California Initiative for Health Equity & Action (Cal-IHEA)

Research Brief

Older Undocumented Enrollees in My Health LA were Less Likely to be Hospitalized After an ED Visit

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Executive Summary

In May 2022, California expanded its full-scope Medicaid health coverage program (Medi-Cal) to low-income undocumented adults aged 50 years or older. This research brief examines Emergency Department (ED) utilization trends among older undocumented adults in Los Angeles (LA) County public hospitals before the 50+ Medi-Cal expansion. We describe healthcare utilization trends using hospital electronic health records (2016-2020).

In 2014, LA County launched the My Health LA (MHLA) program to address constraints with emergency episodic care and limited continuity of primary care for undocumented immigrants. We investigate ED visits resulting in hospital admissions (i.e., ED-originating hospital admission) for three groups: 1) documented immigrant patients (i.e., naturalized citizens or lawful permanent residents) with full-scope Medi-Cal, 2) undocumented patients without MHLA, 3) undocumented patients with MHLA. We also identify leading health conditions prompting treat-and-release ED visits (i.e., discharged home) and ED-originating hospital admissions.

Results reveal that older undocumented adults with MHLA had a comparable number of ED visits (5.9 visits) as documented immigrants with full-scope Medi-Cal ***but were less likely to be hospitalized during those ED visits***. Around 17% of ED visits from undocumented MHLA patients resulted in a hospital admission compared to 23% of documented immigrant patients. Results suggest that older undocumented adults in MHLA more effectively manage their medical conditions outside the ED, likely in their assigned medical home at a local community health center (CHC). Older undocumented adults without MHLA had fewer ED visits overall (5.7 visits), but 1 in 5 of those visits (21%) resulted in hospital admissions. This indicates that undocumented adults without MHLA may have had more significant healthcare needs when they engaged with the healthcare system through the ED.

Findings offer a baseline to evaluate future shifts in healthcare-seeking behaviors and ED use among older immigrants after the 50+ Medi-Cal expansion. Policy and programmatic recommendations are provided to promote timely receipt of preventive care and to mitigate severe health needs for older undocumented immigrants as they transition to obtaining health coverage through the state's Medi-Cal expansion effort.

Background

Demographic shifts will lead to higher healthcare needs among older undocumented populations. By 2038, an estimated 39% of the undocumented U.S. population will be aged 50 years or older—a significant rise from 6% in 2018.[1] This demographic shift will likely result in higher demand for age-related healthcare services, including chronic care management. Few studies have examined how older undocumented patients, who have been historically excluded from federal government insurance programs like Medicaid and Medicare, navigate the healthcare system. Overall, people without legal status use significantly ***less*** healthcare than their U.S.-born counterparts, likely due to structural and political factors and cost-based barriers.[2] Limited healthcare access may result in underdiagnosed chronic conditions and advanced disease progression.[3] Older undocumented individuals face considerable barriers to preventive and ambulatory care, which may further exacerbate their ED utilization to manage chronic conditions and address age-related health issues.[4]

Local efforts to enhance healthcare access have been critical safety nets for older undocumented patients. Evidence from LA County Community Health Centers (CHCs) reveals that ***undocumented patients aged 50 years or older were more likely to have a physician-diagnosed chronic condition compared to full-scope Medi-Cal patients with legal status.*** They were also more likely to receive certain vaccines (e.g., shingles, flu, COVID-19 vaccines) and colon cancer screenings. Increased healthcare access among undocumented older adults is likely due to preventive care availability in MHLA-affiliated CHCs. In New York City, a similar program resulted in 23% fewer ED visits by improving access to primary care for participating undocumented adults.[5]

Despite local efforts to improve healthcare access for undocumented adults, little is known as to how older undocumented patients navigate emergency healthcare services or their ED utilization trends. This brief examines how older undocumented adults used EDs before California's 50+ Medi-Cal expansion. Our results establish baseline trends for older undocumented adults' medical needs in the ED and will help design effective healthcare programs to meet this population's health care needs.

