Annual Report
to the
Los Angeles County Board of Supervisors
Fiscal Year 2020-21

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APPENDICES

I. INTRODUCTION

Fiscal Year (FY) 2020-21 was the seventh year of operation for the My Health LA (MHLA) program.

The Los Angeles County Department of Health Services (DHS) developed the MHLA program in 2014 to fill a gap in health care access in Los Angeles County. MHLA participants receive primary medical care at contracted Community Partner (CP) clinics throughout Los Angeles County. They can also receive dental services at select CP sites. When needed, participants also receive specialty, inpatient, emergency and urgent care at Los Angeles County DHS facilities.

To be eligible for MHLA, participants must be Los Angeles County residents ages 26 and older and be ineligible for publicly funded health care coverage programs such as full-scope Medi-Cal. MHLA participants must also have a household income at or below 138% of the Federal Poverty Level.

MHLA is closely aligned with the Department of Health Services mission, "To advance the health of our patients and our communities by providing extraordinary care."

The goals of the MHLA program are to:

Preserve Access to Care for Uninsured Patients.

- Ensure that Los Angeles County residents who are not eligible for comprehensive public health care coverage have a medical home and can access needed services.

Encourage coordinated, whole-person care.

- Encourage better health care coordination, continuity of care and patient management within the primary care setting.

Payment Reform/Monthly Grant Funding.

- Encourage appropriate utilization and discourage unnecessary medical visits by providing monthly grant funding as opposed to fee-for-service payment.

Improve Efficiency and Reduce Duplication

- Encourage collaboration among health clinics and providers and avoid unnecessary service duplication by improving data collection, developing performance measurements and tracking health outcomes.

This annual report, covering FY 2020-21, is designed to provide the public, policy makers, participants, clinics, researchers and other interested groups with detailed information about the MHLA program. At the end of FY 2020-21, 132,336 Los Angeles County residents were enrolled in the MHLA program. There were also 51 Community Partner clinic agencies and 227 clinic sites contracted to provide care for participants. MHLA participants had an average of 3.75 primary care visits during the year, and nearly two-thirds (66.2%) of the MHLA population had at least one primary care visit during the fiscal year.

Payments to clinics for MHLA participants totaled $45.96 million for primary care services and $2.95 million for dental services. MHLA also paid about $9.33 million for pharmacy services. Payments were lower for the second year in a row due to lower enrollment and utilization, in large part due the COVID-19 pandemic.

The pandemic also led to several program changes in March 2020, which continued through FY 20-21. The Board of Supervisors approved a temporary waiver allowing clinics to conduct enrollment/re-

enrollment and renewals by phone rather than in-person. In addition, the MHLA audit teams began conducting clinical audits and facility site reviews remotely.

One of the newest parts of the program in FY 20-21 was the addition of mental health prevention services, the result of a partnership between DHS and the LA County Department of Mental Health. The Mental Health Prevention Services project is designed to help build protective factors and reduce risk factors associated with the onset of serious mental illness. Under the program, CPs are responsible for screening MHLA participants and providing them with prevention services, through curriculums on stress management, trauma-informed care and grief and loss.

CPs receive a Supplemental Behavioral Health MGF payment of $3.30 per month for each enrolled participant who had a qualifying, in-person primary care visit in the prior 24 months. They receive that payment in addition to the $32.00 primary care Monthly Grant Payment per participants who had a qualifying primary care visit.

MHLA had a successful year serving its participants, and we are thankful to the CPs, the Community Clinic Association of Los Angeles County and community-based organizations for everyone's contributions to the program.

II. 2020-21 PROGRAM ACTIVITIES

A. ENROLLMENT AND COMMUNICATIONS

This section of the report discusses outreach, application and enrollment trends in the MHLA program.

Key 2020-21 highlights were:

- MHLA ended its fifth programmatic year with 132,336 uninsured Los Angeles County residents enrolled in the program.
- 76% of MHLA participants renewed or reenrolled in the program this fiscal year.
- MHLA ended the year with 55,307 individuals disenrolled from the program, the vast majority due to failure to renew.

MHLA Eligibility Review Unit (ERU)

The MHLA Eligibility Review Unit (ERU) develops, implements and communicates the eligibility and enrollment rules for MHLA. The unit also monitors how those rules are applied in the online One-e-App enrollment and eligibility system. Additionally, the ERU provides MHLA eligibility trainings for CP enrollers on the process for enrolling patients in MHLA. In FY 2020-21, the ERU conducted six online eligibility trainings for about 150 CP enrollers.

To keep CPs informed, the ERU holds regular conference calls with "eligibility leads" from the clinics. Eligibility leads are key CP staff members responsible for staying abreast of changes to MHLA eligibility policies and processes and sharing this information with the enrollers at their clinic. The ERU helps CP enrollers through the enrollment and re-enrollment process in real time through the Subject Matter Expert telephone line. This help line assists enrollers who have questions about the specifics of a MHLA application in progress, and enrollers frequently use the line to call the ERU with eligibility issues in real time. In FY 2020-21, the line received 1,681 calls from CPs.

Applications and Enrollment

MHLA enrollment is conducted at the CP clinics through the One-e-App system. Trained enrollers screen potentially eligible individuals for the program during the enrollment process. Once eligibility has been assessed, the CP staff enroll participants into the program. An applicant is considered enrolled in MHLA when the application is completed and all required eligibility documents are clearly uploaded (i.e., proof of identification, Los Angeles County residency and income).

During FY 2020-21, 1056 individuals had MHLA One-e-App access. That included 395 enrollers taking applications, 540 clinic staff with read-only access, 69 system administrators and 52 supervisor users.

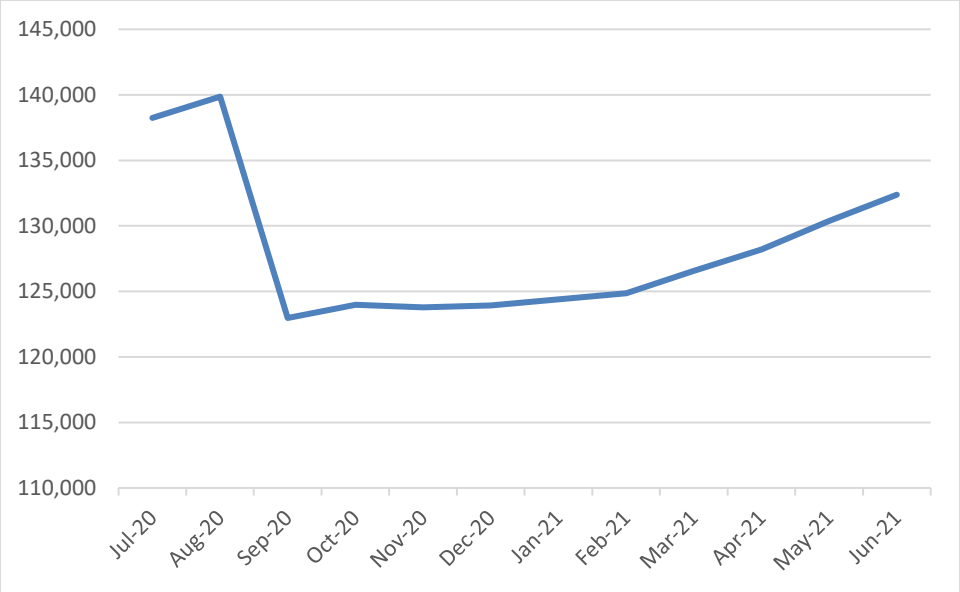
At the end of this fiscal year, there were 132,336 participants enrolled in MHLA, down from previous fiscal years (Table A1). Enrollment declined after August 31, 2020 when MHLA participants whose renewals were automatically extended through the end of August 2020 (due to COVID-19) failed to renew. Also, federal immigration policies continue to create fear and uncertainty among immigrant communities and likely contributed to the enrollment decline.

The program continues to work closely with community clinics to make sure they enroll eligible participants in MHLA and complete renewals on time. FY 21-22 will see a dramatic drop in enrollment because of the expansion of full-scope Medi-Cal to individuals 50 and older regardless of immigration status. Roughly 55,000 eligible individuals will be disenrolled beginning at the end of FY 21-22.

Table A1
Enrollment by Fiscal Year

Fiscal Year	Enrollment at end of the Fiscal Year
2016-17	145,158
2017-18	147,037
2018-19	142,105
2019-20	136,408
2020-21	132,336

Graph A1
MHLA Monthly Enrollment FY 2020-21



Disenrollments and Denials

The MHLA program tracks participant disenrollments and denials. Disenrollments occur when there is a change in a participant's eligibility status resulting in the person no longer meeting the eligibility criteria for the program. For example, participants who move out of Los Angeles County or obtain health insurance are no longer eligible. Participants may also decide to voluntarily disenroll from the program or not to renew their coverage at their annual renewal date. Since participation is completely voluntary, participants may choose to seek care at DHS clinics or other, non-MHLA clinics.

A denial occurs when a person is enrolled in MHLA but is subsequently retroactively denied by the ERU going back to their initial date of application. This denial happens if program staff determine during an eligibility audit that a participant had full-scope Medi-Cal during the entire duration of their MHLA coverage or that the documentation required to prove the participant's eligibility (i.e. proof of income, residency and/or identity) was never submitted by the enroller. Participants can also be denied if ERU determines that the CP processed the application incorrectly and the participant was found to be ineligible.

Participants who have been denied or disenrolled from MHLA can re-apply at any time provided they meet eligibility requirements. There is no cost or waiting period to re-apply. Enrollment in the program fluctuates daily as new applicants enroll, existing participants renew eligibility and participants are disenrolled or denied.

There was a total of 161,028 participants enrolled in the program during FY 2020-21. During the year, 5,590 (3.47%) were denied (Table A2) and 55,307 participants (34.35%) were disenrolled (Table A3).

The vast majority of denials were due to incomplete applications (Table A2). The majority of disenrollment were due to participants not completing the renewal process before their annual renewal deadline (Table A3).

The Eligibility Review Unit continues to work with clinic enrollers to inform them about the importance of completing applications and helping participants renew on time. The MHLA program permits participants to submit affidavits when proof of income, identity, and residency are not possible for the applicant to produce. If any of these are missing, however, the person's application will be denied. Under the temporary waiver allowing remote enrollment, participants can submit paperwork remotely. CPs reported some difficulty completing the remote renewal and re-enrollment process and obtaining all necessary documents from applicants.

Table A2
MHLA Post-Enrollment Denials by Reason

Denial Reason	FY 18-19	FY 19-20	FY 20-21
Incomplete Application	5,333	4,454	5,164
Enrolled in Full-Scope Medi-Cal	71	86	26
Income Exceeds 138% of FPL	316	530	296
Determined Eligible for Other Programs	16	9	25
Not a Los Angeles County Resident	16	14	15
False or Misleading Information	90	31	18
Duplicate Application	13	6	6
Enrolled in Private Insurance	0	4	1
Participant Request	2	22	15
Enrolled in Public Coverage	0	3	1
Participant has DHS Primary Care Provider	1	23	14
Enrolled in Employer-Sponsored Insurance	3	7	3

Denial Reason	FY 18-19	FY 19-20	FY 20-21
Did Not Complete Renewal	1	1	4
Not Eligible Due to Other Reasons	1	0	2
Total	**5,863**	**5,190**	**5,590**

Table A3
MHLA Disenrollments by Reason

Disenrollment Reason	FY 18-19	FY 19-20	FY 20-21
Did Not Complete Renewal	66,467	42,730	54,451
Enrolled in Full Scope Medi-Cal	169	842	58
Incomplete Application	20	21	9
Participant Request	213	222	325
Participant has DHS Primary Care Provider	312	516	371
Not a Los Angeles County Resident	39	31	31
Determined Eligible for Other Programs	24	15	6
Income Exceeds 138% of FPL	44	20	12
Enrolled in Employer Insurance	13	20	18
Enrolled in Private Insurance	10	9	7
Enrolled in Public Coverage	7	4	0
False or Misleading Information	2	1	1
Duplicate Application	2	6	4
Participant is Deceased	3	7	14
Program Dissatisfaction	0	1	0
Under Program Age Requirement	2	0	0
Enrollee is Incarcerated	2	0	0
Total	**67,329**	**44,445**	**55,307**

Renewals

Participants are required to renew their MHLA coverage every year during an in-person interview at their medical home clinic prior to the end of the participant's one-year enrollment period. However, the temporary waiver that took effect in late March 2020 permitted clinics to take applications for enrollment, re-enrollment and renewal by phone. The temporary waiver also allowed MHLA to extend eligibility past one year for identified participants. All enrolled MHLA participants who were due for renewals in July and August 2020 were automatically extended until August 31, 2020.
The MHLA program notifies participants by postcard 90, 60 and 30 days prior to the end of their 12-month program coverage that their renewal date is approaching. MHLA participants may renew their coverage up to 90 days prior to their renewal date. Failure to complete the renewal process prior to the end of their 365-day coverage results in the participant's disenrollment from MHLA. Individuals who are

disenrolled from the program have the option to re-enroll at any time with no penalty or waiting period and at no cost.

