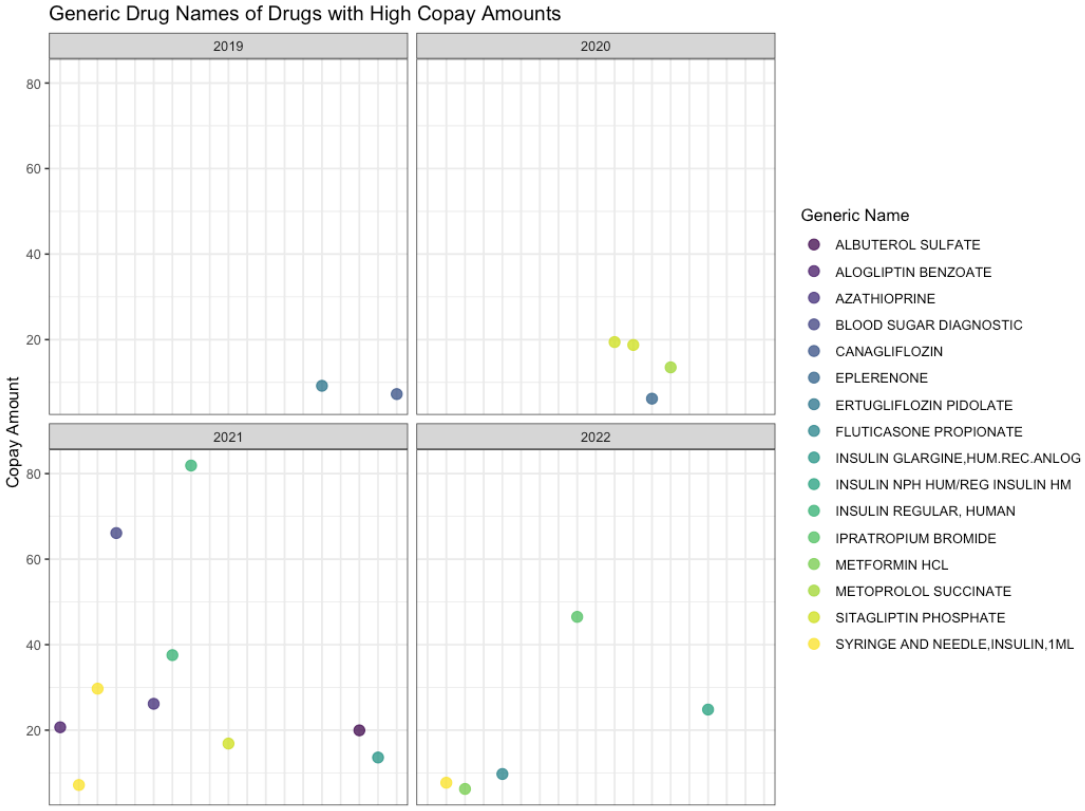
The graph below depicts a histogram of the total copay amount each member paid per approved pharmacy claim across the 2019-2023 study period. Enrolled members are responsible for $5 co-pays per medication with a maximum of $500 per prescription and $1,500 for each 6-month enrollment period. Each bar of the histogram is $10 wide, suggesting that the vast majority of members paid $0-10 total in copays, across all approved claims.

Figure 18. Copay Amounts per Member



PTH set the copay limit as $5 per member per drug. However, in detailed analysis of pharmacy data we found that some reported copays were greater than $5. This could have been because, for example, brand-name drugs tend to be more expensive than generic, but a prescription may specify a brand-name drug. Members may have had to pay copays greater than $5 if a physician prescribed a brand-name drug, or if the pharmacy used coverage other than PTH for a patient. The most expensive copays of approved claims tended to be for insulin and anti-diabetic drugs, as shown below in Figure 19. No members paid over $5 for a copay in 2023.

Figure 19. Prescriptions with Copays Over $5



CMSP paid a median of $4.55, $3.55, and $2.61 per approved pharmacy claim before, during, and after the public health emergency, respectively. This suggests that more members using pharmacy benefits were receiving less expensive prescriptions in the last year of the program. This may also have been related to the 26-49 age range (i.e., not older adults) served in the last year of the program.

