Annual Report
to the
Los Angeles County Board of Supervisors
Fiscal Year 2015-16

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I. SUMMARY AND OVERVIEW OF 2015-16 ACCOMPLISHMENTS

Fiscal Year 2015-16 was the second year of operation for the My Health LA (MHLA) program.

MHLA provides primary health care services to Los Angeles County residents whose household income is at or below 138% of the Federal Poverty Level (FPL) and who are not eligible for publicly-funded health care coverage programs such as full-scope Medi-Cal. At the end of the Fiscal Year, MHLA provided primary medical care through a contracted network of 51 Community Partner (CP) agencies representing 176 clinic sites throughout Los Angeles County. Diagnostic, specialty, inpatient, emergency and urgent care are provide by Los Angeles County Department of Health Services (DHS) facilities.

Through the MHLA program, DHS endeavors to meet the health care needs of certain low-income, uninsured Los Angeles residents who remain uninsured after implementation of the federal Affordable Care Act's (ACA) individual health insurance mandate. These individuals are known as the residually uninsured. The DHS' Managed Care Services (MCS) office developed the MHLA program to fill this gap in health care access in Los Angeles County.

MHLA is closely aligned with DHS' mission is to "ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners." 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 health care coverages under the Affordable Care Act or other publicly financed program have a medical home and 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 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, by improving data collection, developing performance measurements and tracking of health outcomes to avoid unnecessary service duplication.

Simplify Administrative Systems.

- Create a simplified administrative infrastructure that encourages efficiency, and an electronic eligibility determination and enrollment system (for enrollment, renewal and disenrollment) for individuals participating in the program.

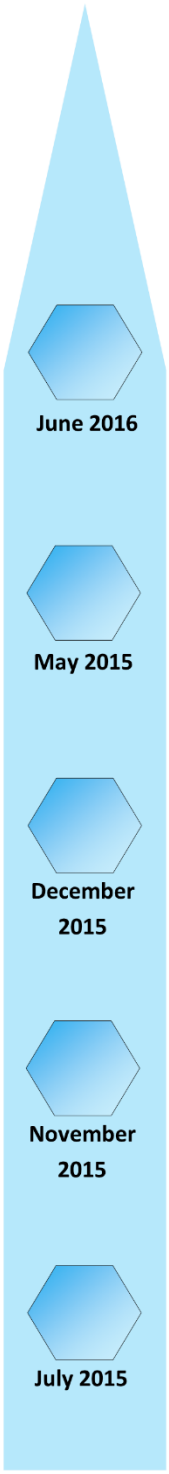
The accomplishments during MHLA's second programmatic year were significant:

- By June 30, 2016, there were 143,769 residents participating in the program which represented 98.5% of the target 146,000 enrollment. This represents an increase of 19% from last fiscal year, when 120,518 participants were enrolled by the end of FY 2014-15.
- The number of participating clinic locations increased from 165 to 176 sites in this fiscal year.
- Planning for the launch of the Pharmacy Phase II (retail pharmacy network pilot program) and the addition of Substance Use Disorder (SUD) treatment services at the end of the fiscal year were major new milestones for the program. .
- Nearly two-thirds of MHLA participants had at least one primary care visit during their enrollment.
- The MHLA website had 55,799 visitors.

In FY 2015-16, payments to community partner clinics for MHLA participants totaled $57,462,497. This amount includes: (1) $52,686,176 in payments to CP clinics for preventive, primary care and pharmacy services and (2) $4,776,321.07 in payments to community partner clinics for dental services provided by those CP clinics contracted with DHS to provide dental care to MHLA enrolled and eligible patients (dental services are invoiced separately by clinics on a fee-for-service basis). In FY 2015-16, the per participant per month payment rate was $32.00 for primary care services (excluding dental) which is based on 1,646,443 participant months.

This annual report is designed to provide the public, policy makers, participants, clinics, researchers and other interested groups with detailed information about the ongoing performance of the MHLA program throughout the course of FY 2015-16.

Summary of My Health LA Milestones
July 2015 to June 2016



July 2015

•Senate Bill (SB) 75 was signed by the Governor on June 24, 2015 which made full scope Medi-Cal benefits available for children under the age of 19.

November 2015

•LA County Board of Supervisors approved programmatic and administrative changes to the MHLA Agreement. MHLA Stakeholders (DHS, Ventegra, select CPs and CCALAC) created a Pharmacy Phase II workgroup to plan for and pilot a successful implementation of Pharmacy Phase II.

December 2015

•135,661 participants enrolled.
LA County Board of Supervisors approved the inclusion of Substance Use Disorder (SUD) treatment services to the MHLA program.

May 2015

•145,025 participants enrolled.
Age eligibility requirements for the MHLA Program changes due to implementation of SB 75 (19 and over). 10,000 MHLA children begin to transition to full scope Medi-Cal.

June 2016

•The second year of the program concludes with 143,769 participants enrolled.

II. 2015-16 PROGRAM ACTIVITIES

A. COMMUNICATIONS, OUTREACH, APPLICATIONS AND ENROLLMENT

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

Key 2015-16 highlights were:

- MHLA ended its second programmatic year with 143,769 uninsured Los Angeles County residents enrolled in the program.
- MHLA ended its second programmatic year with 48,936 individuals disenrolled and 2,338 denied from the program.
- The MHLA website had 55,799 visits this fiscal year.

Communications and Outreach

The MHLA website (dhs.lacounty.gov/mhla) continues to be one of the most accessible and versatile program communications tools. MHLA uses a combination of word of mouth, print materials, the website, radio and advocacy/community outreach to generate program interest and attention. The website has both English language and Spanish language pages, including a Spanish-first section of the website dedicated specifically to prospective and enrolled MHLA participants. There is also a section of the website dedicated solely to policy and operational aspects of the program for MHLA Community Partner (CP) clinics.

The website had a total of 55,799 visits during Fiscal Year (FY) 2015-16, for an average of 4,650 visits per month. Average monthly websites visits in this fiscal year were less than the 6,096 in FY 2014-15 which is not surprising given that FY 2014-15 was the inaugural year for the MHLA program and it was anticipated that more applicants, participants and CP clinic staff would visit the website more often. The decrease in website volume this year was most likely due to a reduction in MHLA CP clinic staff visits. The website provides programmatic guidance to the CPs, which was probably less needed by the CPs. It is also possible that applicants and participants were also more familiar with the program by the second year.

The MHLA fact sheets are now available in eight languages - Armenian, Chinese, Korean, Tagalog, Thai, Vietnamese, English and Spanish. These detailed, easy to read documents explain the basics about the MHLA program (i.e., information about how to enroll in the program and who is eligible). The fact sheets are available to download free of charge to every CP and DHS facility as well as advocacy and community groups. Downloadable updated versions of the fact sheets are available on the MHLA website. In addition, the Community Clinic Association of Los Angeles County (CCALAC), in partnership with Fenton Communications, developed additional MHLA outreach materials in English and in Spanish that are also available for download on the website.

The MHLA Program continues to produce two newsletters: one for Community Partners called “The CP Connection” (monthly) and one for the program participants called “My Healthy News” (quarterly). Ongoing program information is distributed via these two mechanisms to keep our CP clinics and program participants updated and informed about the program on a regular basis.

Two other communication strategies that have been developed to keep CP staff updated on operational and programmatic changes to the program are Provider Information Notices (PINs) and Provider Bulletins. PINs relay detail related to the contractual requirements of the MHLA program while Provider Bulletins provide program support, technical assistance and operational instructions related to fulfilling program requirements.

MHLA Eligibility Review Unit (ERU)

The MHLA Eligibility Review Unit (ERU) oversees the development and implementation of all eligibility and enrollment processes under the MHLA program, including the development of MHLA eligibility and enrollment rules and how those rules are applied in the One-e-App (OEA) enrollment and eligibility system. The ERU also conducts regular trainings for CP enroller staff on MHLA eligibility rules and how to refer individuals to other governmental medical assistance programs for which they may be eligible (e.g., Medi-Cal, Los Angeles County Reduced Cost Health Care Programs, etc.). The ERU conducted four (4) full-day eligibility trainings this fiscal year. In addition, the ERU holds regular (usually monthly) meetings with designated "Eligibility Leads" from each CP clinic. Eligibility Leads are key CP staff members responsible for staying abreast of changes and updates to MHLA eligibility policies and processes, and sharing this information with the enrollers at their clinic.

The ERU also helps CP enrollers through the enrollment and re-enrollment process in real time (through the Subject Matter Expert (SME) telephone line), which has been especially helpful for clinic enrollers who may need assistance in processing more complex applications in real time. During FY 2015-16, the MHLA Eligibility and Enrollment Unit SME telephone line received 1,925 calls, down from 2,167 calls last fiscal year. This 11% decrease in ERU calls received can likely be attributed to fewer eligibility questions from the CPs now that the program has been operational for over 18 months, as clinics and enrollers are more familiar than they were last year with both the OEA system and the enrollment rules of the program.

MHLA Applications

MHLA enrollment occurs through trained CP Certified Enrollment Counselors (CECs) and/or Certified Application Assistors (CAAs) who screen potentially eligible individuals for the program. Once eligibility has been assessed, the CECs enroll the new participants into the program using the One-e-App (OEA) system. In this fiscal year 2015-16, MHLA had 188 CEC enrollers taking applications in the OEA system, and an additional 482 clinic staff with "read only" access, for a total of 670 OEA users at the CP clinics. The number of CECs/CAAs taking applications this fiscal year was down significantly from las year, when the program had 409 CEC/CAA enrollers and 257 read-only users. This reduction in CP enrollers was most likely attributable to the fact that when the program was first beginning, CP clinics designated as many people as possible to take MHLA applications, not knowing how many would actually be needed, but subsequently came to realize throughout the year that not all of these people would actually take MHLA applications at the clinic. In the OEA system, when a person does not use their OEA log-in for over forty-five (45) days, the account becomes inactive. Most likely, clinics initially over-estimated the number of enrollers they would need in the inaugural year, and let the accounts expire naturally due to lack of use.

Enrollment

Clinics enroll eligible applicants into MHLA using the One-e-App (OEA) system. An applicant is considered enrolled in MHLA when an application is completed and all eligibility required documents are clearly

uploaded (i.e., proof of identification, Los Angeles County residency and income). OEA applications for enrollment were taken and processed at MHLA medical homes/enrollment sites.