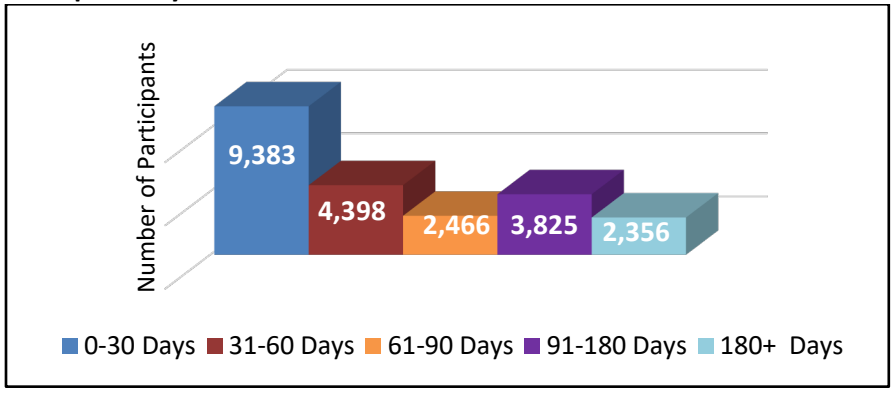
Table A4 provides the current renewal and re-enrollment rates compared to the previous fiscal year. Of the 134,279 MHLA participants due to renew FY20-21, 79,820 (59%) participants renewed on time. Of the 53,900 individuals that did not renew, 22,428 (17%) came back within the year to reenroll in the program, meaning 76% of MHLA participants renewed or reenrolled in the program the fiscal year. The re-enrollment rate for the program increased comparing to prior fiscal years, though that was in part due to the automatic extension of MHLA participants.

Table A4
Renewal and Re-enrollment Rates

Fiscal Year	Total Due to Renew	Renewal Approved	Renewal Denied	Disenrolled for Failure to Renew	Renewal Rate – Percent Approved	Reenrolled after Failure to Renew	Percent Re-enrolled	Total Renewed and Re-enrolled	Percent Renewed and Re-enrolled
	A= B+C+D	B	C	D	B/A	E	F=E/A	G=B+E	H=G/A
2018-2019	139,995	72,553	975	66,467	52%	28,713	21%	101,266	72%
2019-2020	116,852	74,073	527	42,252	63%	15,396	13%	89,469	77%
2020-2021	134,279	79,820	559	53,900	59%	22,428	17%	102,248	76%

Graph A2 captures the time gap between disenrollment and the participant's subsequent re-enrollment in the program. 22,428 participants chose to re-enroll in MHLA after their disenrollment, a majority of whom (9,383, or 42%) did so within the first 30 days of their disenrollment. 4,398 individuals (20%) reenrolled between 31-60 days of being disenrolled, and 3,825 (17%) re-enrolled within 91-180 days. These rates of re-enrollment are consistent with the previous fiscal year.

Graph A2
MHLA Participant Days between Disenrollment for Failure to Renew and Re-enrollment



The MHLA program looked at the utilization trends of those MHLA participants who were disenrolled from the program for failure to renew and who never re-enrolled into the program. Of the 53,900 participants who were disenrolled from MHLA for failure to renew and never returned to the MHLA program (Table A4), 34% of them never had a visit with their MHLA CP clinic, indicating that many of these participants may not have renewed because they were not using the program.

Communications and Outreach

The MHLA program utilizes its website (https://dhs.lacounty.gov/my-health-la/) to convey information to MHLA CP clinics, current and potential enrollees and the general public. The website is a comprehensive repository of information and contains all programmatic and contractual documents required by CPs to participate in the MHLA program. This includes CP newsletters, fact sheets, reports and detailed pharmacy information such as formularies. The website also displays instructions and guidance related to One-a-App, the online program used to screen and enroll participants. The public-facing section of the website can be translated into Spanish and other languages.

The MHLA program also posts Provider Information Notices, which describe contractual and operational changes to the program. During FY 2020-21, MHLA issued two Provider Information Notices announcing contractual changes to the program. The first detailed updates on eConsult and specialty care. The second explained new dental billing instructions.

MHLA produces a variety of information sheets in eight languages - Armenian, Chinese, English, Korean, Spanish, Tagalog, Thai and Vietnamese. The two most used information sheets explain the basics of the MHLA program and describe how and where to enroll. All information sheets are available on the website for download free of charge. MHLA has several other information sheets, including information on pharmacy services and how participants can access behavioral health services.

MHLA staff occasionally participate in community health fairs and other County or community events and share program information and materials during those events. The MHLA program also continues to disseminate program information and updates to CPs through the monthly newsletter, “CP Connection.” MHLA also sends out “My Healthy News” in English and Spanish to participants with important information as needed. The most recent version included updates about COVID-19 safety, testing and vaccines. These two publications are intended to keep CPs and MHLA program participants up to date with program information. The program completed a redesign of the MHLA webpages and plans to redesign the handbook in FY 21-22.

In FY 2019-20, MHLA began using texts and robocalls (in English and Spanish) to provide important information to participants. The texts and robocalls, which began in the final quarter of FY 2019-20, have continued through FY 2020-21, providing information about how to stay safe during the COVID-19 pandemic, where and how to get tested for COVID and how to access food, housing and other community resources. MHLA also sent out brief videos with safety tips. The program also began using texts and robocalls to remind participants of their upcoming renewal dates and plans to test robocall reminders as well.

B. PARTICIPANT DEMOGRAPHICS

This section of the report examines the demographic makeup of the individuals enrolled in MHLA.

Key FY 2020-21 demographic highlights for the MHLA Program are:

- 95% of participants identified as Latinos.
- 60% were female and 40% were male.
- SPA 6 had the largest concentration of MHLA participants at 22%.

Latinos continued to comprise the largest group of enrollees, making up over 95% of program participants. More participants were female (60%) than male (40%). About 92% participants indicated that Spanish was their primary spoken language and 6.5% indicated that English was their primary spoken language. Most MHLA participants (37%) were between 45 and 54 years old. In FY 2020-21, MHLA had 548 enrolled homeless individuals - less than 1% of enrolled participants.

Participant Demographics

Table B1 provides demographic detail on the participants enrolled at the end of FY 2020-21.

Table B1
Demographics of MHLA Participants (as of June 30, 2021)

Age	
25-44	36.1%
45-54	36.9%
55-64	18.8%
65+	8.2%
Ethnicity	
Latino	95.01%
Asian/Asian Pacific Islander	2.35%
Other/Declined to State	1.71%
Caucasian	.82%
Black/African American	.11%
Language	
Spanish	92.09%
English	6.50%
Korean	.54%
Thai	.42%
Other	.20%
Armenian	.12%
Tagalog	.05%
Cambodian/Khmer	.03%
Chinese	.03%

Service Planning Area (SPA) Distribution

MHLA participant distribution by SPA highlights the geographic dispersion of enrollment. The overall percentages were nearly identical to previous fiscal years as noted in Table B2. SPA 6 continued to have the largest percentage of MHLA program participants of all eight SPAs, at nearly 22%.

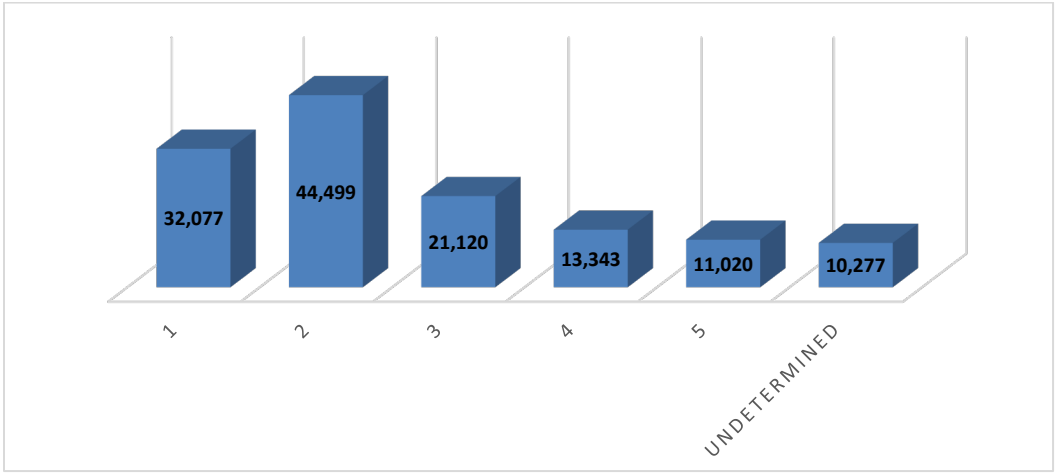
Table B2
SPA Distribution of MHLA Participants

SPA	FY 2018-19		FY 2019-20		FY 2020-21	
	Total Number of Participants	Total % of Participants	Total Number of Participants	Total % of Participants	Total Number of Participants	Total % of Participants
1	2,688	1.89%	3,050	2.24%	3,249	2.46%
2	27,162	19.11%	24,519	17.97%	22,432	16.95%
3	13,016	9.16%	12,308	9.02%	10,269	7.76%
4	26,615	18.73%	25,406	18.63%	22,734	17.18%
5	3,182	2.24%	3,026	2.22%	3,060	2.31%
6	31,261	22.00%	30,139	22.09%	28,619	21.63%
7	19,564	13.77%	19,685	14.43%	18,010	13.61%
8	14,919	10.50%	14,686	10.77%	13,686	10.34%
Undetermined	3,698	2.60%	3,589	2.63%	10,277	7.77%

MHLA Program Participant Distribution by Supervisorial District

Graph B1 provides the MHLA participant distribution by Supervisorial District. District 2 shows the largest number of MHLA program participants of all five districts, at 44,499 which is similar to previous years.

Graph B1
Distribution of MHLA Participants by Supervisorial District



C. PROVIDER NETWORK

This section of the report describes the MHLA provider network, including the CP medical homes and DHS facilities providing services.

Key FY 2020-21 highlights were:

- There were 227 MHLA medical homes at the end of FY 2020-21, similar to the prior year.
- 72% of MHLA medical homes were open to accept new participants throughout the fiscal year.
- A total of 63 (28%) medical home clinic sites were closed to new patients at some point during the fiscal year.

Clinic Sites and Capacity

MHLA ended FY 2020-21 with a total of 51 CP agencies and 227 primary care clinics.

The MHLA Contract Administration Unit surveys CPs twice a month to determine whether there are any changes in clinic capacity and whether clinic panels should remain open or closed to new patients. The MHLA database and website are updated immediately upon notification of a change of open/closed status. A clinic is considered to have capacity if it can schedule an urgent primary care appointment within 96 hours and a non-urgent primary care appointment within 21 days.

During FY 2019-20, 63 clinic sites closed to new patients at some point in the fiscal year due to limited capacity to meet the access standards. Several CPs reported staffing shortages as a result of the pandemic. Last fiscal year the same amount clinics were closed. However, several CPs reported that they temporarily closed sites due to COVID-19.

Medical Home Distribution and Changes

At the time of enrollment, MHLA participants select a primary care medical home. The medical home is where they receive their primary and preventative care services. This includes prevention, diagnosis, treatment of illness or injury, health advice, diagnostic services (basic labs and radiology), chronic disease management, immunizations, referrals, health education, medicines and other services. Participants retain their medical home for 12 months.

Participants may change their medical home during the first 30 days of enrollment for any reason. They also can change throughout the year for any of the following reasons: 1) if the participant has a new place of residence or employment; 2) if the participant has a significant change in their clinical condition that cannot be appropriately cared for in the current medical home; 3) if the participant has a deterioration in the relationship with the health care provider/medical home that cannot be resolved; or 4) if there is a termination or permanent closure of a medical home. If the MHLA participant has some other special circumstance that merits a medical home transfer, this may be approved by MHLA management. Transfer requests are infrequent.

DHS Participation in the MHLA Network

DHS provides a range of specialty, urgent care, emergency care and inpatient services to MHLA participants—all at no cost to the participant. Participants, however, must comply with the Medi-Cal screening and enrollment process when they go to DHS facilities. If they don't, they may be financially liable for the cost of care.

Hospital and specialty care services are critical components in the MHLA service continuum. MHLA participants have access to hospital services at DHS facilities only; hospital services at non-DHS facilities are not covered by MHLA. DHS hospitals available to MHLA participants are LAC+USC Medical Center, Harbor-UCLA Medical Center, Olive View-UCLA Medical Center and Rancho Los Amigos National Rehabilitation Center. However, MHLA participants can and should seek services for emergencies at the nearest hospital emergency department consistent with federal and state laws that govern access to emergency care.

Details on utilization of DHS specialty, urgent care, emergency care and inpatient services are below.

D. CONTRACT AND AUDIT ADMINISTRATION

Key FY 2020-21 highlights were:

- All CPs met the timely access standards (21 calendar days for non-urgent primary care health services and 96 hours for urgent primary health care services).
- The most frequent deficiencies in the Medical Records Reviews were related to foot exam/podiatry referrals, TB screenings, immunizations, diabetic retinal scan/ophthalmology referral, seasonal flu vaccines, and abuse/neglect assessment.
- Fifty-three (25%) of the 213 primary care clinics were required to submit a Corrective Action Plan based on the Medical Record Reviews.

This section of the report focuses on MHLA Contract and Audit Administration unit. The unit conducts annual audits of CPs' facility, administration and medical records while maintaining oversight and compliance with contractual and regulatory agency requirements for all CP medical home clinics. The unit assists in improving the quality and safety of clinical care services provided to MHLA participants through four reviews: Facility Site Review (FSR)/Credentialing Review (CR), Medical Record Review (MRR), Dental Record Review (DRR), and Dental Site Review (DSR).

The unit works with CPs to help them successfully comply with the implementation of any necessary Corrective Action Plans (CAP). Even if a CAP is not required, MHLA informs CPs of the deficiencies and urges the CPs to address those deficiencies.