State Policy Context & Los Angeles County's MHLA Program

Beginning May 1, 2022, California expanded full-scope Medi-Cal coverage to low-income undocumented adults 50 years or older after expanding coverage for young adults (19-25 years old) in 2020. Previously, certain undocumented patients in California received covered preventive care contingent on local programs and funding availability. Restricted Medi-Cal ("Emergency Medi-Cal") covered limited services, including for specific acute conditions or injuries within the ED.

To address the constraints of emergency episodic care and limited continuity of care for undocumented immigrants, Los Angeles (LA) County launched the My Health LA (MHLA) program in 2014. MHLA offered primary care services to low-income adults without access to full-scope Medi-Cal due to immigration status requirements. MHLA facilitated ongoing care through patient-centered medical homes at community health centers (CHCs) and specialty services in the LA County Department of Health Services healthcare system. Approximately 880,000 undocumented residents reside in LA County, comprising >40% of California's 1.9 million undocumented immigrants (2021). MHLA served an average of 135,000 undocumented participants per year. MHLA was discontinued in 2024 after the state expanded full-scope Medi-Cal to low-income undocumented adults aged 26-49 years.

Results

Table 1 provides demographic characteristics of ED encounters (n=239,861) for immigrant patients aged 50 years or older in LA County from 2016-2020. Results are shown for three groups: 1) documented immigrant patients, 2) undocumented patients without MHLA, and 3) undocumented patients with MHLA. A majority of ED encounters were for Hispanic/Latino patients and a majority spoke Spanish. Among documented immigrants, 10% identified as non-Hispanic Asian. Documented immigrants were slightly older on average (61.6 years ± 8.5) compared to undocumented patients enrolled (60.3 ± 8.8) and not enrolled (60.8 ± 9.6) in MHLA. Females were more prevalent among MHLA patient encounters (58.9%) than non-MHLA undocumented (52%) and documented immigrant patient encounters (53.8%). Undocumented patients with MHLA (5.9 ± 6.5) had a similar number of ED visits as documented immigrant patients with full-scope Medi-Cal (5.9± 7.2).

Table 1. Descriptive characteristics of ED encounters among immigrant patients 50 years+ in LA County safety-net hospitals, LADHS ED Encounters 2016-2020 (n=239,861)

	Documented Immigrants n=95,460	Undocumented Non-MHLA n=102,372	Undocumented MHLA n=42,029	Total n=239,861
Demographic Characteristics				
Age (Mean ± SD)	61.6 ± 8.5	60.8 ± 9.6	60.3 ± 8.8	61.0 ± 9.0
% Female	53.8	52.0	58.9	53.9
Race/ethnicity				
Hispanic/Latino	78.3	88.7	93.7	85.4
NH-White	1.6	0.9	0.3	1.1
NH-Asian	10.2	5.1	3.7	6.9
NH-Black	3.3	1.5	0.5	2.0
NH-NHPI	0.2	0.1	0.0	0.2
NH-Other	5.4	2.9	1.6	3.7
NH-Unknown	1.1	0.8	0.2	0.8
Language				
English	20.8	8.9	4.9	12.9
Other	8.4	5.0	2.8	6.0
Spanish	70.8	86.1	92.3	81.1
% Homeless	3.0	2.0	1.2	2.3
Hospital ED Site				
Los Angeles General	46.0	48.9	49.1	47.8
Harbor-UCLA	23.8	22.0	19.0	22.2
Olive-View	30.2	29.2	31.9	30.1
Clinical Characteristics				
Hospital Inpatient Admission	23.0	20.6	16.8	20.9
# ED visits (Mean ± SD)	5.9 ± 7.2	5.7± 6.7	5.9± 6.5	5.8 ± 6.9
1+ Comorbidity	51.1	44.6	46.2	47.5

Note: NH = Non-Hispanic/Latino, ED = Emergency Department, NHPI = Native Hawaiian and Pacific Islander, SD= Standard deviation; percentages are displayed unless otherwise noted.