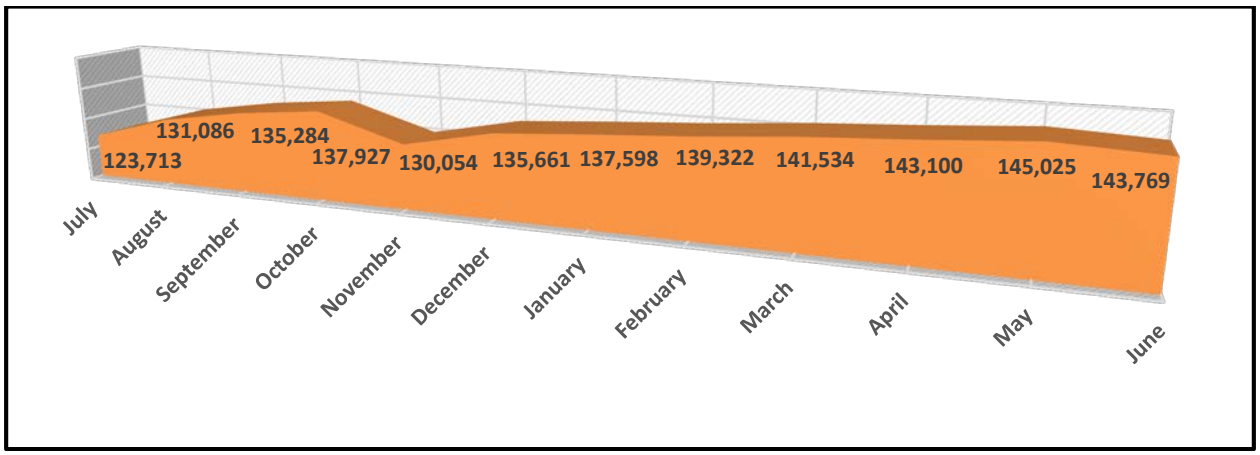
MHLA is a voluntary program. As such, there is no expectation that all eligible uninsured Los Angeles County residents will enroll in the program. While the program is designed to facilitate enrollment to the greatest extent possible and does not have any penalties for failure to enroll, it is inevitable that some uninsured residents will elect not to participate.

The program was budgeted for 146,000 participants in FY 2015-16. At the end of FY 2015-16, there were 143,769 participants enrolled in MHLA. This represented 98.7% of the targeted enrollment.

Table A1
Percentage of MHLA Enrollment Target Met

Fiscal Year	Enrollment at end of the Fiscal Year	MHLA Enrollment Target	Percent of Target Met
2014-15 (9 months)	120,518	146,000	82.5%
2015-16	143,769	146,000	98.5%

Graph A1
MHLA Enrollment FY 2015-16



Disenrollments and Denials

Disenrollments occur when there is a change in eligibility and the participant no longer meets program eligibility criteria (e.g., moves out of Los Angeles County, program discovers that participant provided untrue statements on MHLA application, obtains health insurance, etc.) In addition, participants may request to disenroll from the program for various reasons or opt not to renew their annual eligibility.

A post-enrollment denial, which happens relatively rarely, occurs when a person is enrolled, but then is retroactively denied back to their initial date of application. This might occur if the program learns that a participant had full-scope Medi-Cal during the entire duration of their MHLA coverage, or if it is discovered

upon audit that documentation of the participant's eligibility was never submitted at the time of their application. This action prevents dual coverage and payment.

Participants that were previously denied or disenrolled from the program can re-enroll into MHLA at any time if they meet eligibility requirements. There is no cost or waiting period to re-apply/re-enroll into the MHLA program. Enrollment fluctuates daily as new applicants enroll, existing participants renew eligibility, and participants are disenrolled or denied.

Table A2 illustrates that while there were 143,769 enrolled into the program at the end of FY 2015-16, a total of 179,367 people participated in the program at some point during the year. 35,598 participants were denied or disenrolled from the program and did not return.

Table A2
Unduplicated Count of Total Ever Enrolled in Fiscal Year 2015-16

Fiscal Year	Enrolled at End of Fiscal Year	Disenrolled at End of Fiscal Year	Total Ever Enrolled at End of Fiscal Year (Enrolled + Disenrolled
2014-15	120,518	2,310	122,828
2015-16	143,769	35,598	179,367

Table A3 represents the primary reasons why participants were denied from the program. The vast majority of denials in FY 2015-16 (89% or 2,077 participants) occurred due to "incomplete application." This means that CP clinic enrollers submitted applications that had some or all of the core eligibility documents missing (i.e., proof of income, proof of Los Angeles County residency, etc.). The MHLA program does permit participants to submit affidavits when proof of income, identity, and residency are not possible for the applicant to produce, however, if any or all of these are also missing, the person will be denied for incomplete application. 33% of the individuals who were denied from the MHLA program successfully re-applied to the program, i.e. by bringing back their required documents and submitting a complete application.

Table A3
All MHLA Post-Enrollment Denials by Reason

Denial Reason	Denial Total
Incomplete Application	2,077
Enrolled in Full scope-Medi-Cal	61
Income exceeds 138% of FPL	69
Determined Eligible for Other Programs During Annual Renewal or Modification	65
Not a Los Angeles County Resident	42
False or Misleading Information on MHLA Application	7

Denial Reason	Denial Total
Duplicate Application	10
Enrolled in Private Insurance	4
Participant Request	1
Enrolled in public Coverage	1
Participant has DHS Primary Care Provider	1
Total	**2,338**

Reviewing total disenrollments by reason in FY 2015-16 (Table A4), the highest percentage (93% or 45,596 participants) were due to participants not completing the renewal process. Of the 45,596 participants were who were disenrolled due to failure to renew, 30% re-enrolled into the program after missing their renewal deadline.

Table A4
MHLA Disenrollments by Reason

Disenrollment Reason	Disenrollment Total
Did Not Complete Renewal	45,596
Enrolled in Full scope-Medi-Cal	2,740
Incomplete Application	156
Participant Request	158
Participant has DHS Primary Care Provider	124
Not a Los Angeles County resident	49
Determined Eligible for Other Programs During Annual Renewal or Modification	43
Income exceeds 138% of FPL	16
Enrolled in Employer-Sponsored Insurance	17
Enrolled in Private Insurance	12
Enrolled in public Coverage	8
False or Misleading Information on MHLA Application	7
Duplicate Application	6
Participant is Deceased	4
Total	**48,936**

Renewals

Participants must renew their MHLA coverage every year. Renewals for MHLA eligibility began in FY 2015-16. Clinics re-enroll MHLA participants during an in-person interview prior to the end of the participant's one-year enrollment period and complete the renewal using the OEA system. The MHLA program notifies

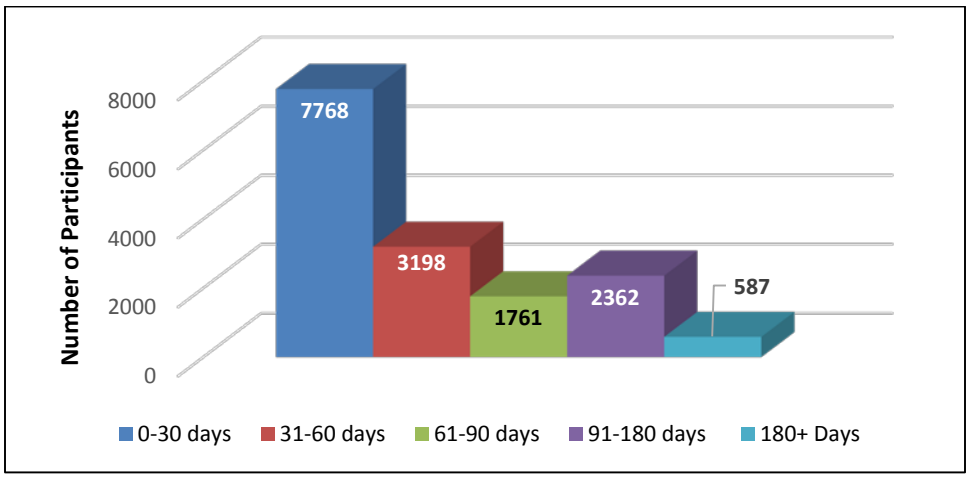
participants ninety (90) days prior to the end of their twelve month program coverage that their renewal date is approaching. As a result, MHLA participants may renew their coverage up to ninety (90) days prior to their renewal date. Failure to complete the renewal process prior to their renewal period will result 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. Table A5 provides the renewal and re-enrollment rates for the program since the inception of renewals.

Table A5
Renewal and Re-enrollment Rates

Total Due for Renewal	Renewal Approved	Renewal Denied	Did not Renew	Renewal Rate – Percentage Approved	Reenrolled after Failure to Renew	Reenrolled Percentage	Total Renewed and Reenrolled	Percent Renewed and Re-enrolled
A= B+C+D	B	C	D	B/A	E	F=E/A	G=B+F	H=G/A
118,082	69,179	910	47,993	57%	16,190	13%	85,369	70.1%

Finally, Graph A2 captures the time gap between disenrollments, denials and re-enrollment. This data demonstrates that of the 15,676 participants who chose to return to MHLA after a disenrollment or denial, a majority of them (7,768 or 50%) re-enrolled into the program within the first thirty (30) days of their disenrollment. The next largest re-enrolling participant group (20%) reenrolled within sixty (60) days of being disenrolled or denied.

Graph A2
MHLA Participant Days between Denials, Disenrollments, and Re-enrollments



The fact that some participants are failing to renew their MHLA coverage could be due to a variety of reasons. This is a population with a number of social economic determinants – they are low income, many work multiple jobs and/or have limited transportation options. Because there is no penalty or cost to re-apply to the program, participants may opt to wait until their next primary care visit to re-enroll. If these

participants feel healthy, they may decide to renew their MHLA when it is convenient.

In addition, if participants are not receiving or opening their mail from MHLA, they may be unaware that renewals are not automatic and that they must complete a renewal process to remain in the program. Participants are sent renewal reminder postcards at 30, 60 and 90 days prior to the termination of their enrollment. However if they have moved without telling MHLA, or do not open the mail the program sends, they may not be aware that their renewal is due.

It is important to know that during this fiscal year, the MHLA program also began to implement SB 75, Healthcare for All Children, which made all children in the State of California under 266% FPL eligible for full-scope Medi-Cal regardless of immigration status. This had an impact on the disenrollment rate of the MHLA program this fiscal year. In May 2016, there were 10,198 children between the ages of 6-18 enrolled in the MHLA program. 5,930 of these children were disenrolled from MHLA during FY 2015-16 once they successfully enrolled in full scope Medi-Cal, adding to the total disenrollment rates for this fiscal year.