In FY 2020-21 the audits were conducted remotely. The FSR/CR consisted of a desk review, self-assessment/attestation and telephone survey. The MRR and DSR were conducted via teleconference.

Facility Site Review (FSR)/Credentialing Review (CR)

FSR/CR includes the process of evaluating the facility for patient access and appropriate service provision. Through the FSR/CR, MHLA also ensures that all required professional licenses and certifications are current and issued from the appropriate licensing/certification agency.

The MHLA Contract and Audit Administration Unit conducted a total of 208 FSRs/CRs. Only one site was required to submit a Corrective Action Plan (CAP) due to a critical deficiency (One of the two [2] storage containers for infectious materials was not appropriately locked). There were 21 deficiencies among the 208 clinic sites. In the prior fiscal year, there was just one deficiency.[1] None of the 208 FSRs/CRs showed repeat deficiencies when compared to audit deficiencies from Fiscal Year 2019-20.

Table D1
FSR/CR Deficiencies (Total deficiencies = 21)

Rank	Deficiency	Frequency	Percentage
1	No CLIA Certificate was provided	8	38.1%
2	No cultural and linguistic P&P was provided	7	33.3%
3	No current HRSA report (Credentialing/recredentialing section) was provided	5	23.8%
4	One of the two (2) storage containers for infectious materials was not appropriately locked (Critical element: "Regulated Wastes")	1	4.8%
	Total	***21***	***100.0%***

The Contract and Audit Administration unit also monitored timely access standards as part of the FSR. Under the MHLA Agreement, Community Partner clinics shall make available to MHLA participants appointments for included services within 21 calendar days for non-urgent primary care health services and within 96 hours for urgent primary health care services. Timely access standards were verified during the annual audits, and every clinic site met these standards for FY 2020-21.

Medical Record Review (MRR)

The MRR includes the process of measuring, assessing and improving quality of medical record documentation. The medical record review supports effective patient care, information confidentiality and quality review processes that are performed in a timely manner. The MRR ensures documentation is accurate, complete and compliant according to the standards of care.

MHLA conducted a total of 213 MRRs. Fifty-three (25%) of the 213 MRRs required a CAP. Although the 53 sites met the passing threshold of 90.0%, they were required to submit a CAP due to repeat deficiencies. In the prior fiscal year, 66 sites (34%) were required to submit a CAP.

There were 176 deficiencies identified in the 213 MRRs conducted during this fiscal year.
The most frequent MRR deficiencies were as follows:

[1] In FY 20-21, all sites were audited remotely. In FY 19-20, only 43 of 194 sites were audited remotely.

Table D2
Most Frequent MRR Deficiencies (Total deficiencies = 176)

Rank	Deficiency	Frequency	Percentage
	Lack of documentation of:		
1	● foot exam/podiatry referral	41	23.3%
2	● TB screening	35	19.9%
3	● immunization	20	11.4%
3	● diabetic retinal scan/ophthalmology referral	20	11.4%
4	● seasonal flu vaccine	18	10.2%
5	● abuse/neglect assessment	11	6.3%

There are 11 DHS core elements in the MRR (follow-up of specialty referral, TB screening, lipid screening, mammogram, cervical cancer screening, immunization, seasonal flu vaccine, colorectal cancer screening, abuse/neglect assessment, diabetic retinal scan/ophthalmology referral, and foot exam/podiatry referral). If a clinic site has five or more of the same repeat core element deficiencies during each of three consecutive fiscal years and does not reduce its total number of repeat deficiencies between the first and third fiscal years, liquidated damages may be assessed. *There were no sites showing five or more of the same repeat DHS core element deficiencies.*

Table D3
Most Frequent MRR Deficiencies

Deficiency	FY 2020-21 (Total Deficiencies=176)			FY 2019-20 (Total Deficiencies=364)		
	Ranking	Frequency	Percentage	Ranking	Frequency	Percentage
Lack of documentation of:						
● foot exam/podiatry referral	1	41	23.3%	1	68	18.7%
● TB screening	2	35	19.9%	4	55	15.1%
● immunization	3	20	11.4%	3	59	16.2%
● diabetic retinal scan/ophthalmology referral	3	20	11.4%	5	41	11.3%
● seasonal flu vaccine	4	18	10.2%	2	60	16.5%
● abuse/neglect assessment	5	11	6.3%	6	17	4.7%

Dental Record Review (DRR)

DRR includes the process of assessing the quality of dental record documentation for accuracy and performance. The DRR ensures documentation for dental services is compliant with recognized standards of care. As necessary, the DRR includes a claims processing review to verify that billed services concur with documentation within the dental record and meet the definition of a billable visit.

For FY 2020-21, 52 sites provided dental services to MHLA participants. Only three of the 52 sites were required to submit a CAP, one less than in FY 2019-20. Two of the three sites required to submit a CAP showed repeat deficiencies. There were nine deficiencies identified among the 52 sites.

Table D4
Total deficiencies among the 52 dental sites

Rank	DRR Deficiencies	Frequency	Percentage
1	Dental Material Fact Sheet was not present in chart	3	33.3%
2	Lack of documentation of "Time Out" before surgical procedures in the patient's dental record/progress notes	1	11.1%
2	Provision of oral cancer screening was not documented	1	11.1%
2	The billed service(s) did not concur with documentation in the patient's medical record and are within the contract term	1	11.1%
2	Emergency contact was not documented	1	11.1%
2	Lack of documentation of follow-up of specialty referrals made	1	11.1%
2	No documentation that clinic provided a disclaimer and obtained patient's signature after a referral was made	1	11.1%
	Total	***9***	***100.0%***

There were only 9 deficiencies identified among the 52 sites, much lower than the previous fiscal year, when sites had 47 deficiencies.

Table D5
Most Frequent DRR Deficiencies

Deficiency	FY 2020-21 (Total Deficiencies=9)			FY 2019-20 (Total Deficiencies=47)		
	Ranking	Frequency	Percentage	Ranking	Frequency	Percentage
Dental Material Fact Sheet was not present in chart	1	3	33.3%	3	5	10.6%
Lack of documentation of "Time Out" before surgical procedures in the patient's dental record/progress notes	2	1	11.1%	4	4	8.5%
No provision of oral cancer screening	2	1	11.1%	3	5	10.6%
The billed service(s) did not concur with documentation in the patient's medical record and are within the contract term	2	1	11.1%	4	4	8.5%

Deficiency	FY 2020-21 (Total Deficiencies=9)			FY 2019-20 (Total Deficiencies=47)		
	Ranking	Frequency	Percentage	Ranking	Frequency	Percentage
Emergency contact was not documented	2	1	11.1%	7	0	0.0%
**Lack of documentation of follow-up of specialty referrals	2	1	11.1%	N/A	N/A	N/A
No documentation that clinic provided a disclaimer and obtained patient's signature after a referral was made	2	1	11.1%	4	4	8.5%
No signed informed consents when invasive procedure was performed	N/A	0	N/A	1	10	21.3%
No documentation on cleaning prophylactic	N/A	0	N/A	2	9	19.1%
Clinic did not provide a disclaimer and did not obtain patients' signature after a referral is made.	N/A	0	N/A	4	4	8.5%

**This element was not audited during FY 2019-20

Dental Site Review (DSR)

MHLA conducted 50 DSRs. Eleven (22%) of the 50 sites showed deficiencies but only two (4%) were required to submit a CAP. In the prior fiscal year, no CAPs were required.[2] One of the two CAPs was due to not meeting the minimum overall compliance score of 90.0% and the other CAP was required due to repeat deficiencies. There were 15 deficiencies identified among the 11 sites, higher than the previous fiscal year, when six sites had seven deficiencies.

Table D6
DSR Deficiencies

Rank	DSR Deficiencies	Frequency	Percentage
1	Contractor did not provide evidence of last X-ray Safety Inspection performed by the County of Los Angeles Radiology Dept. or California Remote Dose (CaRRD) Program - DIQUAD Report from California Department of Public Health (CDPH) Radiologic Health Branch (required every 5 years).	4	26.7%

[2] In FY 20-21, all sites were audited remotely. In FY 19-20, more than half (27) of 50 sites were audited remotely.

Rank	DSR Deficiencies	Frequency	Percentage
2	No documentation of amalgam separator one-time compliance report submitted to Control Authority was provided.	3	20.0%
2	Contractor did not provide evidence that amalgam separator installed is compliant with the International Organization for Standardization (ISO) 11143 2008 standard (or equivalent)	3	20.0%
3	Contractor did not provide log for in-house DUWL testing performed for each unit.	2	13.3%
4	No evidence of an emergency eyewash station is installed which can provide 15min of continuous irrigation and is no more than 10 seconds (approx. 55ft) from the potential hazard.	1	6.7%
4	Contractor did not provide copy of the most recent dosimetry report.	1	6.7%
4	Contractor did not provide evidence of oxygen tank log with remaining psi.	1	6.7%
	Total	***15***	***100.0%***

E. PARTICIPANT EXPERIENCE

This section highlights program participants' experience with the MHLA program and includes data related to the MHLA call center and the filing of formal complaints.

Key FY 2020-21 highlights were:

- Member Services received a total of 15,685 calls in FY 2020-21.
- There were three formal participant complaints filed by participants, with complaints being related to access to care and quality of service.

Member Services Call Center

Member Services staff is available to answer questions for MHLA participants Monday through Friday from 7:30 a.m. – 5:30 p.m. at 844-744-MHLA (844-744-6452). Interpreters are available for MHLA participants who speak a language not spoken by a call center agent. Member Services staff also help participants and process medical home changes, complete disenrollments, process address and phone number changes and order replacement identification (ID) cards.

During FY 2020-21, MHLA's Member Services call center received 15,685 calls. The number of incoming calls decreased 11% from last year's total of 17,596.

Participant Complaints

Member Services staff also take calls from MHLA participants who are experiencing issues related to the MHLA program and the staff try to resolve those issues. When the problem requires more intensive research or involves a clinical investigation, a participant's concern is escalated to the DHS Complaints Unit and is logged as a formal complaint.

MHLA works closely with CPs to address participant concerns and complaints. The program believes that direct communication with the CP is essential to improve participant experience and satisfaction.

Of the calls that came into Member Services in FY 2020-21, 3 were "formal complaints." This is a decrease from the 11 formal complaints in FY 2019-20. The formal complaint reasons were related to inappropriate care and delay in services. Table E1 identifies formal complaints by category as well as the percentage of complaints by category over a three-year period. Participants who file formal complaints are notified by letter within 60 days of the filing of the complaint with the resolution of their issue.

Table E1
MHLA Participant Formal Complaints by Category

Complaint Type	FY 2018-19		FY 2019-20		FY 2020-21	
	Total	Percent	Total	Percent	Total	Percent
Mistreatment/Misdiagnosis/Inappropriate Care by Provider	4	29%	1	9%	2	67%
Delay or Refusal in Receiving Clinical Care Services	7	50%	2	18%	1	33%
Refusal of Referral to Specialist	0	0%	2	18%	0	0%
Delay in Authorization	0	0%	0	0%	0	0%
HIPAA, Treatment Record Keeping	0	0%	1	9%	0	0%
Prolonged Wait in Provider's Office	0	0%	3	27%	0	0%
Refusal of Prescription by Clinical Provider/Pharmacy/Access Problems	2	14%	1	9%	0	0%
MHLA Medi-Cal	1	7%	0	0%	0	0%
Total	**14**	**100%**	**11**	**100%**	**3**	**100%**

F. SERVICE UTILIZATION

This section of the report provides an analysis of the clinical and service data from both CP and DHS facilities. The information helps the MHLA program assess participants' health status and utilization of services.

Key FY 2019-20 highlights were:

- 66% of MHLA participants had a primary care visit.
- MHLA participants had an average of 3.75 primary care visits per year.
- 30,805 unduplicated MHLA patients accessed 180,356 specialty care visits.
- 6% of all MHLA participants had an emergency department (ED) visit.
- 18% of visits to the ED were considered avoidable.

Summary of Clinical Utilization Data

In the MHLA program, primary care services are provided by CP medical homes, while specialty, urgent, emergency and inpatient care services are provided at DHS facilities. Tables F1 and F2 provide participant utilization information for FY 2020-21 at CPs and DHS facilities.

Table F1
Summary of Utilization Data – Participants Utilizing at Least One Service at a CP

Fiscal Year	Service Category	Unique Participants	Number of Participants Utilizing at Least One Service	Percentage of Participants Utilizing at Least One Service	Number of Encounters
2017-18	Primary Care (CP)	185,695	125,828	68%	517,958
	Prescription (CP)	185,695	93,755	49%	880,676
2018-19	Primary Care (CP)	181,902	126,748	70%	514,546
	Prescription (CP)	181,902	97,543	54%	1,044,996
2019-20	Primary Care (CP)	166,055	117,001	70%	475,503
	Prescription (CP)	166,055	90,668	55%	1,011,036
2020-21	Primary Care (CP)	161,028	106,606	66%	479,219
	Prescription (CP)	161,028	80,715	50%	946,358

Table F2
Summary of Utilization Data – Participants Utilizing at Least One Service at a DHS Facility
FY 2020-21

Service Category	Unique Participants	Number of Participants Utilizing at Least One Service	Percentage of Participants Utilizing at Least One Service	Number of Encounters
Specialty (DHS)	161,028	30,805	19.13%	180,356
Emergency (DHS)	161,028	8,964	5.57%	12,899
Prescription (DHS)	161,028	13,538	8.41%	121,796
Urgent Care (DHS)	161,028	5,344	3.32%	7,924
Inpatient (DHS)	161,028	2,914	1.81%	4,057

Primary Care

During FY 2020-21, 66% of MHLA participants had at least one primary care visit at their medical home clinic. The average number of visits for a MHLA participant in FY 2020-21 was 3.75. This is a slight increase from last fiscal year, when MHLA participants had 3.49 primary care visits per year on average. Appendix 1 provides detailed information on the number of primary care visits for MHLA participants by medical home.[3] Table F3 provides a comparison of the average number of primary care visits from the inception of the program.