Undocumented MHLA patients were <u>less likely</u> to have an ED hospital admission compared to documented immigrant and undocumented patients without MHLA.

- Around 17% of ED visits from undocumented MHLA patients resulted in a hospital admission compared to 23% of documented immigrant patients with full-scope Medi-Cal. The share of ED visits that resulted in hospital admissions was **27% lower** for MHLA patients than documented counterparts. This trend remained *even after accounting for health conditions and demographic characteristics*.
- Undocumented older adults with MHLA may have specific protective factors against hospital admission and may engage more frequently with primary care providers – leading to better-managed chronic conditions and less severe ED visits. MHLA may have also enabled outpatient clinical pathways as alternatives to hospitalization for ED providers and patients, ensuring more effective care transitions and continuity of care.[6]

Health conditions prompting treat-and-release ED visits (i.e., visits that were discharged) among undocumented immigrants (both MHLA and non-MHLA) resembled those of their documented immigrant counterparts.

- Table 2 shows the top 10 leading conditions accounted for approximately 40% of treat-and-release visits in each group (documented: 39.7%, non-MHLA: 40.3%, MHLA: 43.3%).
- While category *rankings* were similar across all groups, we observed variations in the *distribution* of six clinical conditions. For instance, abdominal pain and other digestive signs

were ranked #1 across all groups, but MHLA patients had a higher share of these encounters (10.9%) compared to documented (9.1%) and non-MHLA patients (9.7%).

- Most diagnostic categories for treat-and-release visits were related to symptoms (not confirmed diagnoses) which is aligned with national statistics of treat-and-release ED visits.[7] This may be partly due to detailed charting for inpatient visits compared to ED visits.

Table 2. Top 10 diagnostic categories for ED treat-and-release visits among immigrant patients over 50 by patient legal status, LADHS ED Encounters 2016-2020 (n=239,861)

Treat-and-release ED visits	Documented Immigrant (n=73,503)		Undoc. Non-MHLA (n=81,284)		Undocumented MHLA (n=34,942)	
Top 10 Diagnostic Categories	%	Rank	%	Rank	%	Rank
Abdominal pain and other digestive/abdomen signs and symptoms	9.05%	1	9.66%	1	10.91%	1
Musculoskeletal pain, not low back pain	7.66%	2	7.44%	2	8.11%	2
Nonspecific chest pain	5.80%	3	5.79%	3	6.24%	3
Respiratory signs and symptoms	3.83%	4	3.64%	5	3.58%	5
Headache; including migraine	3.59%	5	3.84%	4	4.23%	4
Urinary tract infections	2.97%	6	2.89%	6	3.20%	6
Skin and subcutaneous tissue infections	1.79%	7	1.88%	7	1.87%	8
General sensation/perception signs and symptoms	1.74%	8	1.67%	9, 10	1.61%	9
Skin/Subcutaneous signs and symptoms	1.70%	9	1.67%	9, 10	1.52%	10
Diabetes mellitus with complication	1.54%	10	1.82%	8	2.04%	7

MHLA enrollees face similar health conditions but are less likely to suffer from psychotic disorders and schizophrenia than their documented counterparts.

- Septicemia was the most common cause of ED-originating hospital admissions among all three immigrant patient groups, consistent with national trends (Table 3).
- Among the ten most prevalent conditions for ED-originating hospital admissions in our sample, three cardiovascular conditions (i.e., heart failure, acute myocardial infarction, coronary atherosclerosis), diabetes with complications, UTIs, cerebral infarctions, biliary tract disease, and renal failure were also the most prevalent among U.S. hospitalized older adults.[8] Notably, schizophrenia spectrum and other psychotic disorders were more prevalent among documented immigrant patients.
- Results suggest a potential erosion of the "immigrant health advantage" as individuals acculturate and assume health risk profiles akin to the broader aging population.[9]