Summary and Conclusions

The Path to Health pilot program effectively partnered with rural community health clinic organizations in 29 CMSP counties. Though 35 counties total had access to Path to Health coverage, enrollment data showed participation in 29 of these counties. The pilot increased access to timely primary care and preventive services for members, and clinics were able to redirect resources as a result. Path to Health had continuous enrollment throughout the duration of the program from 2019-2023 and provided coverage for primary care office visits, routine labs, office-based minor procedures, preventive and viral screenings, adult immunizations, prescription medications, COVID-19 services, physical therapy, and mental health and substance use services. Previous evaluation reports described results from the qualitative interviews with members and key stakeholders from partner clinics, site visits, telephone patient experience surveys, and analysis of limited datasets (2019 – 2021). This final report includes additional analyses of data from across the program's duration (2019-2023).

In considering all evaluation analyses across the five years of the coverage pilot program, we highlight the following summary and conclusions:

- 19,415 patients enrolled in the Path to Health pilot program between February 2019 and December 2023.
- There were high levels of satisfaction with the pilot among members and participating clinical organizations. The 2020-2021 telephone survey respondents from the pilot program (n=200) reported a high satisfaction rate with the program. Of the 96% of respondents who reported they were very/somewhat satisfied with the program, most were very satisfied (81%).
- Early evaluation activities confirmed that the pilot program was strongly endorsed by partner Clinic Organizations during site visits and key stakeholder interviews. Trusted clinic partners were a key component to the implementation success of the pilot.
- The program enabled partner Clinic Organizations to deliver covered services to eligible patients and redirect existing resources to other clinic needs such as services to those remaining uninsured, clinic outreach, staff trainings, health education programs, enrollment counselors, new medical staff, new clinic programs, and additional administrative needs.

The 8-item survey administered at the time of enrollment in Path to Health was an important source of patient self-reported outcomes. Trends and results from this analysis were consistent throughout the five years of the pilot program. The final analysis using all enrollment surveys from 2019 to 2023 showed consistent and important pilot program findings:

- Across members who took at least two enrollment surveys, we observed changes in emergency department use in the six months prior to each survey. A smaller proportion of members utilized emergency services later in the program. Proportions of self-reported hospitalizations also decreased among members' last survey responses.
- Members self-reported fewer delays in care than they had previously experienced due to high cost of services.
- More members self-reported better health status than poorer health status when comparing their final enrollment surveys to their first enrollment surveys. The medical literature has established that poorer self-reported health status is correlated with health service utilization, mortality, and chronic diseases. 40% of members self-reported at least one preexisting chronic condition.
- Members who had more than five years in the US, a chronic condition, and/or identified as female were more likely to re-enroll in the pilot program.

Claims data analyses demonstrated the program provided coverage for primary care services for patients with diabetes mellitus, high blood pressure, high cholesterol, and other chronic conditions. Pharmacy claims support a similar trend in medication treatment for predominantly patients with chronic medical conditions that require an ongoing source of regular primary care and access to prescription medications for disease management and for optimal health.

- Type 2 diabetes, hypertension, and cholesterol/hyperlipidemia were the primary reasons for 15.6% of the pilot's service claims. The majority of services were for Type 2 diabetes, hypertension, and immunizations, including vaccinations and boosters for COVID-19.
- CMSP processed the most pharmacy claims in 2021. In 2021, the member population was larger, since Medi-Cal expanded to include all members over 50 years old in 2022. Not all Path to Health members submitted pharmacy claims, but the average number of pharmacy claims submitted per member was at least five annually. Members with chronic conditions were more likely to submit pharmacy claims.

The pilot adapted to the COVID-19 public health emergency in California by automatically continuing enrollments for members and providing important and relevant COVID-19 services, including testing, vaccinations, and boosters. During the pandemic primary care relied heavily on telehealth visits, either by telephone or video. CMSP also successfully adapted and implemented reimbursement for claims related to telehealth services.