Table F3
Average Number of Primary Care Visits per Year

Fiscal Year	Unique Participants	Total # of Visits	Total Number of Participant Months	Average Participants per Month	Average Visits per Year
2017-18	125,828	517,958	1,769,441	147,453	3.51
2018-19	126,748	514,546	1,730,998	144,250	3.57
2019-20	117,001	475,503	1,636,504	136,375	3.49
2020-21	106,606	479,219	1,531,473	127,623	3.75

Of the 106,606 MHLA participants who had a primary care visit this fiscal year, individuals with chronic conditions had a higher average number of visits per year (5.76) than those without chronic conditions (1.78). The top three chronic conditions were diabetes, hypertension and hyperlipidemia. The average number of visits per year for participants with both chronic and non-chronic conditions have not changed significantly through the life of the program (Table F4).

[3] In the MHLA program, participants generally receive the majority of their primary care visits at their chosen medical home clinic site, but they may obtain care at other clinic sites within the same agency. Encounter data is reported by the clinic that provided the service to the participant (even if the visit was not at the participant's chosen medical home). As a result, it is possible that a participant had primary care encounter data submitted for them on behalf of a clinic site that was not their chosen medical home.

Table F4
Primary Care Visits – Participants with and without Chronic Conditions
FY 2020-21

Fiscal Year	Type of Condition	Unique Participants	% Participants	Total Number of Visits	Total Number of Participant Months	Average Visits per Year
2018-19	With Chronic Conditions	61,452	48%	313,133	674,553	5.57
	Without Chronic Conditions	65,296	52%	201,413	1,056,445	2.29
2019-20	With Chronic Conditions	73,220	63%	349,327	814,640	5.15
	Without Chronic Conditions	43,781	37%	126,176	821,864	1.84
2020-21	With Chronic Conditions	68,720	64%	364,703	760,173	5.76
	Without Chronic Conditions	37,886	36%	114,516	771,300	1.78

Table F5
Primary Care Visit Distribution

	0 Visits	1 Visit	2 Visits	3 Visits	4 Visits	5 - 9 Visits	10+ Visits	Total with a CP Visit	Total Participants
Number of Participants	54,422	18,967	17,922	15,527	13,186	31,915	9,089	106,606	161,028
% Participants	33.8%	11.8%	11.1%	9.6%	8.2%	19.8%	5.6%	66.2%	100%

MHLA Pharmacy Program

MHLA contracts with Ventegra, a local Pharmacy Services Administrator, to provide more than 600 retail pharmacy options for MHLA participants to fill their prescriptions. This pharmacy network is in addition to the dispensaries or pharmacies that some CPs have on-site. Participants also can have medications mailed to their home or clinic using the DHS Central Pharmacy (participants receive a telephone consultation by a DHS pharmacist).

Outside of DHS Central Pharmacy, DHS pharmacies can also provide medications to MHLA participants if the prescription is written by a DHS physician (i.e. during an emergency, specialty or urgent care visit at a DHS facility).

Table F6 shows the number and percentage of MHLA participants who filled a prescription through the MHLA program over the last three fiscal years. The data indicate that 53% of MHLA participants filled at least one medication in FY 2020-21, down from 58% last fiscal year.

According to data received from Ventegra, 54% of medications dispensed in the MHLA program in FY 2020-21 were generic, 14% were purchased under the 340B program, 24% were over the counter (OTC) medications, and 8% were diabetic supplies. Ventegra's data also shows that 93.5% were filled at contracted pharmacies, 5.1% were filled at on-site CP dispensaries, and 1.5% were mailed to patients via the DHS Central Pharmacy.

Table F6
Pharmacy Utilization (CP and DHS)

Fiscal Year	Unique Participants	Total Number of Participants Receiving Prescriptions (DHS & Ventegra)	% of Participants Receiving Prescriptions	Medications Dispensed by Ventegra	Medications Dispensed at DHS (Prescribed by DHS)	Total Prescriptions Dispensed
2018-19	181,902	102,362	56%	1,044,996	96,154	1,141,150
2019-20	166,055	95,588	58%	1,011,036	125,336	1,136,372
2020-21	161,028	85,158	53%	946,358	121,796	1,068,154

Table F7 shows the top ten therapeutic classes of medications taken by those MHLA participants. Medications/products related to diabetes represented 28% of total prescriptions and medications for high blood pressure and high cholesterol represented 16% of the total.

Table F7
DHS & CPs Pharmacy Utilization by Therapeutic Class

Therapeutic Class	Description	% of Total Approved Prescriptions
Antidiabetics	Used for diabetes	16%
Antihypertensives	Used for high blood pressure	8%
Antihyperlipidemics	Used for high cholesterol	8%

Therapeutic Class	Description	% of Total Approved Prescriptions
Medical Devices and Supplies	Mostly diabetes related products like syringes and lancing devices	7%
Analgesics- Non-narcotic	Used for pain and fever (Tylenol and Aspirin)	6%
Diagnostic Products	Mostly diabetes related products to test blood sugar	5%
Analgesics – Anti-Inflammatory	Used for pain, fever and inflammation (NSAID's)	4%
Ulcer Drugs/ Antispasmodics/Anticholinergics	GI diseases	3%
Dermatologicals	Topical dermatological agents	3%
Diuretics	Increases the flow of urine	3%

Specialty Care Services

On average, a MHLA participant who saw a specialist had 5.85 specialty visits during the year. About 19% of all MHLA participants saw a specialist, which is the same as last fiscal year.

The following section provides analysis on specialty care utilization by MHLA participants at DHS clinics and hospitals in FY 2020-21.

DHS' eConsult is a web-based system that allows CPs and DHS specialists to securely share health information, discuss patient care and determine if MHLA participants need a face-to-face visit with a specialist. The total number of eConsults submitted from MHLA CPs in FY 2020-21 was 70,611. Of those, 44,397 were closed for a face-to-face visit.

Table F8 reflects the total number of eConsults requested by CP clinicians or staff during the fiscal year and the subsequent specialty care visits that followed. There were 30,805 unduplicated MHLA participants who received a total of 180,356 specialty care visits at DHS in FY 2020-21. This fiscal year saw an 19% increase in the total number of specialty care visits provided to MHLA patients (from 150,593 to 180,356).

Table F8
Specialty Care Services by Unique Participants

Fiscal Year	Unique Participants	Number of Participants Receiving Specialty Care	Number of eConsult Requests Recommended for a Specialty Care Visit	Number of Specialty Care Visits	Number of Specialty Care Visits Per 1,000 Participant Months per Year	Average Number of Specialty Care Visits per MHLA Participant Utilizing Specialty Services
2017-2018	185,695	32,123	40,591	150,528	1,020.85	4.69
2018-2019	181,902	36,186	63,736	162,920	1,129.43	4.50
2019-2020	166,055	31,431	60,910	150,593	1,104.25	4.79
2020-2021	161,028	30,805	44,397	180,356	1,413.20	5.85

Table F9 highlights the number of specialty care visits per MHLA participant within the fiscal year. The percentage of specialty care visits per MHLA participant remained largely the same between fiscal years.

Table F9
Distribution of Unduplicated Specialty Care Participants by Number of Visits

Fiscal Year	Number and Percent of MHLA Patients	0 Specialty Visits	1 Specialty Visit	2 Specialty Visits	3 Specialty Visits	4 Specialty Visits	5 – 9 Specialty Visits	10+ Specialty Visits	Total
2018-19	Number of MHLA Patients with Specialty Visits	145,716	12,121	5,876	4,060	2,961	7,063	4,105	181,902
	% of Total	80.11%	6.66%	3.23%	2.23%	1.63%	3.88%	2.26%	100%

2019-20	Number of MHLA Patients with Specialty Visits	134,624	9,507	5,281	3,674	2,604	6,506	3,859	166,055
	% of Total	81.07%	5.73%	3.18%	2.21%	1.57%	3.92%	2.32%	100%
2020-21	Number of MHLA Patients with Specialty Visits	130,223	7,712	4,754	3,532	2,578	6,843	5,386	161,028
	% of Total	80.87%	4.79%	2.95%	2.19%	1.60%	4.25%	3.34%	100%

Table F10 details the total number of specialty care visits provided to MHLA participants in FY 2020-21 by DHS facility. The 30,805 unduplicated participants reflected in this table may have been seen multiple times at different facilities for different specialty care services; the participant count reflected at each DHS location is unduplicated within the facility. LAC+USC continued to be the largest provider of specialty care services (36.54% of the total) for the MHLA program. Olive View Medical Center and Harbor-UCLA Medical Center followed as the largest DHS specialty care providers for MHLA.

Table F10
Specialty Care Services by DHS Facility
FY 2020-21

Facility Name	Participants (Unduplicated by Facility)	Specialty Care Visits	% of Total Specialty Care Visits
LAC+USC MEDICAL CENTER	12,262	65,905	36.54%
OLIVE VIEW-UCLA MEDICAL CENTER	6,039	31,213	17.31%
HARBOR-UCLA MEDICAL CENTER	5,848	33,103	18.35%
MARTIN LUTHER KING, JR. OUTPATIENT CENTER	6,016	27,453	15.22%
RANCHO LOS AMIGOS NATIONAL REHAB. CENTER	1,396	6,181	3.43%
HIGH DESERT REGIONAL HEALTH CENTER	1,165	4,480	2.48%
HUDSON COMPREHENSIVE HEALTH CENTER	1,208	2,951	1.64%
ROYBAL COMPREHENSIVE HEALTH CENTER	574	2,180	1.21%
MID-VALLEY COMPREHENSIVE HEALTH CENTER	796	1,867	1.04%
EL MONTE COMPREHENSIVE HEALTH CENTER	377	1,371	0.76%
HUMPHREY COMPREHENSIVE HEALTH CENTER	433	1,204	0.67%
LONG BEACH COMPRENSIVE HEALTH CENTER	508	1,069	0.59%

SOUTH VALLEY HEALTH CENTER	133	368	0.20%
SAN FERNANDO HEALTH CENTER	80	287	0.16%
WILMINGTON HEALTH CENTER	44	282	0.16%
HEALTH HOME PROGRAM	62	90	0.05%
TORRANCE HEALTH CENTER	21	85	0.05%
CURTIS TUCKER HEALTH CENTER	18	69	0.04%
WEST VALLEY HEALTH CENTER	27	63	0.03%
DOLLARHIDE HEALTH CENTER	17	31	0.02%
ANTELOPE VALLEY HEALTH CENTER	16	39	0.02%
BELLFLOWER HEALTH CENTER	12	40	0.02%
LA PUENTE COMMUNITY CLINIC	12	22	0.01%
LAKE LOS ANGELES COMMUNITY CLINIC	2	2	0.00%
EAST LOS ANGELES HEALTH CENTER	1	1	0.00%
Overall (All DHS Facilities)	**30,805**	**180,356**	**100.00%**

Urgent Care Services

MHLA covers urgent care services for MHLA program participants at any of the DHS hospitals or comprehensive health centers that have an urgent care clinic. Participants are instructed to go to DHS, if possible, in the event the participant experiences an urgent care situation requiring care that is beyond the scope of the CPs' capabilities.

Tables F11 and F12 illustrate urgent care utilization among MHLA participants. 3.32% of all MHLA participants (5,344) utilized urgent care services at DHS for a total of 7,924 urgent care visits.

Table F11
Distribution of Unduplicated Urgent Care Patients by Number of Visits

	0 Urgent Visits	1 Urgent Visit	2 Urgent Visits	3 Urgent Visits	4 Urgent Visits	5 - 9 Urgent Visits	10+ Urgent Visits	Total Participants w/ Visits	Total Participants
Number of Participants with Urgent Care Visits	155,684	3,857	912	338	116	113	8	5,344	161,028
Percentage of Participants	96.68%	2.40%	0.57%	0.21%	0.07%	0.07%	0.00%	3.32%	100%

Table F12
Urgent Care Rate per 1,000 Participants (DHS Facilities)

Urgent Care	Total Participants	Participants w/ Urgent Care Visit	Visit Count	Urgent Care Visits Per 1,000 Participants Per Year	Average Visits Per Participant Per Year
FY20-21	161,028	5,344	7,924	62.09	0.06

Emergency Department (DHS)

MHLA participants can receive no-cost emergency services at LAC+USC Medical Center, Olive View-UCLA Medical Center and Harbor-UCLA Medical Center. This section provides an analysis of emergency department (ED) utilization by MHLA participants in FY 2020-21. It is important to note that actual ED utilization among the MHLA population may be underreported as this data only includes ED utilization at DHS hospitals.

In FY 2020-21, 8,964 MHLA participants had 12,899 ED visits at DHS facilities. That represents 5.6% of the total 161,028 MHLA enrolled. The rate of ED visits was just over 101 per 1,000 participants in FY 2020-21, compared to 96 per 1,000 participants last fiscal year (Table F13).