B. PARTICIPANT DEMOGRAPHICS

This section of the report provides an overview of the demographic makeup of the individuals enrolled in MHLA. Latinos comprise the largest group of enrollees at over 94% of program participants, while almost 92% of all participants indicate that Spanish is their primary language. The next largest group was English speaking participants at almost 7%. Regarding age, the largest percentage of participants, 49%, are between 25 and 44 years old. MHLA enrolled 749 homeless individuals which was less than 1% of all enrolled participants. More participants are female (60%) than male (40%).

Key FY 2015-16 demographic highlights for the MHLA Program are:

- 94% of participants identify as Latino.
- 60% are female and 40% are male.
- Less than 1% identify as homeless.
- Service Planning Area 6 has the largest concentration of MHLA participants at 22%.

Participant Demographics

The following table provides demographic detail on the 143,769 participants who were enrolled at the end of FY 2015-16 along with any observed changes in demographic trends. Compared to the previous fiscal year, there are few significant changes in the demographic makeup of program participants.

Table B1
Demographics for MHLA Participants (as of June 30, 2016)

Age	4.7% 6-18 years old 2.4% 19-24 years old 49% 25-44 years old 27% 45-54 years old 11.6% 55-64 years old 5.2% 65+	**Income**	6.8% at/below 0%-25% FPL 22.3% between 25.01%-50% FPL 20.9% between 50.01%-75% FPL 22.3% between 75.01%-100% FPL 17.8% between 100.01%-125% FPL 10.1% between 125.01%-138% FPL
Ethnicity	2.7% Asian/Asian Pacific Islander 94.4% Latino .95% Caucasian 0.18% Black/African-American 1.8% Other/Declined to State	**Language**	91.8% Spanish 6.7% English 0.41% Thai 0.15% Armenian 0.32% Korean 0.46% Other 0.26% Chinese 0.07% Tagalog 0.04% Cambodian/Khmer
Gender	59.7% Female 40% Male 0.24% Other		

Service Planning Area (SPA) Distribution

MHLA participant distribution by SPA highlights the geographic dispersion of enrollment. As in FY 2014-15, SPA 6 continued in this fiscal year to have the largest percentage of MHLA program participants of all eight SPAs, at 22%.

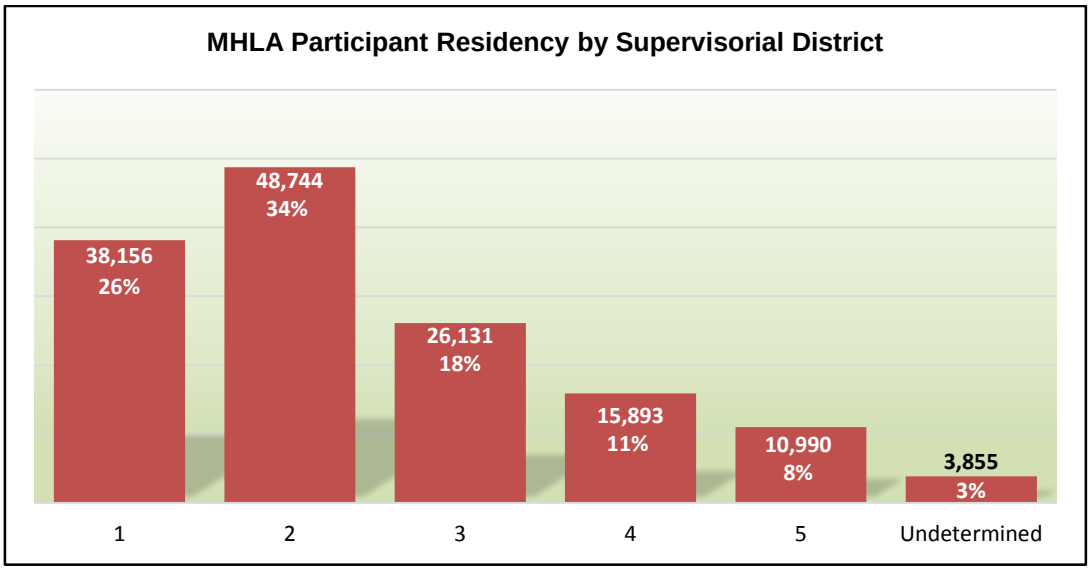
Table B2
SPA Distribution of MHLA Participants

SPA	Total Number of Participants	Total Percentage of Participants
1	2,340	2%
2	27,214	19%
3	13,385	9%
4	26,428	18%
5	3,553	2%
6	31,936	22%
7	19,231	13%
8	15,827	11%
Undetermined	3,855	3%

MHLA Program Participant Distribution by Supervisorial District

Graph B1 provides the MHLA participant distribution by Supervisorial District. Consistent with FY 2014-15, Supervisorial District 2 had the largest percentage of MHLA program participants of all five districts at 34%.

Graph B1
Distribution of MHLA Participants by Supervisorial District



C. PROVIDER NETWORK (DELIVERY SYSTEM)

This section of the report describes the MHLA delivery system (e.g., community partner medical homes, DHS facilities, etc.).

Key FY 2015-16 highlights were:

- The number of MHLA medical homes increased to a total of 176.
- Overall, 79% of MHLA medical homes were open to accepting new participants throughout the fiscal year.
- A total of 37 (21%) medical home clinic sites had closed to new patients at some point during Fiscal Year 2015-16.

Medical Home Expansions and Capacity

MHLA ended FY 2015-16 with a total of 51 Community Partner (CP) agencies and 176 medical home clinics. This compares to 52 CP agencies and 165 medical home clinics in FY 2014-15. Children's Dental Clinic left the program in FY 2015-16 as most of their MHLA participants were children and therefore became Medi-Cal eligible in May 2016.

The MHLA Contract Administration Unit surveys CPs twice a month to determine whether there are any changes to their clinic's open/closed status based on clinical capacity. 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 they can schedule a non-urgent primary care appointment for a new participant within ninety (90) calendar days.

In FY 2015-16, 37 medical homes closed to new patients due to limited capacity to take new patients. This means that 79% of the MHLA medical homes were open to accepting new participants during FY 2015-16. This is a decrease in capacity from last fiscal year, where 11 medical homes closed to new participants resulting in 93% of CPs accepting new participants in FY 2014-15. This means that there was a 14% decrease in medical home capacity from 2014-15 to 2015-16.

Medical Home Distribution and Changes

At the time of enrollment, MHLA participants select their primary care medical home. The medical home is where participants receive all of their primary care and preventative care services. This includes prevention, diagnosis, treatment of illness or injury, health advice, diagnostic services (labs and basic radiology), chronic disease management, immunizations, referral services, health education, prescribing medicines and other related services.

Participants will retain this medical home for twelve (12) months. The participant may receive care at any clinic site within a clinic agency's network, but may not receive their primary care outside of the agency. All CP clinics can view a participant's medical home in One-e-App (the program's system of record). On a monthly basis DHS creates a report of the distribution of MHLA participants by medical home and this information is posed on the program's website.

Participants may change their medical home during their twelve (12) month enrollment period for any of the following reasons: 1) during the first thirty (30) days of enrollment for any reason; 2) if the participant has moved or changed jobs and is seeking a new medical home closer to his/her new place of residence or employment; 3) if the participant has a significant change in his/her clinical condition that cannot be appropriately cared for in the individual's current medical home that cannot be resolved by the participant or clinic; 4) if the participant has a deterioration in the relationship with the health care provider/medical home; or 5) if the medical home closes permanently. If the MHLA participant has some other special circumstance that merits a medical home transfer, this may be approved by MHLA management, using the medical home transfer reason of "Administrative Request."

Table C1 shows the requested medical home changes for this fiscal year. A total of 1,194 medical home changes were made during this fiscal year with the largest number (830 or 76%) made during the first 30 days of enrollment at the request of the patient. The next largest reason for a medical home transfer was due to the participant moving or changing jobs, at 169 requests (16% of the total).

Table C1
Medical Home Changes/Routine Transfers by Reason

Transfer Reasons	Total	% of Total
Within 30 days of initial enrollment	830	76%
New place of residence or changed job	169	16%
Administrative Request	134	7%
Change in clinical or personal condition	54	1%
Clinic Termination (i.e. permanent clinic closure)	7	0%
Significant problem with the provider/patient relationship	-	0%
Total	**1,194**	**100.0%**

DHS Participation in the MHLA Network

Hospital and specialty clinic care are critical components in the MHLA service continuum. The Los Angeles County Department of Health Services (DHS) provides a range of specialty, urgent care, diagnostic, emergency care and inpatient services to all MHLA participants at no cost. MHLA participants have access to hospital services at DHS facilities only; MHLA does not cover hospital services at non-DHS facilities. However, in cases of medical emergency, MHLA participants can and should seek services at the nearest hospital emergency department (if there is no DHS hospital nearby) consistent with federal and State laws that govern access to emergency care for all individuals in the United States. The DHS hospitals available to MHLA participants are:

- LAC+USC Medical Center
- Harbor-UCLA Medical Center
- Olive View-UCLA Medical Center
- Rancho Los Amigos National Rehabilitation Center

Disempanelment

Because enrollment in the MHLA program is immediate, DHS is able to know in real time where a MHLA participant's primary medical home is located. When the MHLA program learns that someone has enrolled in MHLA who already has a primary care provider at DHS (i.e., they are "empaneled" to a DHS primary

care provider), that person is "disempaneled" by DHS. The MHLA program assumes that the newly enrolled participant has selected a CP clinic to be their primary care medical home, and therefore no longer wants or needs to retain their DHS primary care provider. At this point, they are automatically disempaneled from their DHS primary care provider (their relationship with their specialty care provider is unaffected by this process). The participant is sent a letter (in English or Spanish) reaffirming their enrollment in MHLA, their selection of a CP medical home to receive their primary care, and notice of their disempanelment from their DHS primary care provider/clinic. They can call Member Services within 30 days of receipt of the letter if they want to retain their DHS provider/clinic and disenroll from MHLA.

In FY 2015-16, 645 MHLA enrolled individuals were disempaneled from DHS, opening up primary care slots for other uninsured patients within DHS. This compares to 2,236 MHLA enrolled participants who were disempaneled from DHS in FY 2014-15. Of the 645 participants, 128 (20%) opted to disenroll from MHLA and maintain enrollment in DHS primary care (re-empanel) upon learning that their enrollment in MHLA would result in their being disempaneled from their DHS primary care medical home. Table C2 identifies the disempaneled patients by DHS clinic upon enrollment into the MHLA program.