Table 3. Top 10 diagnostic categories for ED-originating hospital admissions among immigrant patients over 50 by patient legal status, LADHS ED Encounters 2016-2020 (n=239,861)

Hospital admissions	Documented Immigrant (n=21,957)		Undoc. Non-MHLA (n=21,088)		Undocumented MHLA (n=7,087)	
Top 10 Diagnostic Categories	%	Rank	%	Rank	%	Rank
Septicemia	9.42%	1	9.34%	1	8.98%	1
Hypertension with complications and secondary hypertension	6.82%	2	6.59%	2	7.82%	2
Diabetes mellitus with complication	2.85%	3	3.41%	4	4.31%	4
Acute myocardial infarction	2.27%	4	2.12%	5	2.09%	9
Biliary tract disease	2.13%	5	3.95%	3	4.47%	3
Fluid and electrolyte disorders	1.92%	6	1.76%	11, 12	1.89%	10
Other specified and unspecified liver disease	1.84%	7	1.91%	6	1.79%	11
Coronary atherosclerosis, other heart disease	1.75%	8	1.76%	11, 12	2.11%	8
Urinary tract infections	1.73%	9	1.85%	7	2.24%	5, 6
Schizophrenia spectrum and other psychotic disorders	1.69%	10	0.63%	55	0.20%	42
Nonspecific chest pain	1.62%	11	1.65%	13	2.18%	7
Cerebral infarction	1.58%	12	1.78%	10	1.45%	13
Acute and unspecified renal failure	1.51%	13	1.79%	9	2.24%	5, 6
Heart failure	1.44%	16	1.84%	8	1.18%	17

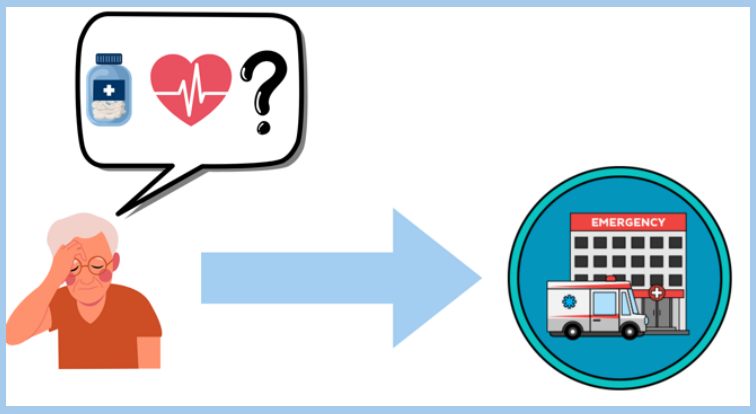
Note: Shaded cells represent rankings outside of the top 10 within each group; p-values are adjusted for multiple group comparisons.

Policy and Programmatic Recommendations

1 **Successful management of chronic conditions requires more than simply providing health coverage.** The positive outcomes among MHLA patients suggest that features of the program facilitated successful treatment of conditions in primary care and reduced the need for costly inpatient care. First, the transition to full-scope Medi-Cal should prioritize continuity of primary care. Having a CHC as a medical care home is key, as these clinics help patients address broader social determinants of health in addition to providing preventive care. This population will also benefit from CalAIM when officially enrolled in full-scope Medi-Cal. Medical homes could offer targeted outreach programs that offer culturally and linguistically appropriate resources to help older immigrant adults navigate the healthcare system. Programs should also aim to successfully tackle challenges beyond health coverage—like healthcare mis/distrust, fears about disclosing personal information, concerns about public charge programs and immigration status, and difficulties understanding and accessing healthcare institutions.