- Members utilized these COVID-19 services during the public health emergency, which filled a critical gap for this population that was disproportionately impacted by COVID-19. CMSP saw increased paid claims for services provided in 2022,

reflecting expanded coverage of COVID-19 immunizations, which applied retroactively to vaccines and boosters that patients received in 2021.

- The Path to Health pilot had a favorable re-enrollment rate of 66% before the institution of automatic re-enrollments in March 2020 due to the COVID-19 pandemic. This rate was higher than that of similar programs in large urban counties.

In 2022, Path to Health expanded coverage to include mental health, substance use, and physical therapy services. Site visit and key stakeholder interviews previously identified these services as priority areas for partner clinic organizations.

- Of these categories, members used mental health services, such as individual and family counseling, the most. Substance use services were not utilized. However, this may reflect larger systemic challenges with access to substance use services across the state, specifically in rural areas.

As more Californians gain Medi-Cal coverage, these findings support early learnings about healthcare utilization among uninsured populations in CMSP counties. Although recent Medi-Cal expansions should increase reach to low-income and undocumented populations, CMSP programs are critical to ensuring coverage among those vulnerable populations who do not meet eligibility requirements for Medi-Cal. Future or current CMSP programs for populations that remain underinsured – for example, those who make slightly above the income requirements for Medi-Cal but do not receive health insurance through work – can use these data to inform future program implementation, evaluations, priorities and needs in CMSP counties.

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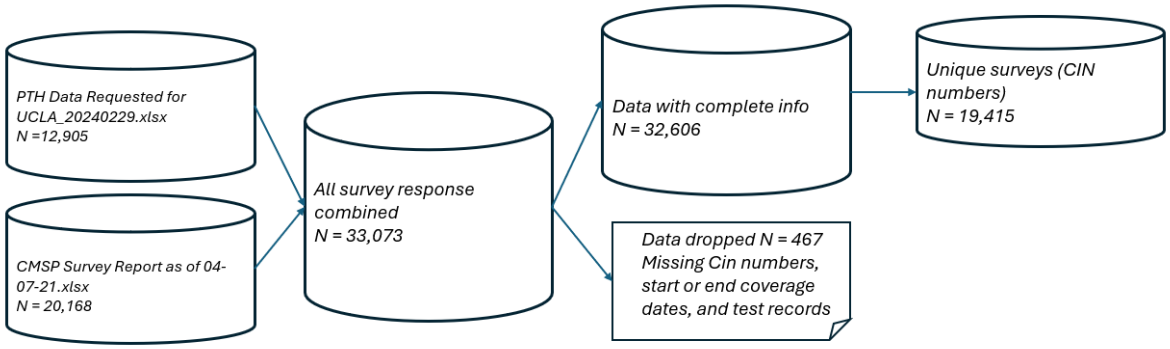
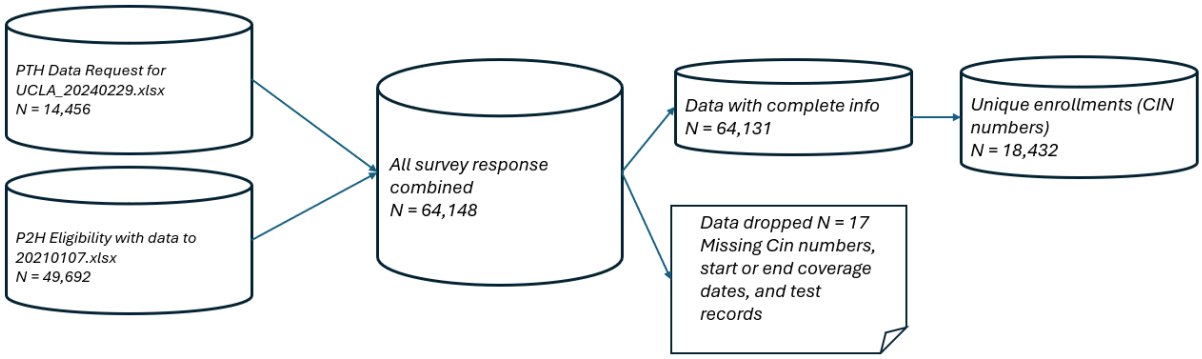
Appendix