Table F13
ED Visits per 1,000 Participants per Year

Fiscal Year	Number of ED Visits	Participant Months	ED Visits/1,000
2017-18	14,872	1,769,441	100.86
2018-19	18,174	1,730,998	125.99
2019-20	13,119	1,636,504	96.20
2020-21	12,899	1,531,473	101.07

Table F14 illustrates the number of primary care visits that MHLA participants had in the same fiscal year that they visited a DHS ED. Nearly 20% of MHLA participants who had an ED visit in FY 2020-21 did not have a visit at their CP medical home that same year. Table F15 is distribution of unduplicated ED patients by number of visits, and Table F16 is ED visits by DHS facility.

Table F14
Distribution of ED Patients by Number of CP Primary Care Visits

	0 CP Primary Care Visits	1 CP Primary Care Visit	2 CP Primary Care Visits	3 CP Primary Care Visits	4 CP Primary Care Visits	5-9 CP Primary Care Visits	10+ CP Primary Care Visits	Total Participants

# of participants with primary care visits who had an ED Visit	1,766	849	876	842	789	2,601	1,241	8,964

Table F15
Distribution of Unduplicated ED Patients by Number of Visits

	0 ED Visits	1 ED Visit	2 ED Visits	3 ED Visits	4 ED Visits	5 – 9 ED Visits	10+ ED Visits	Total Participants
All Participants	152,064	6,671	1,511	455	161	147	19	161,028
ED Percentage of Total Participants	94.43%	4.14%	0.94%	0.28%	0.10%	0.09%	0.01%	100.00%

Table F16
ED Visits by DHS Facility

Facility Name	Total Participant Visits at Each ED	Visits	% of Total Visits
LAC+USC	4,532	6,457	50.06%
OLIVE VIEW-UCLA	2,514	3,594	27.86%
HARBOR-UCLA	2,045	2,848	22.08%
Total	8,964 (unduplicated)	12,899	100%

Avoidable Emergency Department Visits

ED visits that are not emergency-related and could be considered avoidable[4] are identified as avoidable emergency department visits. Table F17 provides the rate of avoidable emergency department visits for the last four years, and Table F18 lists the avoidable ED visits by type, number of visits and unique participants. Nearly 18% of ED visits by MHLA participants in FY 2020-21 were considered avoidable. This rate is similar from last fiscal year's rate. The top three avoidable ED visit reasons were: headaches, dorsalgia (back pain), and encounter for general examination.

In January 2020, MHLA began sending notifications to CPs each month with the names of their MHLA participants who had visited a DHS emergency department, along with data on whether those visits were considered avoidable. Several CPs reported using that list to conduct outreach to the MHLA participants to get them in for a follow-up primary care visit.

[4] This analysis uses conditions defined by the "Medi-Cal Managed Care Emergency Room Collaborative Avoidable Emergency Room Conditions" when designating an ED visit as avoidable.

Table F17
Avoidable ED (AED) Visits and Rate by MHLA Participants

Fiscal Year	AED Visits	ED Visits	AED Rate
2017-18	2,563	14,872	17.23%
2018-19	3,086	18,174	16.98%
2019-20	2,222	13,119	16.94%
2020-21	2,282	12,899	17.69%

Table F18
Avoidable Emergency Department (AED) Visits – Diseases

Avoidable Emergency Department Visits	Unique Participants	AED Visits	% of AED Visits
Other headache syndromes	1,094	1,218	53.37%
Dorsalgia	570	610	26.73%
Encounter for general examination	91	95	4.16%
Acute Pharyngitis	54	56	2.45%
Conjunctivitis	51	51	2.23%
Hematuria	40	40	1.75%
Cystitis	32	33	1.45%
Obstructive and reflux uropathy	27	29	1.27%
Acute upper respiratory infections of multiple or unspecified sites	18	18	0.79%
Candidiasis	18	18	0.79%
Pruritus	17	17	0.74%
Inflammatory disease of cervix, vagina & vulva	15	15	0.66%
Chronic pharyngitis & nasopharyngitis	12	12	0.53%
Chronic sinusitis	11	12	0.53%
Suppurative Otitis Media	12	12	0.53%
Special examinations	11	11	0.48%
Dermatophytosis	9	10	0.44%
Other specified pruritic conditions (senillis, Winter itch)	8	8	0.35%
Follow up examination	7	7	0.31%
Encounters of administrative purposes	6	6	0.26%
Acute bronchitis	2	2	0.09%
Chronic disease of tonsils & adenoids	2	2	0.09%
Grand Total	**2,016**	**2282**	**100.00%**

Inpatient Hospitalization Admissions (DHS)

DHS provides inpatient hospitalization for MHLA participants at the four DHS hospitals. Similar to emergency department utilization, this inpatient utilization data only captures information from DHS facilities. Table F19 shows inpatient hospitalization admissions for all MHLA participants. 2,914 of 161,028 MHLA program participants (1.8%) in FY 2020-21 were admitted to a DHS hospital. This rate is largely unchanged from last fiscal year (1.6%).

Table F19
Distribution of Unduplicated Hospital Admissions by Number of Inpatient Stays

	No Admissions	1 Admission	2 Admissions	3 Admissions	4 Admissions	5 – 9 Admissions	10+ Admissions	Total Participants
Number of Participants with Inpatient Stays	158,114	2,235	434	143	43	56	3	161,028
% of Total Participants	98.19%	1.39%	0.27%	0.09%	0.03%	0.03%	0.00%	100.00%

Table F20 reflects DHS hospitalization by facility, including bed days and average length of stay (ALOS). 2,914 MHLA participants had 4,057 hospital admissions totaling 20,171 inpatient bed days at DHS facilities. The average length of stay for these patients was five days.

LAC+USC Medical Center continues to be the DHS hospital with the highest number of MHLA inpatient admissions – 50.60% of the total. Rancho Los Amigos National Rehabilitation Center has the highest average length of stay, at 9.61 days.

Table F20
DHS Hospitalization Admission by Facility

Facility Name	Total Participant Admissions at each DHS Hospital	Admissions	% of Total Admissions	Bed Days	ALOS
LAC+USC	1,549	2,053	50.60%	9,446	4.60
OLIVE VIEW-UCLA	569	766	18.88%	3,718	4.85
HARBOR-UCLA	740	963	23.74%	4,365	4.53
RANCHO LOS AMIGOS	208	275	6.78%	2,648	9.61
Total	**2,914 (Unduplicated)**	**4,057**	**100%**	**20,171**	**4.97**

Table F21 shows that the majority (83.51%) of MHLA participants who were hospitalized had a chronic medical condition.

Table F21
DHS Hospitalization Admission

	Unique Participants	Admissions	% of Total Admissions	Bed Days	ALOS
With Chronic Condition	2,361	3,388	83.51%	17,036	5.03
Without Chronic Condition	553	669	16.49%	3,135	4.69
Total Participants	2,914	4,057	100%	20,171	4.97

Table F22 provides a comparative analysis of admissions, acute days and average length of stay. The average length of stay has remained relatively consistent for all years of the program. The number of patient admissions, admissions per 1,000, acute days and acute days per 1,000 participants has increased from last fiscal year.

Table F22
Acute Hospital Days per 1,000 Participants per Year and Average Length of Stay (ALOS)

Fiscal Year	Admissions	Admissions/ 1,000	Bed Days	Acute Days/ 1,000	ALOS
2017-18	3,766	25.54	17,749	120.37	4.71 Days
2018-19	4,206	29.16	21,010	145.65	5.00 Days
2019-20	3,478	25.50	16,395	120.22	4.71 Days
2020-21	4,057	31.79	20,171	158.05	4.97 Days

Hospital Readmissions

The readmission rate for MHLA participants within 90 days at all DHS facilities combined is 18%, as shown in Table F23. The majority of hospital readmissions occurred within the first 30 days. Table F24 provides readmission rates by DHS hospital; Olive View-UCLA Medical Center had the highest readmission rate for MHLA participants, at 19.97%.

Table F23
DHS Hospital Readmission Rate for 30, 60 and 90 Days

Readmit Time After Discharge	Readmissions	Total Admissions	Readmission Rate
01-30 Days	461	4,057	11.36%
31-60 Days	176	4,057	4.34%
61-90 Days	96	4,057	2.37%
Total	**733**	**4,057**	**18.07%**

Table F24
Readmission Rate by DHS Hospital (1 - 90 Days)

Facility Name	Readmissions	Total Admissions	Readmission Rate
LAC+USC MEDICAL CENTER	404	2,053	19.68%
OLIVE VIEW-UCLA MEDICAL CENTER	153	766	19.97%
HARBOR-UCLA MEDICAL CENTER	162	963	16.82%
RANCHO LOS AMIGOS	14	275	5.09%
Total (All DHS Hospitals)	**733**	**4,057**	**18.07%**

Table F25 compares the MHLA readmission rate by fiscal year and by chronic versus non-chronic conditions. The readmission rates for both chronic and non-chronic conditions were slightly higher in FY 2020-21 than last fiscal year.

Table F25
Re-admission Rate by Fiscal Year for Participants with and without Chronic Conditions

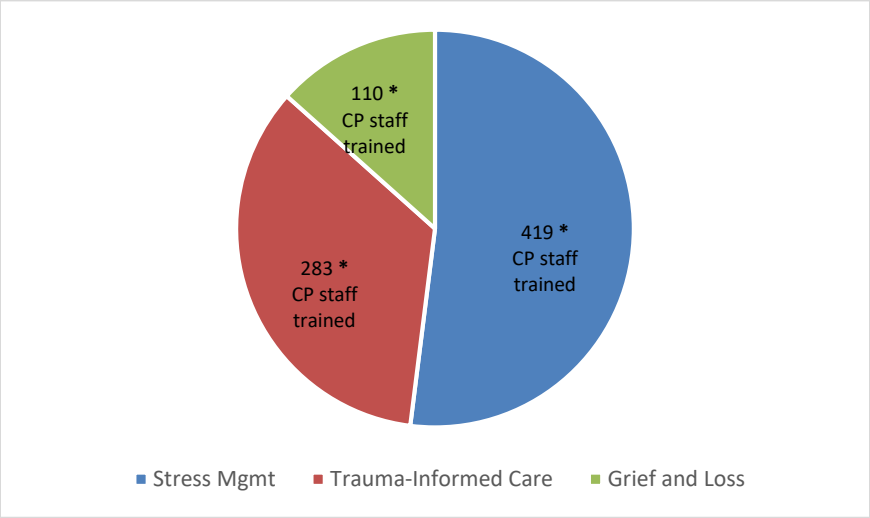
Condition Type	FY 2017-2018 Readmission Rate	FY 2018-2019 Readmission Rate	FY 2019-2020 Readmission Rate	FY 2020-2021 Readmission Rate
W/ Chronic Condition	18.89%	16.56%	15.84%	17.37%
W/O Chronic Condition	16.83%	18.48%	14.09%	18.77%
Overall Inpatients	**17.23%**	**18.07%**	**14.95%**	**18.07%**

G. Mental Health Prevention Services (MHPS)

In 2019, DHS and DMH started a workgroup with Community Clinic Association of Los Angeles County (CCALAC) and several contracted MHLA Community Partner agencies to create a Board-directed project aimed at expanding mental health services for MHLA participants. The two department finalized a Memorandum of Understanding (MOU) in January 2020 and all CPs signed a contract amendment in March 2020. The project was designed to fund and support mental health prevention services to assess protective factors and manage risk factors associated with the onset of serious mental illness of MHLA participants. The project start date was postponed until July 2020 due to the pandemic.

The amendment requires CPs to conduct initial screening of all MHLA participants by administering the Patient Health Questionnaire-9 (PHQ-9), and when appropriate, the Generalized Anxiety Disorder-7 (GAD-7), to determine appropriate prevention services. CP staff are required to get trained on approved curriculums (covering topics such as stress management and trauma-informed care) before providing services. Graph G1 shows the number of staff trained in FY 20-21.

Graph G1
MHPS - CP Staff Training by Curriculum



**CP staff trained in more than one curriculum are counted more than once*

The project is funded by the Mental Health Services Act. DHS pays the CPs a supplemental behavioral health payment of $3.30 per month for each enrolled participant who qualifies for payment, and DMH reimburses DHS for payments made. Table G1 shows in FY 20-21, DMH reimbursed DHS a total of $4,200,051.90.

Table G1
FY 20-21 MHPS Expenditures

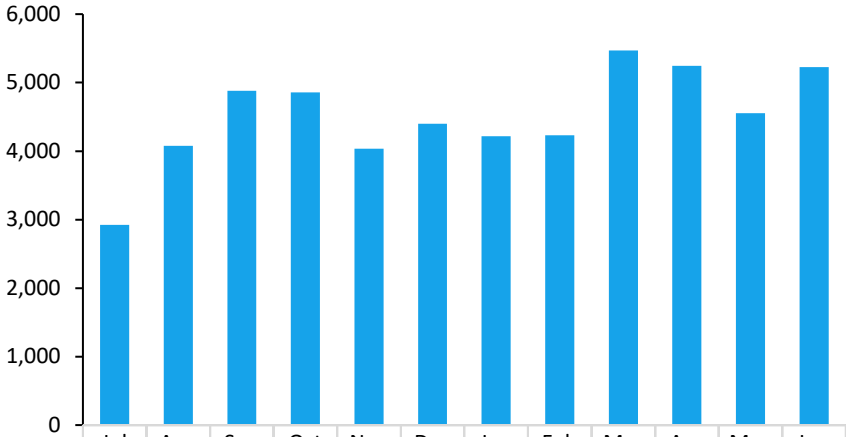
Invoice Date	Payment
July 2020	$285,308.10
August 2020	$400,078.80
September 2020	$352,855.80
October 2020	$352,354.20
November 2020	$352,393.80
December 2020	$351,644.70
January 2021	$345,892.80
February 2021	$343,157.10
March 2021	$351,017.70
April 2021	$346,919.10
May 2021	$357,330.60
June 2021	$361,099.20
Total	**$4,200,051.90**

The mental health prevention services can be provided by phone or in person. CPs are required to submit claims for both screening and services and are required to document in the medical record. Based on the data analysis conducted by DMH, Graph G2 shows there was a total of 54,113 claims submissions for 27,603 unique individuals for FY 20-21. DMH was unable to validate all of the claims

data for completeness and accuracy due to some data anomalies. DMH also provides regular technical assistance calls with the CPs to make sure they understand the requirements and how to provide and document screening and services.