One important feature of CHC-based care is community health workers (CHWs) and patient navigators who are well-positioned to build trust in historically marginalized communities. CHWs can be a vital human resource that provide community-based health education focused on chronic disease management, timely routine screenings, and vaccination receipt among older immigrant populations regardless of legal status. Additional state or philanthropic funding for CBOs and healthcare organizations may be needed to adequately train CHWs, increase capacity building, and provide robust and sustained technical assistance, particularly in medically underserved communities. In clinical settings, the Department of Health Care Services (DHCS) can incentivize team-based care teams composed of clinical providers, community pharmacists, and CHWs to assist older undocumented immigrants in navigating the healthcare system, coordinating their care, and improving their medication adherence.

2 **Expand funding, capacity, and operational support for primary care services offered by CHCs to mitigate unnecessary ED use and hospital care.** Every year, CHCs provide care to 15 million Medicaid recipients nationwide, including 4.2 million patients enrolled in Medi-Cal in California. These figures highlight CHCs' critical role in providing care to low-income Medi-Cal recipients. Our study indicated undocumented older adults with MHLA had a lower probability of being hospitalized during their ED visit, likely because they were assigned to CHCs as their medical home for primary care and referrals to specialty care. As Medi-Cal gains occur, older undocumented immigrants will potentially continue to receive care from CHCs, especially as they may experience a difficult time finding a provider who accepts new patients outside these settings.[10]



Despite their importance in medically underserved communities, CHCs are already operating under significant constraints: workforce shortages, limited specialty care access, and unpredictable reimbursement. As the newly eligible Medi-Cal population expands, there is an urgent need to increase the pipeline of healthcare professionals (HCPs), including medical doctors, physician assistants, nurse practitioners, registered nurses, and other allied health professionals who can deliver culturally competent care. Policymakers can allocate state and federal funds to bolster educational programs that prepare these professionals to work in underserved communities. This includes promoting partnerships between healthcare institutions and community colleges to create pathways for

students from diverse backgrounds to enter the healthcare workforce and improve racial/ethnic and language concordance between providers and patients to improve health outcomes and healthcare experiences. Further, state and federal funds should include incentives for HCPs to work in underserved areas (i.e., robust loan forgiveness programs) and well-funded base grants from HRSA's Bureau of Primary Health Care. Other Medi-Cal managed care plans could replicate LA Care Health Plan's Provider Loan Repayment Program as an "effort to recruit high-quality primary care physicians into the Los Angeles County safety net."

Lastly, to continue providing essential primary care services, CHCs require increased and sustained federal funding to care for patients from capitated managed care organizations (MCO) and timely supplemental payments (i.e., wraparound payments) from DHCS to meet the cost-related reimbursement requirements.[11] If an MCO payment to a CHC is less than the amount they pay other contracted providers for similar services, the state pays the difference through an interim payment paid on a per-visit basis each time a claim is filed and a final payment once the reconciliation process is complete. This process can result in delayed reimbursement and unstable funding streams. MCOs can reduce administrative burdens and provide more stable revenue streams for CHCs.

3 **Sustain and support California's Medi-Cal expansion with state funds.** The state's long-term support of Medi-Cal to undocumented residents is being reevaluated in light of budget constraints. Our results underscore the potential of full-scope Medi-Cal to improve disease management among this population; using MHLA as a case study, older undocumented patients who have a medical care home are less likely to have an ED-originated hospitalization. Further, our results suggest that older undocumented patients are not any more vulnerable or medically complex than their documented counterparts and their coverage will not require unique care needs or resources. On the contrary, targeted primary care delivery—like that provided under MHLA—can lead to **cost savings** by reducing hospital-based care.

Long-term funding for Medi-Cal is needed to protect California's advances in providing healthcare to all low-income residents regardless of legal status. Creating a state reserve fund to backfill potential state tax shortfalls or federal funding gaps can help to ensure continued support for all Medi-Cal enrollees. The state may also reduce its dependence on federal funds for Medi-Cal by increasing reliance on state-level funding sources, such as implementing new taxes or reallocating budget priorities.

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