A.1. Data Flow Chart for Enrollment Survey Data



A.2. Data Flow Chart for Enrollment Transaction Data



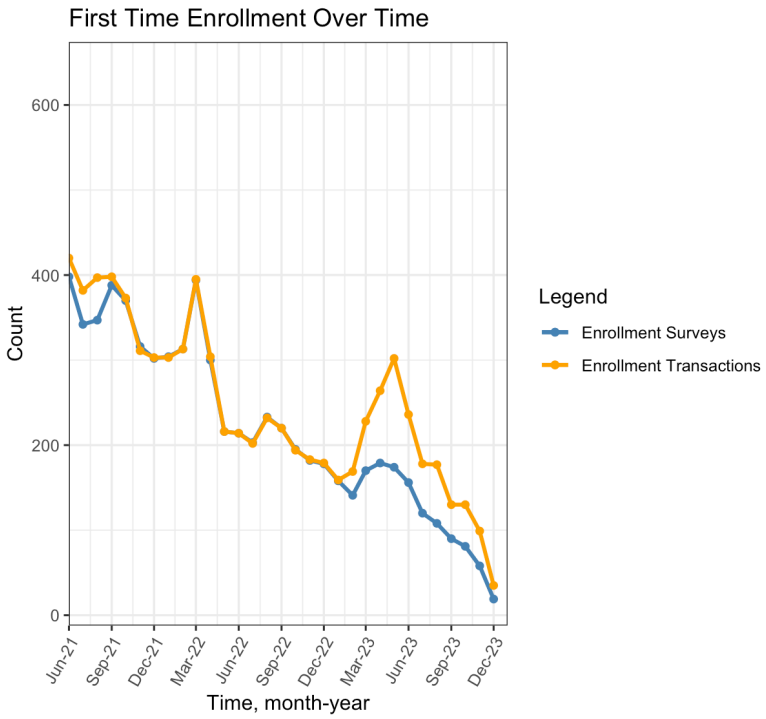
A.3 Enrollment Survey: All First-Time Enrollments 2019-2023

	N	N = 19,415
How did you first hear about Path to Health	18,995	
Clinic or hospital employee		18,263 (96%)
Friend or family member		611 (3.2%)
Printed materials or flyer		70 (0.4%)
Social Media or online		30 (0.2%)
Radio or TV		21 (0.1%)
Self-reported health status	13,433	
Good		9,894 (74%)
Poor		1,530 (11%)
Very good		1,271 (9.5%)
Excellent		738 (5.5%)
Delays in care due to cost	18,377	
No		11,622 (63%)
Yes		6,572 (36%)
Don't know		183 (1.0%)
Delays in medication due to cost	1,235	
No		909 (74%)
Yes		319 (26%)
Don't know		7 (0.6%)
Emergency department use in the last 6 months	18,345	
0		13,608 (74%)
1-2		4,245 (23%)
3-4		399 (2.2%)
5 or more		93 (0.5%)
Hospitalizations use in the last 6 months	18,317	
0		16,712 (91%)
1-2		1,307 (7.1%)
3-4		182 (1.0%)
5 or more		116 (0.6%)
Primary care office visit in the last 6 months	18,349	
1-2		7,173 (39%)

	N	N = 19,415
0		6,001 (33%)
3-4		3,013 (16%)
5 or more		2,162 (12%)
Pre-existing chronic conditions	17,457	
No		10,414 (60%)
Yes 1-2		6,123 (35%)
Yes 3 or more		920 (5.3%)
Years in the US	11,729	
5 or more		10,384 (89%)
1-2		544 (4.6%)
3-4		533 (4.5%)
0		268 (2.3%)

A.4. Enrollment Survey Data and Transaction Data, 2019-2023

Since the final evaluation covered June 2021 – December 2023, we received enrollment transaction data covering that period. However, there was a gap in transaction data between January 2021 – June 2021. The survey enrollments and transaction data align before and after that period of time. This was our rationale for using enrollment survey data to count first-time enrollments, which proxies new members.