Table C2
Disempanelment by DHS Medical Facility

DHS Facility	Number of Patients
LAC+USC MEDICAL CENTER	196
EL MONTE COMPREHENSIVE HEALTH CENTER	62
HUBERT H. HUMPHREY COMPREHENSIVE HEALTH CENTER	62
HARBOR/UCLA MEDICAL CENTER	59
H. CLAUDE HUDSON COMPREHENSIVE HEALTH CENTER	46
MARTIN LUTHER KING, JR. (MLK)	45
OLIVE VIEW-UCLA MEDICAL CENTER	38
EDWARD R. ROYBAL COMPREHENSIVE HEALTH CENTER	27
LONG BEACH COMPREHENSIVE HEALTH CENTER	24
MID-VALLEY COMPREHENSIVE HEALTH CENTER	21
WILMINGTON HEALTH CENTER	11
BELLFLOWER HEALTH CENTER	10
SOUTH VALLEY HEALTH CENTER	8
DOLLARHIDE HEALTH CENTER	7
LA PUENTE HEALTH CENTER	7
RANCHO LOS AMIGOS NRC	7
SAN FERNANDO HEALTH CENTER	7
GLENDALE HEALTH CENTER	4
HIGH DESERT REGIONAL HEALTH CENTER	3
ANTELOPE VALLEY HEALTH CENTER	1
LITTLEROCK COMMUNITY CLINIC	0
Total Disempaneled from DHS	**645**

New Empanelment Referral Form (NERF) Patient Referrals from DHS to CPs

In an effort to connect as many uninsured patients to a primary care provider as possible, DHS refers uninsured patients to CP clinics when the patient is in need of a primary care provider. These referrals occur on behalf of patients who present at DHS clinics or hospitals (i.e. DHS emergency, urgent or specialty care clinics) and are uninsured and likely eligible for MHLA.

For these patients, staff at DHS facilities complete a New Empanelment Referral Form (NERF) to begin the process of getting the patient empaneled to a primary care provider at DHS or referred to a CP for MHLA enrollment. For those patients referred via NERF for enrollment in MHLA, the Appointment Services Center (ASC), within the Office of Managed Care Services (MCS), reaches out to these individuals by phone and by mail in an attempt to discuss the MHLA program and identify an appropriate CP clinic close to the patient's home. If the patient is reached and expresses a desire to enroll in MHLA, the ASC provides their information, along with some medical background about the patient, to the CP via secure email. The CP is then expected to follow-up with the patient to set up a screening an enrollment screening appointment.

The following table demonstrates the total number of unduplicated patients that were referred to CPs for MHLA enrollment (9,184), the number of these patients that were reached and who expressed interest in enrollment in MHLA at a particular CP (4,943) and of those, the total number that actually enrolled (699 or 14%). This number would not include those that did not meet the MHLA eligibility criteria but agreed to see the CP under a sliding-fee scale or other program.

Table C3
NERF Referrals to CPs and DHS

Total # DHS Patients Referred to ASC	Total # DHS Patients Agreeing to be Referred to a CP for MHLA	% of DHS Patients Agreeing to be Referred to a CP for MHLA	# of Referred DHS Patients Enrolled in MHLA with a CP	% of Referred DHS Patients Enrolled in MHLA
9,184	4,943	54%	699	14%

MHLA is working with all CPs to increase the NERF-to-enrollment success rate for this population with a goal of reaching a 50% referral-to-enrollment rate. The transitory nature of this population does create challenges to enrollment. Mailing addresses and contact phone numbers provided by patients frequently change, or may be invalid or outdated, making it difficult to reach these patients. In addition, some patients do not end up pursuing MHLA enrollment if they feel that their medical issue was resolved at DHS and they do not perceive a need for ongoing primary care.

D. QUALITY MANAGEMENT & CLINICAL COMPLIANCE PROGRAM (QM & CCP)

This section of the report focuses on MHLA Quality Management & Clinical Compliance Program (QM & CCP). This Managed Care Services unit ensures that Community Partners (CPs) are following contractual guidelines as well as federal, State and County regulations in the provision of clinical care to program participants. CPs are responsive to addressing identified corrections/ deficiencies.

QM & CCP conducts annual programmatic reviews while maintaining oversight and compliance with regulatory agency requirements for all CP medical home clinics. QM & CCP audits entail the following:

- Medical Record Review (MRR) of the program participants' clinical file which includes the process of measuring, assessing, and improving quality of medical record documentation - that is, the degree to which the medical record documentation is accurate, complete, and performed in a timely manner. The MRR ensures documentation for compliance with recognized standards of care.

- Facility Site Review (FSR) of the medical home clinic includes the process of evaluating the facility for patient access and appropriate service provision. This is conducted through a review of the following criteria: Access/Safety, Personnel, Office Management, Clinical Services (Pharmaceutical, Laboratory, and Radiology), Preventive Services, and Infection Control, as per DHCS. In addition, Subcontractor/Maintenance Agreements and Documents, Quality Assurance/Improvement Plan, Provider Information Notices (PINs), Cultural and Linguistic, and Primary Care Medical Home are reviewed per contractual mandates. When required, a Pre-Site Review is conducted to evaluate compliance with contractual requirements and site readiness to provide primary and/or dental services.

- Credential Review (CR) of the clinic's licensed medical providers includes obtaining and reviewing documentation related to licensure, certification, verification of insurance, evidence of malpractice insurance history and other related documents. This audit generally includes both a review of the information provided by the provider as well as a verification that the information is correct, complete and complies with established standards for participation. Credentialing files and minutes are reviewed.

- Dental Record Review (DRR) of the participant's dental file includes the process of assessing the quality of dental record documentation - that is, the degree to which the dental record documentation is accurate, complete, and performed in a timely manner. The DRR ensures documentation for dental services is complaint 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."

- Dental Services Review (DSR) of the dental clinic includes the process of evaluating the facility for patient access and appropriateness of dental service provision. This is conducted through an assessment of infection control, sterilization/autoclaving, Safety Data Sheets (SDS), spore testing, apron usage and other related reviews.

QM & CCP works with CPs to help them successfully comply with the implementation of a Corrective Action Plan (CAP) by providing technical assistance and conducting focused reviews if the audit does not reach compliance thresholds.

By June 30, 2016, QMCCP completed annual audits for all CP agencies. Table D1 shows the total audits for each service category.

Table D1
Quality Management/Clinical Compliance Program
Annual Audit Results (by QM & CCP)

	FY 2015-16		FY 2014-15		
Type of Audit	**Total Audits**	**% Requiring a CAP**	**Total Audits**	**% Requiring a CAP**	**Change 2014-15 to 2015-16**
* Credentialing Review	52	40%	53	87%	⇩ in % CAPs
Facility Site Review	192	61%	180	46%	⇧ in % CAPs
* Dental Services Review	24	75%	24	38%	⇧ in % CAPs
Medical Record Review	183	79%	166	45%	⇧ in % CAPs
Dental Record Review	48	29%	38	21%	⇧ in % CAPs

* = Agency Review

QM & CCP also advises CPs of repeat deficiencies. A repeat deficiency is when an issue or problem was identified in the past fiscal year, and the same issue or problem re-occurred the subsequent fiscal year. There were 45 CPs (88% of total 51 CP agencies) that had the same MRR and/or FSR repeat deficiencies in FYs 2015-16 and 2014-15. Appendix 1 provides a list of CP agencies with repeat MMR and/or FSR deficiencies.

There were a total of 616 repeat deficiencies (by category) identified for Medical Record Review (MRR) for CPs. Table D2 outlines the top five repeat deficiencies (totaling 377) for MRRs in FY 2015-16.

Table D2
Top 5 MRR Repeat Deficiencies for FY 2015-16

	Total	**%**
Immunization screening	105	17%
Seasonal flu vaccine	101	16%
TB screening	73	12%
Colorectal cancer screening	53	9%
Diabetic foot exam/podiatry referral	45	7%

There were a total of 270 repeat deficiencies (by category) identified for Facility Site Review (FSR) for CPs. Table D3 outlines the top five repeat deficiencies (totaling 135) for FSRs in FY 2015-16.

Table D3
Top 5 FSR Repeat Deficiencies for FY 2015-16

	Total	%
No evidence of TB skin test or chest x-ray/TB questionnaire	32	12%
No evidence of immunization or vaccination for Tdap/Td	31	11%
No evidence of influenza vaccination	26	10%
Annual performance evaluation was not completed	25	9%
No evidence of immunization or vaccination for MMR	21	8%

E. PARTICIPANT EXPERIENCE AND SATISFACTION

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

Key FY 2015-16 highlights were:

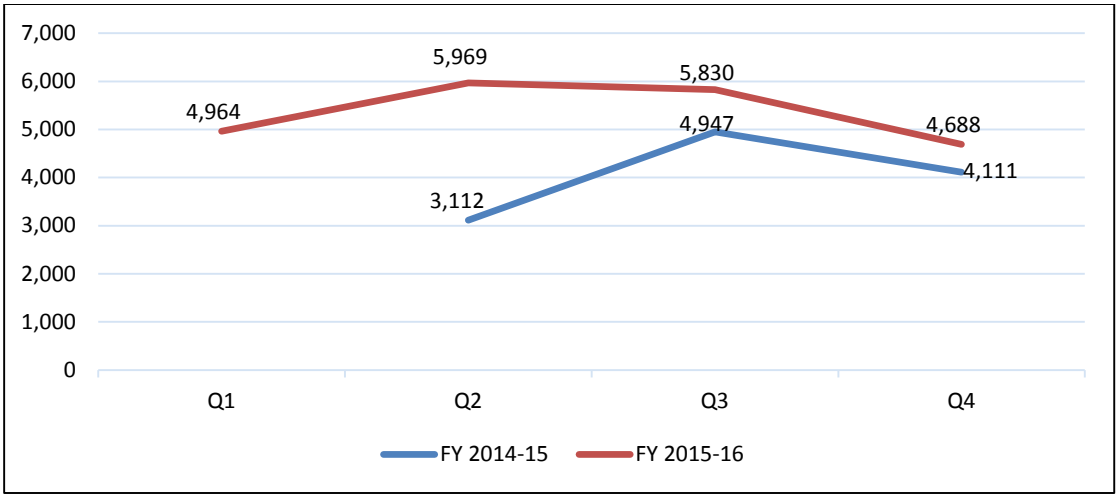
- MHLA Customer Service handled a total of 21,451 calls in FY 2015-16 (86 per day).
- There were a total of 20 formal participant complaints filed by participants, with the top complaints being related to access to care and quality of service.

Customer Service Center Call Center

Member Services is available to answer questions for MHLA participants Monday through Friday from 8:00 am to 5:00 pm by calling 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 is available to help participants with questions about the MHLA program, request medical home changes, disenroll, report address and phone number changes, process participant complaints and order replacement ID cards.