The demographics of those receiving screening and/or services in FY 20-21 largely reflected the MHLA population, though the percentage of women was slightly higher in the mental health prevention project than in the MHLA program. And the largest age group to receive one or more of the services was the age group, 45 to 54 years old.

Graph G2
FY 20-21 Monthly Claims Submission
(for mental health prevention services)



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	2020						2021					
Total Monthly Claims	2,921	4,078	4,883	4,859	4,033	4,399	4,215	4,229	5,470	5,246	4,554	5,226
Percent	5%	8%	9%	9%	7%	8%	8%	8%	10%	10%	8%	10%

H. SUBSTANCE USE DISORDER (SUD) SERVICES

In July 2016, MHLA partnered with the Los Angeles County Department of Public Health's (DPH) Substance Abuse Prevention and Control Division (SAPC) to provide substance use disorder (SUD) treatment services at no-cost to any MHLA participant who needs them.

With the addition of SUD services to the MHLA program, a full array of substance use disorder treatment services became available to MHLA participants. These services include withdrawal management (detox), individual and group counseling, patient education and family therapy, recovery support services, opioid treatment, recovery bridge housing, and case management.

MHLA participants can access SUD services several ways. They can self-refer by calling DPH's Substance Abuse Service Helpline, find a provider nearby through the SAPC website or receive a referral from their MHLA CP medical home clinic. Some CPs also employ their own substance use disorder treatment providers and provide services to their MHLA participants.

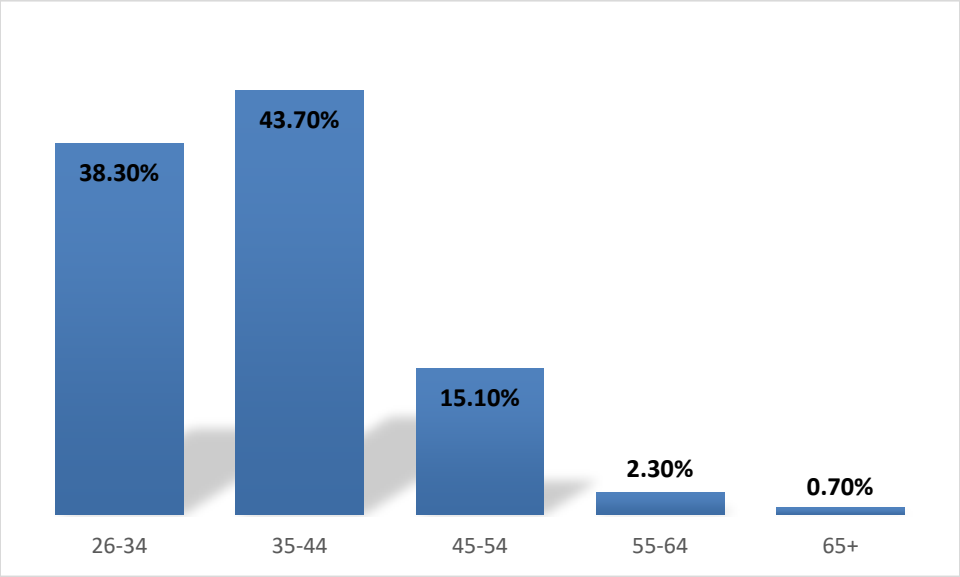
This fiscal year, 703 MHLA participants accessed SUD services through the LA County Department of Public Health (DPH). This represents a 2% increase from last fiscal year, when 691 patients accessed SUD treatment services.

MHLA launched two pilot projects with DPH in the fourth quarter of FY 2019-20. The first enabled five SUD treatment providers to enroll eligible participants into MHLA. The SUD providers were trained on MHLA enrollment and given access to the One-e-App enrollment program. Because of the overall decline in people seeking SUD services, the SUD providers only enrolled a few people into MHLA. The SUD enrollers also received a temporarily waiver to process applications over the phone.

The second project, SAPC's Field-Based Services (FBS) program, which paired Substance Use Disorder treatment providers with four CP agencies to provide services to MHLA participants on-site at the clinics. The project is intended to help meet needs of populations that have been historically difficult to serve. However, due to COVID, the treatment providers could not go on-site and instead provided services by phone. The MHLA program also continues to do outreach campaign with clinics, advocacy groups and patients regarding the availability of these services.

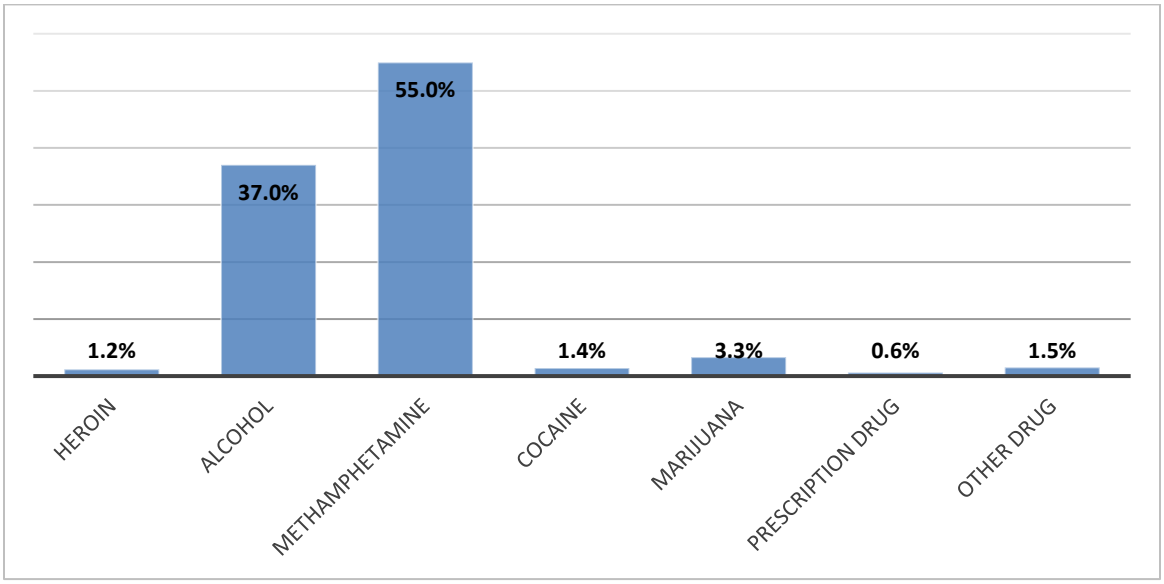
Graph H1 illustrates those MHLA participants who sought SUD treatment services from DPH, sorted by age. The largest group of SUD treatment recipients was the age group, 35 to 44 years old, most being male Hispanic.

Graph H1
MHLA SUD Participant by Age



Graph H2 provides a breakdown of MHLA participants by SUD issue. The 703 participants may have had more than one SUD issue (total of 934 SUD issues) during the fiscal year. 55% of patients sought SUD treatment services for methamphetamine addiction, 37% individuals utilized treatment for alcoholism, and 3.3% of the participants sought help for marijuana addiction. The remaining participants, sought SUD treatment for cocaine, heroin, prescription drug use or other drugs.

Graph H2
MHLA SUD Participant by SUD Issue



I. EXPENDITURES

This final section of the annual report provides information on the payments made to CP clinics under the MHLA program in FY 2020-21.

Key FY 2020-21 highlights were:

- Total Monthly Grant Funding (MGF) payments to Community Partners for primary care related services totaled $45.96 million.
- Payments for dental services totaled $2.95 million.
- Payments for pharmacy services totaled $9.33 million.

MHLA Health Care Service Payment Categories

Primary and Dental Care

DHS pays CPs in two ways: (1) MGF payments for preventive and primary care, and (2) Fee-for-service payments for dental services provided by those CP clinics with dental contracts with MHLA. In addition, MHLA pays for medications on behalf of participants.

A total of $45.96 million in MGF payments and $2.95 million in dental funding were paid to the CPs in FY 2020-21. Dental expenditures have continued to dramatically decline in FY 2020-21 due to COVID; CPs effectively shut down their dental services for the last quarter of the fiscal year 2019-20 and participants are slowly coming back for dental services.

MGF Payments

CPs receive an MGF payment per month of $32 plus the $3.30 Supplemental Behavioral Health payment based on enrolled participants who also had an in-person primary care visit in the prior 24 months.

Throughout the fiscal year, the percentage of participants qualifying for MGF payment ranged from 82.73% to 87.04% (Table H1).

Table I1
Participants Qualifying for MGF Payment

	Enrolled Participants	Enrolled Participants Qualifying for MGF Payment	Percentage of Participants Qualifying for MGF Payment
July 2020	138,400	120,464	87.04%
August 2020	139,926	121,236	86.64%
September 2020	122,992	106,926	86.94%
October 2020	124,077	107,397	86.56%
November 2020	123,841	106,786	86.23%
December 2020	123,999	106,549	85.93%
January 2021	124,447	106,229	85.36%
February 2021	124,991	105,879	84.71%
March 2021	126,648	106,432	84.04%
April 2021	128,256	107,072	83.48%
May 2021	130,480	108,348	83.04%
June 2021	132,336	109,484	82.73%

Although enrollment increased during the last quarter of FY 2020-21, the percentage of participants qualifying for MGF payment decreased. The primary reason for this is the decline in in-person visits due to the pandemic. MHLA encouraged telehealth as a part of overall primary care services. Telehealth visits are not counted as qualifying primary care visits for purposes of payment, meaning participants still need one in-person, qualifying visit within 24 months.

Pharmacy Payments

In FY 2020-21, MHLA paid $9.33 million for pharmacy-related services, $2.50 million less than the budgeted $11.83 million. The expenditures include payments to Ventegra for medication costs, administration and Surescript fees, as well as payments to CPs for dispensary costs. Most of the reduction came from reduced payments to Ventegra for medication and administrative costs ($1.71 million) and from reduced payments to CP dispensaries as in-person visits declined in FY 2020-21. There is evidence suggesting that COVID may have played some role in mitigating pharmacy costs of lower-level utilizers. Despite reduced overall expenditures, however, there is also evidence that pharmacy costs on a per member per month basis continue to increase.

Table I2
Total Pharmacy Expenditures

Pharmacy Expenditures	
Drug Costs (Ventegra-contracted pharmacies & CP dispensaries)	$8,282,888.45
Ventegra's Administration and Surescript Fees	$909,710.42
Ventegra – 2020 340B MFR Charges Remediation	$20,575.30
Cardinal Health	$111,856.03
Cerner Expenses	$7,842.58
Total	$9,332,872.78

MHLA Health Care Service Payments

Table I3 outlines the total payments, $58.25 million, for the MHLA Program for FY2020-21. Appendix 2 provide total expenditures by CP clinic for both the MHLA primary and dental care.

Table I3
Total MHLA Expenditures

Community Partner Payments	
Primary Care	$45,959,753.10
Pharmacy	$9,332,872.78
Dental Care	$2,953,398.01
GRAND TOTAL	$58,246,023.89

III. CONCLUSION AND LOOKING FORWARD

FY 2020-21 was the seventh programmatic year for the MHLA program. As the report demonstrates, the services available to the MHLA participants continued to expand under the program to provide a comprehensive array of primary and supportive services to meet the needs of these patients. Participants receive regular primary care, and when needed, specialty, emergency, urgent and inpatient care. They also obtain medications through a robust network of community pharmacies as well as through CPs and DHS. They also receive substance use disorder treatment and mental health prevention and treatment, through partnerships with LA County DPH and DMH respectively.

This year, community clinics began providing the Mental Health Prevention Services to all MHLA participants and we look forward to continuing providing the services in FY2021-22. We will also continue to partner with DPH and CP clinics to increase participant's knowledge of and participation in SUD treatment programs. In January 2021 the program redesigned the MHLA website to make it easier and more user friendly to view and find information. The program also enhanced materials and continued expanding texting and robocalling.

In 2022, the program plans to start a patient advisory council with the vision of "collaborating with our participants and their families to improve their experience and the quality of the MHLA program." In

addition, we will work to seamlessly transition adults 50 years of age and older who will become eligible for full-scope Medi-Cal in May 2022. MHLA has approximately 55,000 adults who will be eligible for the Medi-Cal expansion regardless of immigration status. MHLA also started a quality improvement project to incentivize CPs to bring MHLA participants into their assigned medical home clinic for in-person included services.

Additional plans include bringing MHLA data into DHS's ELM system, which will help DHS providers accurately determine if someone is enrolled in MHLA and will help with transitions of care out of the hospitals and specialty care clinics. The data also will help ensure that individuals are not both empaneled to DHS and enrolled in MHLA.