A.5. Expanded Services: Procedures Across Clinics 2019 – 2023

Clinic Site	Procedure	Total
MARIN COMMUNITY CLINIC	COVID-19 vaccine administration, second dose.	1117
MARIN COMMUNITY CLINIC	COVID-19 vaccine administration, first dose.	960
MARIN COMMUNITY CLINIC	Psychotherapy	534
COMMUNITY HEALTH CLINIC OLE	Psychotherapy	178
OLE HEALTH FAIRFIELD	Psychotherapy	135
MENDOCINO COMMUNITY HEALTH CLINIC	Psychotherapy	115
SOUTHWEST COMMUNITY HEALTH CENTER	Psychotherapy	83
MARIN COMMUNITY CLINIC	COVID-19 vaccine administration, third dose.	56
MARIN COMMUNITY CLINIC	COVID-19 vaccine administration, booster dose.	54
COMMUNITY HEALTH CLINIC OLE	COVID-19 vaccine administration, booster dose.	51
LITTLE LAKE HEALTH CENTER	Psychotherapy	43
COMMUNITY HEALTH CLINIC OLE	COVID-19 vaccine administration, first dose.	42
AMPLA HEALTH CHICO MEDICAL	COVID-19 vaccine administration, first dose.	38
SAN BENITO HEALTH FOUNDATION	COVID-19 vaccine administration, first dose.	36
SAN BENITO HEALTH FOUNDATION	COVID-19 vaccine administration, second dose.	36
PETALUMA HEALTH CENTER	Psychotherapy	35
ROHNERT PARK HEALTH CENTER	Psychotherapy	27
PETALUMA HEALTH CENTER	COVID-19 vaccine administration, initial dose.	25
AMPLA HEALTH CHICO MEDICAL	COVID-19 vaccine administration, second dose.	24
AMPLA HEALTH LINDHURST MEDICAL	COVID-19 vaccine administration, first dose.	23

Clinic Site	Procedure	Total
AMPLA HEALTH RICHLAND MEDICAL	COVID-19 vaccine administration, first dose.	23
PETALUMA HEALTH CENTER	COVID-19 vaccine administration, third dose.	23
SANTA ROSA COMMUNITY HEALTH	COVID-19 vaccine administration, first dose.	23
DEL NORTE COMMUNITY HEALTH CENTER	Psychotherapy	22
ROHNERT PARK HEALTH CENTER	COVID-19 vaccine administration, third dose.	21
SOUTHWEST COMMUNITY HEALTH CENTER	COVID-19 vaccine administration, first dose.	21
AMPLA HEALTH LINDHURST MEDICAL	COVID-19 vaccine administration, second dose.	20
COMMUNITY HEALTH CLINIC	Psychotherapy	19
VISTA FAMILY HEALTH CENTER	COVID-19 vaccine administration, first dose.	19
LA CLINICA NORTH VALLEJO	Psychotherapy	17
AMPLA HEALTH YUBA CITY MEDICAL	COVID-19 vaccine administration, first dose.	13
COMMUNITY MEDICAL CENTERS	COVID-19 vaccine administration, first dose.	12
COMMUNITY MEDICAL CENTERS	Psychotherapy	12
LA CLINICA VALLEJO	COVID-19 vaccine administration, first dose.	12
AMPLA HEALTH RICHLAND MEDICAL	COVID-19 vaccine administration, second dose.	11
MARIN COMMUNITY CLINIC	COVID-19 vaccine administration, initial dose.	11
PLACERVILLE CENTER	Psychotherapy	11
SAN BENITO HEALTH FOUNDATION	COVID-19 vaccine administration, third dose.	11