On average, MHLA's Member Services handled 86 calls each day during FY 2015-16 for a total of 21,451 incoming calls. This is nearly double the average number of daily calls handled in FY 2014-15 which averaged 44 per day for a total of 12,170 calls. Graph E1 displays the amount of incoming calls and calls handled during FY 2015-16.

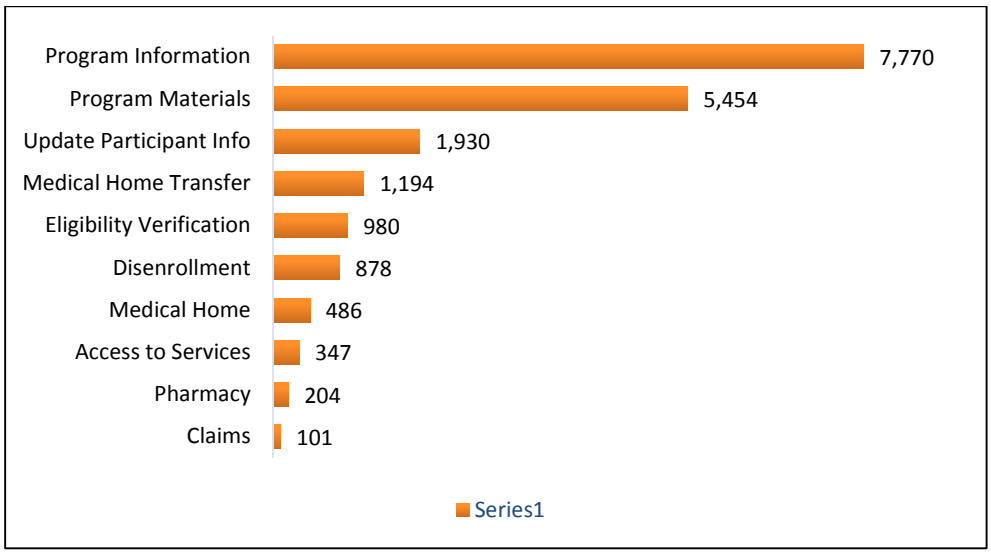
Graph E1
Total Call Volume per Quarter



Graph E2 displays the top ten reasons participants contacted Member Services (calls from individuals who were not enrolled in MHLA are not reflected in Graph E2). The majority of MHLA participants called Member Services to obtain information about the program (i.e., what services are and are not covered by MHLA, how to re-enroll, questions regarding received MHLA correspondence, etc.). The second largest volume of calls was to request program material such as ID cards, member handbooks and provider

directories.[1] Updates to MHLA participant information was the third highest reason for calling Member Services. These calls consist of making demographic changes, medical home changes, etc. The fourth highest reason for calling was medical home transfer requests. The fifth highest reason was related to MHLA eligibility verification from CPs. CPs sometimes contact Member Services to check whether their patients are enrolled in MHLA.

Graph E2
Top 10 Reasons MHLA Participants and Clinics Called Member Services



Participant Complaints

The MHLA Customer Service Center takes calls from MHLA participants who are experiencing problems and challenges and is responsible for helping to resolve their issues, if possible. When the problem requires more intensive research for resolution, or involves a clinical investigation, the call is escalated to Managed Care Services' (MCS) Grievance and Appeals Unit and/or the Quality Management-Clinical Compliance Unit for clinical related complaints. In the MHLA program, these are called "formal complaints."

Of the 21,451 calls handled by Member Services in FY 2015-16, twenty (20) were "formal complaints." This is a 39% decrease in the number of formal complaints from FY 2014-15 in which there were 33. The top three (3) formal complaint reasons were:

- Mistreatment/Misdiagnosis/Inappropriate Care by Provider
- Refusal of Referral to Specialist Services not covered by MHLA
- Attitude/Miscommunication/Behavior by Physician

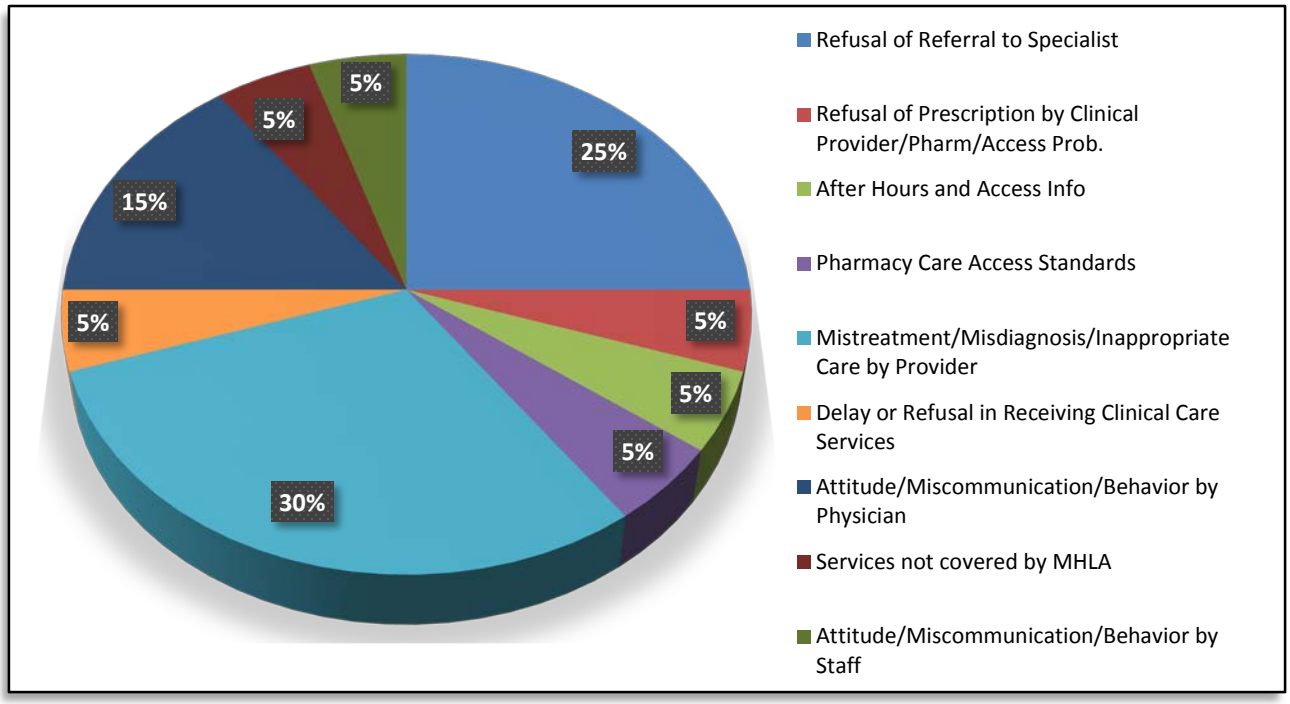
[1] Many of these requests were the result of participants not receiving their MHLA materials after enrollment. This can occur when CP clinic enrollers mistakenly enter the incorrect address into the MHLA eligibility and enrollment system. During FY 201-16, MHLA launched a significant education campaign geared towards CP enrollers stressing the importance of inputting correct and complete applicant addresses, including but not limited to the importance of including apartment and unit numbers in the application database. This helped to reduce the number of requests for program material over the course of the year.

Table E1 and Graph E3 both identify formal complaints by category as well as the percentage of complaints by category for FY 2015-16.

Table E1
MHLA Participant Formal Complaints by Category (FY 2015-16 and FY 2014-15)

	FY 2015-16		FY 2014-15	
Type	**Total**	**Percent**	**Total**	**Percent**
Mistreatment/Misdiagnosis/Inappropriate Care by Provider	6	30%	5	15%
Refusal of Referral to Specialist	5	25%	3	9%
Attitude/Miscommunication/Behavior by Physician	3	15%	4	12%
After Hours and Access Info	1	5%	0	0%
Pharmacy Care Access Standards	1	5%	0	0%
Refusal of Prescription by Clinical Provider/Pharm/Access Problems	1	5%	2	6%
Delay or Refusal in Receiving Clinical Care Services	1	5%	5	15%
Services not covered by MHLA	1	5%	2	6%
Attitude/Miscommunication/Behavior by Staff	1	5%	1	3%
Other (primary care access standards, denial of ER/urgent care, medical care claims/billing/charge discrepancy, etc.)	0	0%	11	33%
Total	20	100%	33	100%

Graph E3
MHLA Participant Formal Complaints by Category (FY 2015-16)



MHLA staff work closely with the participants' CP medical home clinics to address concerns/complaints before they are escalated to "formal complaints." The program believes that it is important to provide CP medical homes with this important feedback to continually improve participant experience and satisfaction. If the patient does wish to file a formal complaint, they are notified by letter within sixty (60) days of the filing of the complaint as to the resolution of their issue.

F. SERVICE UTILIZATION

This section examines clinical and service data from both Community Partner and DHS facilities in order to assess disease morbidity, access to care, health outcomes and utilization of services.

Key FY 2015-16 highlights were:

- 65% of MHLA participants had a primary care visit.
- MHLA participants had an average of 3.22 primary care visits per year.
- 23,002 unduplicated MHLA patients accessed 87,074 specialty care visits.
- 12,064 emergency department (ED) visits were provided for 5% of MHLA participants.
- 1,970 avoidable ED utilization visits resulted in an Avoidable Emergency Department (AED) rate of 16.3% at DHS facilities.
- The overall (30, 60, 90 day) hospital readmission rate was 13.95%.

When calculating utilization rates, this analysis uses as its baseline all 179,367 participants who were ever enrolled in the program during FY 2015-16.[2]

It is important to note that analysis of service utilization is dependent upon having complete data. Community Partner (CP) clinics are required to submit both primary care and pharmaceutical encounter data to DHS every month that describes the type, quality and level of clinical service being provided by the clinic to MHLA enrolled patients, as well as the prescriptions being filled for those participants. In FY 2015-16, MHLA worked closely with all CPs to improve overall adherence to this contract requirement. The submission of encounter data by CPs for primary care services improved this year, however, encounter data submission for pharmaceuticals remained low.

Summary of Clinical Utilization Data

MHLA provides comprehensive services to program participants. Primary, preventive and prescription drug services are provided by CP medical homes. Specialty, urgent care, emergency, inpatient and associated prescription services are provided by DHS. Tables F1 and F2 provide summary participant utilization information for FY 2015-16 at CP medical homes and DHS facilities, respectively.

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

Service Category	Unique Participants	Number of Participants Utilizing at Least One Service	Percentage
Primary Care (CP)	179,367	116,168	64.77%
Prescription (CP)	179,367	30,988	17.27%

[2] The number used in the analysis for service utilization is 179,367, which represents every participant that was ever enrolled during the fiscal year. By contrast, the 143,769 enrollment number reflects those participants who were enrolled in the program on June 30, 2016.