The MHLA program also will help participants get signed up for the LA Health Portal and continue encouraging CPs to join LANES, the health information exchange in LA County. At the end of FY 2020-21, 38 CPs had signed contracts with LANES and 23 have started to access data through the exchange. Being on LANES enables CPs and DHS to securely share patient health information with the goal of more care coordination.

DHS continues to work in partnership with the Community Clinic Association of Los Angeles County, the Los Angeles health advocacy community and our CP clinics to build and grow a strong, comprehensive health care coverage program for eligible, uninsured residents of Los Angeles County.

APPENDIX 1
Total Enrolled and Office Visits by Community Partner Medical Home[5]

Medical Home Name	Total Enrolled	Unique Participants Seen	% of Participants Seen	Primary Visits	Visit Per Participant Per Year
AAA COMMUNITY CLINIC	184	65	35%	229	2.56
AFH-519	16	10	63%	36	4.24
AFH-BURBANK	70	49	70%	178	3.90
AFH-BURBANK 2	2	2	100%	5	2.50
AFH-CENTRAL	365	236	65%	745	3.23
AFH-PACIFIC	5	3	60%	8	2.40
AFH-SOUTH CENTRAL II	1	0	0%	0	0.00
AFH-SUNLAND	29	18	62%	50	3.00
ALL-INCLUSIVE COMMUNITY HEALTH CENTER	384	281	73%	955	4.35
ALL-INCLUSIVE COMMUNITY HEALTH-EAGLE ROCK	23	6	26%	17	1.45
ALL-INCLUSIVE COMMUNITY HEALTH-NORTHRIDGE	73	56	77%	184	5.23
ALTAMED-COMMERCE	1,010	771	76%	4,140	4.54
ALTAMED-EL MONTE	420	306	73%	1,611	4.27
ALTAMED-FIRST STREET	529	390	74%	2,111	4.45
ALTAMED-HUNTINGTON PARK	1	1	100%	2	2.00
ALTAMED-PICO RIVERA PASSONS	6	3	50%	12	2.00

[5] In the MHLA program, participants generally receive the majority of their primary care visits at their chosen medical home, but they may obtain care at other clinics within the agency. Encounter data is reported by the clinic that provided the service to the participant (even if the visit was not at the participant's chosen medical home). As a result, it is possible that a participant had primary care encounter data submitted for them on behalf of a CP clinic site that was not their medical home.

Medical Home Name	Total Enrolled	Unique Participants Seen	% of Participants Seen	Primary Visits	Visit Per Participant Per Year
ALTAMED-PICO RIVERA SLAUSON	479	377	79%	2,139	4.85
ALTAMED-SOUTH GATE	236	172	73%	922	4.30
ALTAMED-WEST COVINA	268	192	72%	1,003	4.28
ALTAMED-WESTLAKE	9	5	56%	29	3.35
ALTAMED-WHITTIER	975	751	77%	3,901	4.37
APLAHW-BALDWIN HILLS	180	111	62%	410	3.53
APLAHW-LONG BEACH	101	70	69%	206	3.48
ARROYO VISTA-EL SERENO HUNTINGTON DRIVE	470	294	63%	1,245	3.61
ARROYO VISTA-EL SERENO VALLEY	99	36	36%	95	2.10
ARROYO VISTA-HIGHLAND PARK	1,737	1,057	61%	4,179	3.45
ARROYO VISTA-LINCOLN HEIGHTS	2,319	1,239	53%	4,539	3.14
ASIAN PACIFIC HEALTH CARE-BELMONT HC	1,060	623	59%	3,788	5.31
ASIAN PACIFIC HEALTH CARE-EL MONTE ROSEMEAD HC	297	215	72%	1,622	7.56
ASIAN PACIFIC HEALTH CARE-LOS FELIZ HC	1,599	1,158	72%	8,057	6.48
BARTZ-ALTADONNA COMMUNITY HEALTH CENTER	614	379	62%	2,111	4.48
BARTZ-ALTADONNA-EAST PALMDALE	6	0	0%	0	0.00
BENEVOLENCE-CENTRAL MEDICAL CLINIC	434	211	49%	781	2.94
BENEVOLENCE-CRENSHAW COMMUNITY CLINIC	377	160	42%	618	2.69
BHS-EL PUERTO HEALTH CENTER	4	3	75%	37	11.38

Medical Home Name	Total Enrolled	Unique Participants Seen	% of Participants Seen	Primary Visits	Visit Per Participant Per Year
BHS-FAMILY HEALTH CENTER	176	102	58%	352	3.86
CENTER FOR FAMILY HEALTH AND EDUCATION	263	190	72%	721	3.72
CENTRAL CITY COMMUNITY HEALTH CENTER INC.	1,050	750	71%	3,536	4.68
CENTRAL CITY COMMUNITY-BALDWIN PARK	235	147	63%	776	4.76
CENTRAL CITY COMMUNITY-BROADWAY	451	211	47%	648	2.76
CENTRAL CITY COMMUNITY-EL MONTE	306	191	62%	889	4.35
CENTRAL CITY COMMUNITY-LA PUENTE	166	80	48%	421	4.28
CENTRAL NEIGHBORHOOD-CENTRAL	574	450	78%	2,487	5.29
CHAPCARE-DEL MAR	341	212	62%	954	4.08
CHAPCARE-FAIR OAKS	1,299	940	72%	4,269	4.29
CHAPCARE-LAKE ELIZABETH	181	140	77%	518	4.05
CHAPCARE-LIME	170	120	71%	552	3.89
CHAPCARE-PECK	282	192	68%	806	3.76
CHAPCARE-VACCO	527	261	50%	1,069	3.25
CHINATOWN SERVICES CENTER-SAN GABRIEL VALLEY	32	22	69%	121	4.96
CHINATOWN-COMMUNITY HEALTH CENTER	162	119	73%	706	5.72
CLINICA ROMERO-ALVARADO CLINIC	2,644	1,765	67%	6,772	2.80
CLINICA ROMERO-MARENGO CLINIC	1,723	1,127	65%	4,333	2.82
COMPREHENSIVE COMMUNITY-EAGLE ROCK	449	298	66%	1,201	4.57

Medical Home Name	Total Enrolled	Unique Participants Seen	% of Participants Seen	Primary Visits	Visit Per Participant Per Year
COMPREHENSIVE COMMUNITY-GLENDALE	917	613	67%	2,727	4.41
COMPREHENSIVE COMMUNITY-HIGHLAND PARK	1,107	907	82%	4,153	4.40
COMPREHENSIVE COMMUNITY-NORTH HOLLYWOOD	1,321	921	70%	4,012	4.31
COMPREHENSIVE COMMUNITY-SUNLAND	433	304	70%	1,343	5.16
EL PROYECTO DEL BARRIO-ARLETA	1,584	1,013	64%	7,203	5.95
EL PROYECTO DEL BARRIO-AZUSA	1,258	857	68%	6,580	7.14
EL PROYECTO DEL BARRIO-BALDWIN PARK	359	262	73%	2,039	7.95
EL PROYECTO DEL BARRIO-ESPERANZA	315	121	38%	665	3.59
EL PROYECTO DEL BARRIO-WINNETKA	2,021	1,422	70%	10,781	7.59
EVCHC-COVINA HEALTH CENTER	657	441	67%	2,359	4.81
EVCHC-PALOMARES SBC	1	0	0%	0	0.00
EVCHC-POMONA CLINIC	1,930	1,337	69%	5,676	3.89
EVCHC-VILLACORTA SCHOOL-BASED CLINIC	243	53	22%	161	1.82
EVCHC-WEST COVINA CLINIC	2,774	1,857	67%	9,218	4.30
FAMILY HEALTH-BELL GARDENS	3,999	3,076	77%	18,317	5.62
FAMILY HEALTH-DOWNEY	208	150	72%	921	5.24
FAMILY HEALTH-HAWAIIAN GARDENS	673	526	78%	3,213	5.85
FAMILY HEALTH-MAYWOOD	298	217	73%	1,169	4.71
FAMILY HEALTH-SCHOOL BASED HEALTH CENTER	9	5	56%	27	3.45

Medical Home Name	Total Enrolled	Unique Participants Seen	% of Participants Seen	Primary Visits	Visit Per Participant Per Year
GARFIELD HEALTH CENTER	136	92	68%	346	3.31
GARFIELD HEALTH CENTER-ATLANTIC	59	40	68%	234	6.23
HARBOR COMMUNITY CLINIC	147	33	22%	72	1.59
HARBOR-6TH STREET HEALTH CENTER	835	603	72%	2,328	3.44
HERALD CHRISTIAN HEALTH CENTER	47	20	43%	96	2.99
HERALD CHRISTIAN HEALTH CENTER-ROSEMEAD	82	51	62%	250	4.04
JWCH-ABBEY APARTMENT	1	0	0%	0	0.00
JWCH-BELL GARDENS	1,864	876	47%	1,831	1.26
JWCH-DOWNTOWN WOMEN'S CENTER	6	3	50%	15	3.33
JWCH-NORWALK	1,725	1,053	61%	2,492	1.69
JWCH-WEINGART	589	309	52%	1,088	2.76
JWCH-WEINGART 2	1	0	0%	0	0.00
JWCH-WESLEY ANDREW ESCAJEDA	26	7	27%	11	0.87
JWCH-WESLEY BELLFLOWER	1,639	880	54%	1,863	1.42
JWCH-WESLEY DOWNEY	1,182	625	53%	1,670	1.95
JWCH-WESLEY HACIENDA HEIGHTS	419	248	59%	558	1.73
JWCH-WESLEY HEALTH AND WELLNESS	742	387	52%	958	1.69
JWCH-WESLEY LYNWOOD	1,673	864	52%	1,723	1.30
JWCH-WESLEY PALMDALE CENTRAL	741	408	55%	1,033	1.77

Medical Home Name	Total Enrolled	Unique Participants Seen	% of Participants Seen	Primary Visits	Visit Per Participant Per Year
JWCH-WESLEY PALMDALE EAST	396	178	45%	407	1.25
JWCH-WESLEY VERMONT	1,177	704	60%	1,846	2.14
KEDREN COMMUNITY CARE CLINIC	195	125	64%	1,248	10.47
KHEIR CLINIC	2,365	1,756	74%	8,023	4.46
KHEIR-WILSHIRE CLINIC	25	14	56%	46	3.86
LA CHRISTIAN-EXODUS ICM	4	1	25%	1	0.63
LA CHRISTIAN-GATEWAY AT PERCY VILLAGE	2	0	0%	0	0.00
LA CHRISTIAN-JOSHUA HOUSE	263	155	59%	634	4.14
LA CHRISTIAN-PICO ALISO	1,240	773	62%	2,854	3.54
LA CHRISTIAN-WORLD IMPACT	118	49	42%	170	2.49
LOS ANGELES LGBT CENTER	43	25	58%	106	4.05
NEV-CANOGA PARK	360	261	73%	1,249	3.89
NEV-HOMELESS HEALTH	151	115	76%	675	5.79
NEV-HOMELESS MOBILE CLINIC	12	4	33%	17	2.52
NEV-NEWHALL HEALTH CENTER	2,330	1,422	61%	6,486	3.42
NEV-PACOIMA	4,263	2,622	62%	11,741	3.53
NEV-PACOIMA WOMEN'S HEALTH CENTER	56	12	21%	36	1.86
NEV-SAN FERNANDO	2,795	1,851	66%	9,003	3.88
NEV-SAN FERNANDO HIGH SCHOOL TEEN HC	7	3	43%	9	2.35

Medical Home Name	Total Enrolled	Unique Participants Seen	% of Participants Seen	Primary Visits	Visit Per Participant Per Year
NEV-SANTA CLARITA	348	213	61%	902	2.84
NEV-SUN VALLEY	594	430	72%	1,825	3.51
NEV-TTW-NORTH HOLLYWOOD	33	15	45%	72	2.84
NEV-VALENCIA	227	144	63%	734	3.61
NEV-VAN NUYS ADULT	1,393	890	64%	4,556	4.03
PED AND FAMILY-EISNER PED AND FAMILY	3,753	2,348	63%	10,200	3.15
PED AND FAMILY-EISNER-LYNWOOD	188	101	54%	392	2.62
PED AND FAMILY-EISNER-USC EISNER-CA HOSP	1,008	437	43%	1,728	2.46
POMONA COMMUNITY-HOLT	726	401	55%	1,071	2.06
POMONA COMMUNITY-PARK	7	2	29%	3	1.29
QUEENSCARE-EAGLE ROCK	740	505	68%	1,857	2.85
QUEENSCARE-EAST THIRD STREET	2,629	1,629	62%	6,494	3.00
QUEENSCARE-ECHO PARK	1,374	1,063	77%	4,345	3.59
QUEENSCARE-HOLLYWOOD	1,396	1,013	73%	4,160	3.53
QUEENSCARE-WESTLAKE NORTH	179	113	63%	395	3.02
SAMUEL DIXON-CANYON COUNTRY HC	227	163	72%	623	3.30
SAMUEL DIXON-NEWHALL	436	280	64%	1,199	3.42
SAMUEL DIXON-VAL VERDE	45	25	56%	115	3.25
SAN FERNANDO CHC-MISSION HILLS	32	3	9%	8	1.17