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

Service Category	Unique Participants	# of Participants Utilizing at Least One Service	Percentage	# of Encounters
Specialty (DHS)	179,367	23,002	12.82%	87,074
Emergency (DHS)	179,367	8,813	4.91%	12,064
Prescription (DHS)	179,367	7,516	4.19%	86,572
Inpatient (DHS)	179,367	1,956	1.09%	2,444
Urgent Care (DHS)	179,367	1,924	1.07%	2,457

The following sections provide more detailed information on each service category.

Primary Care (CP)

Approximately 65% of MHLA participants had at least one primary care visit at their medical home clinic during their period of enrollment. Appendix 2 provides more detailed information on the number of primary care visits for MHLA participants by medical home.[3] Primary care utilization at the CP clinic in FY 2015-16 was only slightly lower than in FY 2014-15 when 66% of participants had a primary care visit. The average number of visits in FY 2015-16 was 3.22 (total number of visits divided by the average number of participants per month).

Table F3
Average Number of Primary Care Visits per Year

	Unique Participants	Total # of Visits	Total # of Participant Months	Average Participants per Month	Average Visits per Year
Total	116,168	441,702	1,646,443	137,204	3.22

Not surprisingly, Table F3 shows that of the 116,168 MHLA participants who had a primary care visit, those with chronic conditions had a high average number of visits per year (5.27) than those without chronic conditions (1.64). [4]

[3] 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.

[4] The top four chronic conditions were: hepatitis, diabetes, hypertension and hyperlipidemia.

Table F4
Primary Care Visits – Participants With and Without Chronic Conditions

	Unique Participants	% Participants	Total # of Visits	Total # of Participant Months	Average Participants per Month	Average Visits per Year
With Chronic Conditions	66,279	57%	315,030	717,788	59,816	5.27
Without Chronic Conditions	49,889	43%	126,672	928,655	77,388	1.64

Further examination of visit data found in Table F5 provides information on the distribution of visits. As noted above 65% of unique participants had a primary care visit and 35% did not. In addition, average number of visits per year is 3.22. The data reveals that 43% of those with primary care visits had four (4) or more visits per year. With respect to the 63,199 (35%) MHLA participants who did not have a primary care visit, this represented a total of 493,004 enrollment months.

Table F5
Primary Care Visit Distribution

	1 Visit	2 Visits	3 Visits	4 Visits	5 - 9 Visits	10+ Visits	Total with a CP Visit	No CP Visit	Total Participants
# Participants	24,448	22,926	18,571	14,963	29,840	5,420	116,168	63,199	179,367
% Participants	14%	13%	10%	8%	17%	3%	65%	35%	100%
% of Users	21%	20%	16%	13%	26%	5%	100%	N/A	N/A

Pharmacy/Prescription (CP and DHS)

MHLA participants can receive medication services from their CP medical home related to primary and preventive care and from a DHS facility after receiving a non-primary care services, if appropriate. As noted in Table F1, 17% of MHLA participants were given at least one prescription drug by their CP medical home in FY 2015-16 in comparison to 14% in FY 2014-15. Pharmaceutical utilization data reported from the CPs is lower than DHS' expectation and this is likely attributable to under-reporting of pharmacy encounter data by clinics. Forty-five (45) CPs (out of 51) submitted pharmacy encounter data to DHS in FY 2015-16. However, much of the pharmacy data submitted was incomplete.[5] The utilization data for pharmacy services should be significantly improved with the implementation of Pharmacy Phase II for the MHLA program in FY 2016-17. Table F6 provides data on the total number of prescriptions dispensed by both CPs and DHS during the fiscal year. The data indicates that 21% of all participants were prescribed medication and the majority of prescriptions were dispensed by CPs (54%).

[5] As an example, one analysis shows that a CP with 9,189 unique participants submitted pharmacy encounter data for only 11 individuals (0.12% of their total MHLA participants).

Table F6
Pharmacy Utilization (CP and DHS)

Fiscal Year	Unique Participants	# of Participants Receiving Prescriptions	% of Participants Receiving Prescriptions	Dispensed by CP	Dispensed by DHS	Total Prescriptions Dispensed
FY 2014-15	122,330	16,815	13.75%	31,372	30,093	61,465
FY 2015-16	179,367	38,504	21.47%	103,139	86,572	189,711

Specialty Care Services

This section provides data on specialty care utilization by MHLA participants at DHS clinics and hospitals in Fiscal Year 2015-16.

MHLA CPs utilize DHS' eConsult to refer participants to DHS for their first visit with a specialty care service. As noted in Table F7, there were 23,002 unduplicated MHLA participants (or 13% of the MHLA population) who received 87,074 specialty care visits in FY 2015-16. This is a 98% increase in the number of MHLA patients who accessed specialty care compared to the previous fiscal year (11,622). The number of specialty care visits increased this year as well (from 30,643 to 87,074). The number of specialty visits reflects those that were generated via eConsult and any subsequent specialty care visits that do not require an eConsult referral. The specialty care utilization for FY 2015-16 was 634.63 visits per 1,000 participants. The average number of specialty visits in FY 2015-16 was 3.79 for the 23,002 participants in FY 2015-16, as compared to an average of 2.64 visits for 11,622 participants in FY 2014-15.

Table F7
Specialty Care Services by Unduplicated Patients

Fiscal Year	Unique Participants	# eConsults Requests - Specialty Visit Determined	# Participants Receiving Specialty Care	# Specialty Visits	#Visits Per 1,000	Avg. # Specialty Visits
FY 2014-15	122,330	21,581	11,622	30,642	467.52	2.64
FY 2015-16	179,367	40,269	23,002	87,074	634.63	3.79

Table 8 notes that distribution of MHLA specialty care patients by the number of visits. The majority of participants (55%) had no more than two visits.

Table F8
Distribution of Unduplicated Specialty Care Patients by Number of Visits

	1 Specialty Visit	2 Specialty Visits	3 Specialty Visits	4 Specialty Visits	5 – 9 Specialty Visits	10+ Specialty Visits	Total
# of Patients	8,193	4,273	2,713	1,942	4,086	1,795	23,002
% of Total	36%	19%	12%	8%	18%	8%	100%

Table F9 shows the breakdown of total specialty care visits provided to MHLA participants for FY 2015-16 by DHS facility. The 23,002 unique participants in this table may have been seen multiple times at different facilities for different specialty care services. The participant count reflected for each facility is unduplicated within the particular facility.

Table F9
Specialty Care Services by DHS Facility

Facility Name	Participants (Unduplicated by Facility)	Visits	% of Total Visits
LAC+USC MEDICAL CENTER	8,694	31,305	35.95%
HARBOR-UCLA MEDICAL CENTER	4,914	19,630	22.54%
MLK OUTPATIENT CENTER	3,956	13,755	15.80%
OLIVE VIEW-UCLA MEDICAL CENTER	3,733	11,643	13.37%
HUDSON CHC	1,414	3,292	3.78%
RANCHO LOS AMIGIOS NATIONAL REHABILITATION CENTER	629	1,611	1.85%
EDWARD ROYBAL CHC	475	1,412	1.62%
HUBERT HUMPHREY CHC	707	1,401	1.61%
HIGH DESERT REGIONAL HEALTH CENTER	350	764	0.88%
LONG BEACH CHC	255	721	0.83%
EL MONTE CHC	268	675	0.78%
MID-VALLEY CHC	210	330	0.38%
SOUTH VALLEY HC	153	257	0.30%
WILMINGTON HC	46	178	0.20%
SAN FERNANDO HC	19	44	0.05%
DOLLARHIDE HC	9	20	0.02%
BELLFLOWER HC	4	15	0.02%
LA PUENTE HC	8	12	0.01%
GLENDALE HC	3	6	0.01%
ANTELOPE VALLEY HC	2	2	0.00%
VAUGHN STREET ELEMENTARY SCHOOL	1	1	0.00%
Overall Unique Participants and Visits (All DHS Facilities)	**23,002**	**87,074**	**100%**

Urgent Care Services

MHLA program participants can access urgent care at any of the ten (10) DHS hospitals or comprehensive health centers that provide urgent care services. Urgent care is not considered primary or emergency care. 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 Community Partner's capabilities. Tables F10 and F11 show that 1,924 MHLA participants (1% of all participants in FY 2015-16) received 2,457 urgent care visits at DHS. The utilization rate for urgent care is 17.91 per 1,000 participants per year.

Table F10
Distribution of Unduplicated Urgent Care Patients by Number of Visits

	No 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
# Participants	177,443	1,529	294	82	12	7	0	1,924	179,367
% Participants	98.93%	0.85%	0.16%	0.05%	0.01%	0%	0%	1.07%	100%

Table 11
Urgent Care Rate per 1,000 Participants (DHS Facilities)

	Total Participants	Participants w/ Urgent Care Visit	Visit Count	Per 1,000 Participants	Average Visits Per Participant
Urgent Care	179,367	1,924	2,457	17.91	0.02

Emergency Department (DHS)

This section describes emergency department (ED) utilization by MHLA participants at DHS hospitals in FY 2015-16. It is important to note that ED utilization may be underreported due to the fact that MHLA only includes DHS hospital facilities and a MHLA participant may have received emergency services from a non-DHS facility. This clinical data would not be included in this analysis because these facilities are not in the DHS network.

There were 8,813 MHLA participants who had 12,064 ED visits at DHS facilities. On average, MHLA ED users had approximately 1.4 visits to a DHS ED. Table F12 shows that the rate of ED visits per participant per year decreased from 96 per 1,000 participants in FY 2014-15 to 88 per 1,000 participants in FY 2015-16.

Table F12
ED Visits per 1,000 Participants per Year

	Number of ED Visits	Participant Months	ED Visits/1,000
FY 2014-15 (9 months)	6,323	786,521	96.47
FY 2015-16 (12 months)	8,813	1,646,443	87.93

Tables F13 and F14 illustrate the breakdown of participants who accessed ED services at DHS by housing status (i.e., homeless or not homeless). Of the 8,813 MHLA participants who utilized a DHS ED, 117 (1.3%) were MHLA participants who identify as homeless. While homeless participants are a smaller percentage of the participant population, their utilization of ED services is 84% higher (9% of participants versus 4.9% of participants) than that of housed participants, as indicated in Table F13. Table 14 shows that a higher percentage of homeless participants had three or more ED visits at a DHS facility than housed participants. This is not surprising given the instability inherent in the lives of homeless individuals.

Table F13
ED Visits by Unduplicated Housed and Homeless Participants

	Unduplicated Participants	# Participants with ED Visits	% of Participants with ED Visits
All Participants	179,367	8,813	4.9%
Housed Participants	178,066	8,696	4.9%
Homeless Participants	1,301	117	9%

Table F14
Distribution of Unduplicated ED Patients by Number of Visits

	No ED Visits	1 ED Visit	2 ED Visits	3 ED Visits	4 ED Visits	5 – 9 ED Visits	10+ ED Visits
All Participants (179,367)	170,554	6,793	1,393	369	126	114	18
	95%	3.8%	0.8%	0.2%	0.1%	0.1%	0%
Homeless Participants (8,813)	1,184	68	32	6	2	6	3
	91%	5.2%	2.5%	0.5%	0.2%	0.5%	0.2%

Table F15 shows that LAC+USC Medical Center continues to see the most MHLA participants in its ED, with a total of 4,419 unduplicated participants having 5,829 ED visits. LAC+USC represents 48.32% of all MHLA participants seen at a DHS facility for ED services.

Table F15
ED Visits by DHS Facility

Facility Name	Unique Participants	Visits	% of Total Visits
LAC+USC MEDICAL CENTER	4,419	5,829	48.32%
OLIVE VIEW-UCLA MEDICAL CENTER	2,564	3,784	31.37%
HARBOR-UCLA MEDICAL CENTER	1,946	2,451	20.32%
Overall (All DHS Facilities)	**8,813**	**12,064**	**100.00%**

Avoidable Emergency Department (AED) Visit Rate

The Avoidable Emergency Department (AED) visit rate for MHLA describes visits to the ED that were not emergency related and that could be considered avoidable.[6] Appendix 3 lists the avoidable diseases by type, number of visits and unique participants. Table F16 below provides the AED rate for fiscal years 2015-16 and 2014-15. Approximately 16.33% of ED visits by MHLA participants in FY 2015-16 were considered avoidable. This AED rate is comparable to last year's AED annualized rate of 15.96%. The top three avoidable ED visits reasons were: headaches, other headache syndromes, and Dorsalgia (back pain).

Table F16
Avoidable ED (AED) Rate by MHLA Participants

Fiscal Year	AED Visits	ER Visits	AER Rate
FY 2014-15 (9 months)	1,009	6,323	15.96%
FY 2015-16 (12 months)	1,970	12,064	16.33%

Inpatient Hospitalization Admissions (DHS)

This section describes inpatient utilization by MHLA participants at DHS hospitals in FY 2015-16. As with emergency department utilization, it is important to note that inpatient utilization may be underreported due to the fact that MHLA only includes DHS hospital facilities and a MHLA participant may have received inpatient services (as a result of an emergency admission) from a non-DHS facility. This clinical data would not be included in this analysis because these facilities are not in the DHS network.

Table F17 shows inpatient hospitalization admissions for all MHLA participants. It indicates that 1,956 of the 179,367 program participants (1.1%) in FY 2015-16 were admitted to a DHS hospital.

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

Table F17
Distribution of Unduplicated Hospital Admission Patients by Number of Visits

	No Admits	1 Admit	2 Admits	3 Admits	4 Admits	5 – 9 Admits	10+ Admits	All Admits
% Participants	177,411	1,650	206	60	22	16	2	1,956
% Participants	98.9%	0.92%	0.11%	0.03%	0.01%	0.01%	0.0%	1.1%

Table F18 reveals that the 1,956 participants had 2,444 admissions and a total of 12,396 inpatient bed days at DHS facilities with an Average Length of Stay (ALOS) of 5.07 days. LAC+USC Medical Center had the highest number of inpatient admissions with approximately 46% of the total.

Table F18
DHS Hospitalization Admission by Facility

Facility Name	Unique Participants	Admits	% of Total Admits	Bed Days	ALOS
LAC+USC MEDICAL CENTER	918	1,117	45.70%	5,763	5.16
OLIVE VIEW-UCLA MED CTR	484	632	25.86%	3,013	4.77
HARBOR-UCLA MEDICAL CENTER	531	624	25.53%	3,137	5.03
RANCHO LOS AMIGOS MED CTR	66	71	2.91%	483	6.80
Total (All DHS Hospitals)	**1,956**	**2,444**	**100%**	**12,396**	**5.07**

Table F19 reveals that the majority (80%) of MHLA participants who were hospitalized had a chronic condition, but that their ALOS (4.96 days) was lower than for those with a chronic condition (5.59 days). Participants with chronic conditions were 82% of hospital admissions in FY 2015-16.

Table F19
DHS Hospitalization Admission

	Unique Participants	Admissions	% of Total Admissions	Bed Days	ALOS
W/ Chronic Condition	1,574	2,006	82.08%	9,947	4.96
W/O Chronic Condition	382	438	17.92%	2,449	5.59
Total	1,956	2,444	100.00%	12,396	5.07

Table F20 provides comparative information on admissions, acute days and ALOS for FY years 2015-16 and FY 2014-15. The ALOS was similar for both years.

Table F20
Acute Hospital Days per 1,000 Participants per Year and Average Length of Stay (ALOS)

Fiscal Year	Admits	Admits /1,000	Acute Days	Acute Days/1,000	ALOS
FY 2015-16	2,444	17.81	12,396	90.35	5.07 Days
FY 2014-15 (annualized)	978	18.51	6,045	92.23	4.98 Days

Hospital Readmissions

Readmission data is a good indicator of quality of care. The overall readmission rate for all DHS facilities is 13.95% (341 readmits divided by 2,444 total inpatient admissions) – see Table F21. MHLA's 30-day readmission rate for FY 2015-16 was 8.96% which is a decrease from 10.47% in FY 2014-15. Table F22 provides information on the readmissions by DHS hospital.

Table F21
DHS Hospital Readmission Rate for 30, 60 and 90 Days

Readmit Time Period After Discharge	Readmissions	Total Admissions	Readmission Rate
01-30 Days	219	2,444	8.96%
31-60 Days	81	2,444	3.31%
61-90 Days	41	2,444	1.68%
Total	341	2,444	13.95%

Table F22
Readmission Rate by Facility (1 - 90 Days)

Facility Name	Readmissions	Total Admissions	Readmission Rate
OLIVE VIEW-UCLA MED CTR	116	632	18.35%
LAC+USC MEDICAL CENTER	154	1,117	13.79%
HARBOR-UCLA MEDICAL CENTER	69	624	11.06%
RANCHO LOS AMIGOS MED CTR	2	71	2.82%
Total (All DHS Hospitals)	**341**	**2,444**	**13.95%**

The hospital readmission rate for MHLA participants with a chronic conditions improved in FY 2015-16 (i.e., it decreased). As noted in Table F23, the readmission rate for this population was 10.45%, down from the FY 2014-15 rate of 15.14%. The readmission rate for those without a chronic disease had a slight increase at 15.89%, from the FY 2014-15 rate of 15.18%. It is interesting to note that average Medi-Cal readmission rate is 18.6%[7].

Table F23
Re-admission Rate for Participants with and without Chronic Conditions

Condition Type	FY 2015-16 Readmission Rate	FY 2014-15 Readmission Rate
W/ Chronic Condition	10.45%	15.14%
W/O Chronic Condition	15.89%	15.18%
Total	13.95%	15.17%

[7] Medicare Fee-For-Service (FFS) Hospital Readmissions: Q1 2015–Q4 2015, State of California." Centers for Medicare and Medicaid Services (CMS). *Health Services Advisory Group*

G. HEALTH CARE SERVICE EXPENDITURES

This section provides information on payments made to community partner clinics under the MHLA program in FY 2015-16. For this report, DHS tracked payments to each Community Partner (CP) for primary care services during the Monthly Grant Funding (MGF) period.

Key FY 2015-16 highlights were:

- Payments to Community Partners for primary care and pharmacy related services totaled $52,686,176.
- With a total of 1,646,443 participant months, the estimated total per participant per month expenditure for primary care and pharmacy related services was $32.
- Payments for dental services totaled $4,776,321.
- Total payments in FY 2015-16 $57,462,497.

MHLA Health Care Service Payment Categories

Health care service payments are in two areas: (1) payments to CP clinics providing preventive, primary care and pharmacy services, and (2) payments for dental services provided by those CP clinics with dental contracts.

Community Partners – Primary Care

The Los Angeles County Board of Supervisors allocated $56 million for the provision of primary care (including pharmaceutical services) for CPs. Of this allocation, a total of $52,686,176 were paid to the CPs in FY 2015-16.

Community Partners – Dental Care

In addition to the $56 million allocated for MHLA primary care services, the Los Angeles County Board of Supervisors allocates $5 million for MHLA dental services. Although dental care is not a benefit of the MHLA program, twenty-five (25) MHLA Community Partners provide dental services to MHLA eligible or enrolled participants. A total of $4,776,321 of the dental allocation was spent in FY 2015-16.

Per MHLA Participant per Month Health Care Services Costs

There were a total of 1,646,443 MHLA participant months in FY 2015-16. When the total cost expended by DHS to community partner clinics for primary care ($52,686,176) is divided by the total participant months, the average estimated total per participant per month rate for primary care health care services was $32. CPs receive the per participant per month amount for each person who has selected their medical home irrespective of whether the participant uses services in the month. As noted in Section F of the report, 63,199 (35%) MHLA participants did not have a primary care visit in FY 2015-16 representing a total of 493,004 enrollment months. Of the $52.686M provided to CPs, $15,776,128 ($32 * 493,004 months) in payments were made on behalf of participants who did not have a primary care service. This represented 30% of funding provided to the CPs ($15.776M ÷ $52.686M).

Estimated MHLA Health Care Service Payments

Table G1 outlines the total payments ($57,462,497) for the MHLA Program for FY 2015-16.

Table G1
Estimated Total MHLA Payments (FY 2015-16)

ENROLLMENT	
TOTAL PARTICIPANT MONTHS (TOTAL ENROLLMENT OF 179,367):	1,646,443
COMMUNITY PARTNER PROGRAM PAYMENTS	
MONTHLY GRANT FUNDING COST FOR ALL COMMUNITY PARTNERS	
PRIMARY CARE SERVICES	$46,100,404
PHARMACY RELATED SERVICES	$6,585,772
TOTAL MONTHLY GRANT FUNDING	$52,686,176
DENTAL CARE SERVICES	$4,776,321
GRAND TOTAL	**$57,462,497**

Appendices 3 and 4 represent a breakdown of the estimated total expenditures by CP clinic for both the MHLA primary care and dental programs.