Medical Home Name	Total Enrolled	Unique Participants Seen	% of Participants Seen	Primary Visits	Visit Per Participant Per Year
SAN FERNANDO COMMUNITY HEALTH CENTER	1,268	806	64%	4,248	3.75
SOUTH BAY-CARSON	293	208	71%	930	4.13
SOUTH BAY-GARDENA	1,527	1,056	69%	5,424	3.95
SOUTH BAY-INGLEWOOD	1,599	1,046	65%	3,907	2.90
SOUTH BAY-REDONDO BEACH	724	505	70%	2,563	4.20
SOUTH CENTRAL FAMILY HC	4,054	2,925	72%	19,922	5.94
SOUTH CENTRAL FAMILY MEDICAL CENTER	8	3	38%	22	3.83
SOUTH CENTRAL-CUDAHY FAMILY HEALTH	60	43	72%	261	6.46
SOUTH CENTRAL-HUNTINGTON PARK	1,512	1,099	73%	5,960	4.93
SOUTH CENTRAL-SANTA FE	3	3	100%	15	8.57
SOUTH CENTRAL-VERNON	13	3	23%	32	4.36
ST. JOHN'S-COMPTON	2,913	2,113	73%	8,630	3.76
ST. JOHN'S-CRENSHAW	288	220	76%	778	4.15
ST. JOHN'S-DOMINGUEZ	1,844	1,397	76%	5,298	3.50
ST. JOHN'S-DOWNTOWN LOS ANGELES-MAGNOLIA	2,993	2,176	73%	7,873	3.33
ST. JOHN'S-DR. KENNETH WILLIAMS	10,444	7,441	71%	27,804	3.12
ST. JOHN'S-HYDE PARK	1,250	954	76%	3,866	3.69
ST. JOHN'S-LINCOLN HEIGHTS	596	475	80%	2,380	5.27
ST. JOHN'S-LOUIS FRAYSER	136	55	40%	207	2.40

Medical Home Name	Total Enrolled	Unique Participants Seen	% of Participants Seen	Primary Visits	Visit Per Participant Per Year
ST. JOHN'S-MANUAL ARTS	1,572	1,156	74%	4,126	3.40
ST. JOHN'S-MOBILE 2	5	3	60%	16	5.49
ST. JOHN'S-MOBILE UNIT 1	23	9	39%	24	1.58
ST. JOHN'S-RANCHO DOMINGUEZ	1,661	1,294	78%	5,550	4.27
ST. JOHN'S-ROLLAND CURTIS	81	68	84%	197	3.98
ST. JOHN'S-WARNER TRAYNHAM	1,801	1,356	75%	5,417	4.02
ST. JOHN'S-WASHINGTON	1,029	747	73%	2,988	3.73
TARZANA-LANCASTER	680	445	65%	1,444	2.52
TARZANA-PALMDALE	469	267	57%	910	2.46
TARZANA-TARZANA	2	0	0%	0	0.00
THE ACHIEVABLE FOUNDATION	36	31	86%	112	3.60
THE CHILDREN'S CLINIC-ARTESIA	6	4	67%	10	2.50
THE CHILDREN'S CLINIC-ATLANTIC	45	34	76%	119	3.22
THE CHILDREN'S CLINIC-CABRILLO GATEWAY	51	32	63%	109	2.56
THE CHILDREN'S CLINIC-CESAR CHAVEZ ELEMENTARY SCHOOL	149	98	66%	369	2.97
THE CHILDREN'S CLINIC-FAMILY HC BELLFLOWER	346	237	68%	1,018	3.53
THE CHILDREN'S CLINIC-FAMILY HC CENTRAL LB	358	224	63%	812	2.71
THE CHILDREN'S CLINIC-FAMILY HC WESTSIDE	338	248	73%	886	3.02
THE CHILDREN'S CLINIC-LB MULTI-SERVICE CTR HOMELESS	12	5	42%	29	4.14

Medical Home Name	Total Enrolled	Unique Participants Seen	% of Participants Seen	Primary Visits	Visit Per Participant Per Year
THE CHILDREN'S CLINIC-NORTH LB HAMILTON MIDDLE SCHOOL	601	406	68%	1,308	2.66
THE CHILDREN'S CLINIC-ROOSEVELT	154	84	55%	252	1.97
THE CHILDREN'S CLINIC-S. MARK TAPER	1,406	933	66%	3,249	2.77
THE CHILDREN'S CLINIC-VASEK POLAK	641	415	65%	1,348	2.41
THE LA FREE-BEVERLY	1,432	933	65%	4,519	4.11
THE LA FREE-HOLLYWOOD-WILSHIRE	4,226	2,668	63%	10,907	3.28
THE LA FREE-S. MARK TAPER	772	518	67%	2,767	4.39
THE LA FREE-VIRGIL FAMILY HC	50	17	34%	45	2.95
THE NECC-CFC	669	457	68%	2,063	3.71
THE NECC-COMMUNITY MEDICAL ALLIANCE	69	52	75%	220	4.41
THE NECC-HARBOR CITY	122	84	69%	496	4.74
THE NECC-HAWTHORNE	120	78	65%	321	3.63
THE NECC-HIGHLAND PARK	399	280	70%	1,259	3.73
THE NECC-HUNTINGTON PARK CHC	424	266	63%	1,556	4.95
THE NECC-WILMINGTON	322	224	70%	1,003	3.69
THE-LENNOX	217	57	26%	204	2.21
THE-RUTH TEMPLE	1,667	1,170	70%	6,156	4.57
UMMA	1,206	806	67%	4,387	4.96
UMMA-FREMONT WELLNESS CENTER	328	221	67%	1,199	4.79

Medical Home Name	Total Enrolled	Unique Participants Seen	% of Participants Seen	Primary Visits	Visit Per Participant Per Year
UNIVERSAL COMMUNITY	83	54	65%	338	5.75
UNIVERSAL COMMUNITY-SPS	113	85	75%	601	6.84
VALLEY-NORTH HILLS WELLNESS CENTER	1,850	1,144	62%	4,625	3.26
VALLEY-NORTH HOLLYWOOD	4,108	2,785	68%	12,985	3.40
VENICE-COLEN	808	493	61%	1,902	2.76
VENICE-ROBERT LEVINE	106	75	71%	294	3.36
VENICE-SIMMS/MANN	1,829	1,180	65%	4,906	3.23
VENICE-VENICE	1,653	1,109	67%	4,814	3.49
VIA CARE CHC-607	381	214	56%	1,105	4.01
VIA CARE CHC-615	3	2	67%	12	5.54
VIA CARE CHC-EASTSIDE	418	201	48%	884	2.95
VIA CARE CHC-GARFIELD WELLNESS CENTER	481	217	45%	998	3.15
VIA CARE COMMUNITY HEALTH CENTER	1,458	811	56%	3,721	3.29
WATTS-CRENSHAW	13	2	15%	8	0.77
WATTS-WATTS	823	528	64%	2,154	3.21
WESTSIDE FAMILY HEALTH CENTER	20	4	20%	7	2.10
WESTSIDE FAMILY HEALTH-CULVER CITY	398	342	86%	1,961	5.72
WHITE MEMORIAL CHC	412	216	52%	936	3.05
WHITE MEMORIAL-4300	7	4	57%	16	5.05

Medical Home Name	Total Enrolled	Unique Participants Seen	% of Participants Seen	Primary Visits	Visit Per Participant Per Year
WILMINGTON COMMUNITY CLINIC	2,460	1,685	68%	9,910	5.09
WILMINGTON-MARY HENRY COMMUNITY CLINIC	19	7	37%	69	6.57
Grand Total	**161,028**	**106,606**	**66%**	**479,219**	**3.75**

APPENDIX 2
Primary Care and Dental Expenditures

Community Partner	MGF Payment	Dental Payment
AAA COMPREHENSIVE HEALTHCARE, INC.	$13,677.00	
ALL FOR HEALTH, HEALTH FOR ALL, INC.	$37,105.00	
ALL INCLUSIVE COMMUNITY HEALTH CENTER	$95,840.00	
ALTAMED HEALTH SERVICES CORPORATION	$1,376,276.00	
APLA HEALTH AND WELLNESS	$63,437.00	$17,849.00
ARROYO VISTA FAMILY HEALTH FOUNDATION	$1,068,602.00	$32,735.00
ASIAN PACIFIC HEALTH CARE VENTURE, INC.	$794,780.00	
BARTZ-ALTADONNA COMMUNITY HEALTH CENTER	$166,898.00	
BEHAVIORAL HEALTH SERVICES, INC.	$23,892.00	
BENEVOLENCE INDUSTRIES, INCORPORATED	$153,588.00	$24,973.00
CENTER FOR FAMILY HEALTH AND EDUCATION, INC.	$71,106.00	
CENTRAL CITY COMMUNITY HEALTH CENTER, INC.	$529,267.00	
CENTRAL NEIGHBORHOOD HEALTH FOUNDATION	$182,080.00	
CHINATOWN SERVICE CENTER	$52,945.00	$18,269.00
CLINICA MSR. OSCAR A. ROMERO	$1,472,257.00	$30,151.00
COMMUNITY HEALTH ALLIANCE OF PASADENA	$769,469.00	$42,522.00
COMPREHENSIVE COMMUNITY HEALTH CENTERS, INC.	$1,162,351.00	$216,261.00
EAST VALLEY COMMUNITY HEALTH CENTER, INC.	$1,596,130.00	$142,375.00
EL PROYECTO DEL BARRIO, INC.	$1,413,456.00	$81,689.00

Community Partner	MGF Payment	Dental Payment
FAMILY HEALTH CARE CENTERS OF GREATER LOS ANGELES, INC.	$1,503,109.00	$248,111.00
GARFIELD HEALTH CENTER	$52,774.00	
HARBOR COMMUNITY CLINIC	$249,280.00	$64,826.00
HERALD CHRISTIAN HEALTH CENTER	$27,640.00	$45,726.00
JWCH INSTITUTE, INC.	$3,312,597.00	$214,783.00
KEDREN COMMUNITY HEALTH CENTER, INC.	$42,925.00	
KOREAN HEALTH, EDUCATION, INFORMATION & RESEARCH (KHEIR)	$695,375.00	
LOS ANGELES CHRISTIAN HEALTH CENTERS	$354,165.00	$32,669.00
LOS ANGELES LGBT CENTER	$6,814.00	
NORTHEAST VALLEY HEALTH CORP.	$3,208,205.00	$265,288.00
PEDIATRIC AND FAMILY MEDICAL CENTER, DBA EISNER PEDIATRIC & FAMILY MEDICAL CENTER	$1,381,324.00	$45,540.00
POMONA COMMUNITY HEALTH CENTER	$178,371.00	
QUEENSCARE HEALTH CENTERS	$1,918,462.00	$262,676.00
SAMUEL DIXON FAMILY HEALTH CENTER, INC.	$197,150.00	
SAN FERNANDO COMMUNITY HOSPITAL DBA SAN FERNANDO CHC	$381,718.00	$69,927.00
SOUTH BAY FAMILY HEALTH CARE	$1,295,404.00	$26,841.00
SOUTH CENTRAL FAMILY HEALTH CENTER	$1,746,538.00	
ST. JOHN'S WELL CHILD AND FAMILY CENTER, INC.	$8,524,420.00	$413,556.01
TARZANA TREATMENT CENTER, INC.	$326,596.00	
THE ACHIEVABLE FOUNDATION	$10,087.00	
THE CHILDREN'S CLINIC, SERVING CHILDREN AND THEIR FAMILIES	$1,232,217.00	
THE CLINIC, INC.	$515,088.00	
THE LOS ANGELES FREE CLINIC, DBA SABAN COMMUNITY CLINIC	$1,817,526.00	$272,800.00
THE NORTHEAST COMMUNITY CLINIC	$648,931.00	
UNIVERSAL COMMUNITY HEALTH CENTER	$53,056.00	
UNIVERSITY MUSLIM MEDICAL ASSOCIATION, INC. (UMMA)	$427,342.00	
VALLEY COMMUNITY HEALTHCARE	$1,789,639.00	$37,797.00
VENICE FAMILY CLINIC	$1,151,521.00	$58,604.00

Community Partner	MGF Payment	Dental Payment
VIA CARE COMMUNITY HEALTH CENTER, INC.	$725,521.00	$233,967.00
WATTS HEALTHCARE CORP.	$255,325.00	$48,459.00
WESTSIDE FAMILY HEALTH CENTER	$132,340.00	
WHITE MEMORIAL COMMUNITY HEALTH CENTER	$61,351.00	$5,004.00
WILMINGTON COMMUNITY CLINIC	$693,786.00	
Grand Total	**$45,959,753**	**$2,953,398.01**

APPENDIX 3
Data Source and Submission

The data for this report, which included all services provided to MHLA participants between July 1, 2020 and June 30, 2021, came from a variety of sources. The data on inpatient, emergency, urgent care and specialty medical services was extracted from DHS systems. The membership and demographic data came from the One-e-App system. Data for primary care services was submitted by CPs and processed by American Insurance Administrators (AIA).

MHLA's One-e-App database program is a web-based eligibility and enrollment system. One-e-App is the primary tool utilized by the CPs to determine eligibility and enroll applicants to MHLA in real time. It is a comprehensive system that captures patient demographic data and provides the data to DHS. The One-e-App system is maintained by a contract vendor, Alluma. MHLA works with Alluma to maintain data integrity.

The One-e-App system uploads its data into the DHS systems. The DHS systems integrate clinical, utilization, financial and managed care data into one database system that enables timely and accurate reporting of clinical, operational and financial data.

Additionally, MHLA's Pharmacy Services Administrator, Ventegra, compiles the pharmacy claims data for those CPs. This utilization data is then submitted to the DHS systems.