III. CONCLUSION AND LOOKING FORWARD

Fiscal Year 2015-16 completed the second, full programmatic year for the MHLA program. The data gathered this year includes for the first time interesting information about program renewals, primary care referrals between DHS and CP clinics, and urgent care utilization which was not available in the first annual report. In addition, due to the improvement in the quality and quantity of primary care encounter data submitted by the CPs this fiscal year, FY 2015-16 hopefully marks the first year that a more reliable data baseline can be set to compare DHS service utilization to future years, especially as it relates to urgent care and emergency room utilization at DHS. Obtaining pharmacy encounter data from the CPs remained a challenge this year, but the program is certain that pharmacy encounter data will improve as more clinics transition into the MHLA retail pharmacy network ("Pharmacy Phase II") in the next fiscal year.

This year was filled with an incredible amount of positive energy and work. As previously mentioned, the program began building the groundwork for implementation of our Pharmacy Phase II Pilot. MHLA also planned for implementation of the addition of MHLA Substance Use Disorder (SUD) treatment services to the program, working in collaboration with Los Angeles County's Department of Public Health (DPH) Substance Abuse Prevention and Control (SAPC) unit to make SUD services available to MHLA participants free of charge. Both the launch of the Pharmacy Phase II pilot and the addition of SUD services to the program were successfully launched on July 1, 2016. We will provide detailed analysis of these new services in the FY 2016-17 annual report.

DHS continues to work in partnership with its Community Partner (CP) clinics to expand outreach and enrollment opportunities to individuals who are eligible for, but not yet enrolled in, MHLA, and to ensure strong enrollment, renewal and re-enrollment rates. We did a tremendous amount of work with the CPs this year to try and improve renewal rates within the program, working with the Community Clinic Association of Los Angeles County (CCALAC) and six (6) CPs to develop a user-friendly renewal toolkit as well as conducted in-person renewal trainings. It is our mutual goal to expand and preserve access to primary, dental, specialty and emergency health care services as well as expand pharmaceutical access and substance use disorder services for this population.

DHS continues to work in partnership with MHLA clinics and CCALAC on new opportunities to enhance enrollment strategies in order to maximize program enrollment and ensure a stronger, more accessible program for eligible residents of Los Angeles County.

IV. APPENDICES

APPENDIX 1
CPs with MRR and/or FSR Repeat Deficiencies FY 2014-15 and FY 2015-16

	MHLA Community Partners	MRR	FSR
1	All for Health, Health for All, Inc.	X	
2	All Inclusive Community Health Center	X	
3	Altamed Health Services Corporation	X	X
4	Antelope Valley Community Clinic	X	
5	APLA Health and Wellness	X	
6	Arroyo Vista Family Health Foundation	X	
7	Asian Pacific Health Care Venture, Inc.	X	X
8	Bartz-Altadonna Community Health Center	X	X
9	Benevolence Industries, Incorporated	X	
10	Bienvenidos Community Health Center	X	X
11	Central City Community Health Center, Inc.	X	
12	Central Neighborhood Health Foundation	X	
13	Children's Dental Foundation	X	
14	Chinatown Service Center	X	X
15	Clinica Msr. Oscar A. Romero	X	
16	Community Health Alliance of Pasadena	X	
17	Complete Care Community Health Center, Inc.	X	X
18	Comprehensive Community Health Centers, Inc.	X	
19	East Valley Community Health Center, Inc.	X	
20	El Proyecto del Barrio, Inc.	X	
21	Family Health Care Centers of Greater Los Angeles, Inc.	X	X
22	Garfield Health Center	X	
23	Harbor Community Clinic	X	X
24	Herald Christian Health Center	X	
25	JWCH Institute, Inc.	X	X
26	Kedren Community Health Center, Inc.	X	
27	Korean Health, Education, Information & Research (KHEIR)	X	
28	Los Angeles Christian Health Centers	X	X
29	Los Angeles LGBT Center	X	X
30	Mission City Community Network, Inc.	X	X
31	Northeast Valley Health Corporation	X	X
32	Pediatric and Family Medical Center, dba Eisner Pediatric & Family Medical Center	X	X
33	Pomona Community Health Center	X	X
34	QueensCare Health Center	X	
35	South Central Family Health Center		X
36	Southern California Medical Center, Inc.		X
37	St. John's Well Child and Family Center, Inc.		X
38	The Children's Clinic, Serving Children and Their Families		X
39	THE Clinic, Inc.		X

	MHLA Community Partners	MRR	FSR
40	The Los Angeles Free Clinic, dba Saban Community Clinic		X
41	The Northeast Community Clinic		X
42	University Muslim Medical Association, Inc. (UMMA)		X
43	Valley Community Healthcare		X
44	Watts Healthcare Corporation		X
45	Wilmington Community Clinic		X

APPENDIX 2
Total Enrolled and Office Visits by Community Partner Medical Home[8]

Medical Home	Total Enrolled	Unique Participants Seen	% of Participants Seen	Total Participant Visits	Visit Per Participant Per Year (Annualized)
AFH-519	853	536	63%	941	1.69
AFH-BURBANK	24	17	71%	25	2.91
AFH-CENTRAL	76	52	68%	90	2.34
AFH-PACIFIC	9	8	89%	17	3.92
AFH-PEDIATRICS	30	4	13%	4	0.22
AFH-SUNLAND	16	13	81%	26	2.74
ALL-INCLUSIVE COMMUNITY HEALTH CENTER	385	234	61%	758	3.10
ALTAMED-BELL	484	370	76%	1,586	3.57
ALTAMED-BUENA CARE	13	7	54%	17	2.91
ALTAMED-COMMERCE	2,205	1505	68%	5,771	2.94
ALTAMED-EL MONTE	978	760	78%	3,346	3.73
ALTAMED-FIRST STREET	1,271	854	67%	3,537	3.12
ALTAMED-HOLLYWOOD PRESBYTERIAN	313	180	58%	538	1.94
ALTAMED-HUNTINGTON PARK	8	3	38%	11	4.13
ALTAMED-MONTEBELLO	124	96	77%	417	3.80
ALTAMED-PICO RIVERA PASSONS	24	14	58%	76	3.75
ALTAMED-PICO RIVERA SLAUSON	1,178	868	74%	3,990	3.80
ALTAMED-WEST COVINA	621	434	70%	1,505	2.66
ALTAMED-WHITTIER	1,970	1466	74%	6,570	3.65
APLAHW-BALDWIN HILLS	183	110	60%	437	4.67
ARROYO VISTA-EL SERENO HUNTINGTON DRIVE	285	184	65%	860	4.61

[8] 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	Total Enrolled	Unique Participants Seen	% of Participants Seen	Total Participant Visits	Visit Per Participant Per Year (Annualized)
ARROYO VISTA-EL SERENO VALLEY	373	265	71%	1,255	5.40
ARROYO VISTA-HIGHLAND PARK	2,199	1461	66%	6,689	4.33
ARROYO VISTA-LINCOLN HEIGHTS	2,137	1309	61%	5,173	3.74
ARROYO VISTA-LOMA DRIVE	715	479	67%	1,665	3.79
ASIAN PACIFIC HEALTH CARE-BELMONT HC	605	358	59%	1,014	2.39
ASIAN PACIFIC HEALTH CARE-EL MONTE ROSEMEAD HC	393	245	62%	888	3.42
ASIAN PACIFIC HEALTH CARE-JOHN MARSHALL HIGH SCHOOL	15	14	93%	56	4.00
ASIAN PACIFIC HEALTH CARE-LOS FELIZ HC	2,167	1606	74%	4,885	2.91
AVCC-HEALTH AND WELLNESS	700	306	44%	698	1.30
AVCC-PALMDALE	715	336	47%	887	1.60
BARTZ-ALTADONNA COMMUNITY HEALTH CENTER	426	261	61%	1,642	6.11
BENEVOLENCE-CENTRAL MEDICAL CLINIC	405	221	55%	695	3.18
BENEVOLENCE-CRENSHAW COMMUNITY CLINIC	209	98	47%	304	2.78
BIENVENIDOS COMMUNITY HEALTH CENTER	1,698	1020	60%	4,407	4.13
BIENVENIDOS-GARFIELD WELLNESS CENTER	1	0	0%	0	0.00
CENTRAL CITY COMMUNITY HEALTH CENTER INC.	1,789	804	45%	2,108	1.62
CENTRAL CITY COMMUNITY-DOWNTOWN SITE	62	36	58%	123	5.39
CENTRAL NEIGHBORHOOD-CENTRAL	1,604	976	61%	4,629	4.02
CENTRAL NEIGHBORHOOD-GRAND	141	71	50%	281	3.86
CHAPCARE-DEL MAR	673	449	67%	2,732	5.50
CHAPCARE-FAIR OAKS	1,578	1217	77%	8,118	6.54
CHAPCARE-LAKE	280	217	78%	1,229	6.01
CHAPCARE-VACCO	388	252	65%	1,329	5.74
CHINATOWN-COMMUNITY HEALTH CENTER	141	94	67%	348	3.22

Medical Home	Total Enrolled	Unique Participants Seen	% of Participants Seen	Total Participant Visits	Visit Per Participant Per Year (Annualized)
CHINATOWN-CSC CHC-SAN GABRIEL VALLEY	52	30	58%	108	3.03
CLINICA ROMERO-ALVARADO CLINIC	4,013	2811	70%	7,847	2.40
CLINICA ROMERO-CHILDREN'S CLINIC	1	0	0%	0	0.00
CLINICA ROMERO-MARENGO CLINIC	1,760	1126	64%	3,791	2.58
COMPLETE CARE COMMUNITY HEALTH CENTER	215	101	47%	326	3.65
COMPREHENSIVE COMMUNITY-EAGLE ROCK	694	420	61%	1,536	3.01
COMPREHENSIVE COMMUNITY-GLENDALE	845	567	67%	2,108	3.75
COMPREHENSIVE COMMUNITY-HIGHLAND PARK	719	437	61%	1,488	2.90
COMPREHENSIVE COMMUNITY-NORTH HOLLYWOOD	870	597	69%	2,095	3.40
EL PROYECTO DEL BARRIO-ARLETA	1,892	1258	66%	8,360	6.04
EL PROYECTO DEL BARRIO-AZUSA	1,765	1282	73%	8,045	5.88
EL PROYECTO DEL BARRIO-BALDWIN PARK	232	194	84%	1,408	8.85
EL PROYECTO DEL BARRIO-WINNETKA	2,586	1457	56%	5,176	2.70
EVCHC-COVINA HEALTH CENTER	232	175	75%	601	3.29
EVCHC-POMONA CLINIC	2,879	1843	64%	6,714	3.10
EVCHC-VILLACORTA SCHOOL-BASED CLINIC	763	466	61%	1,768	3.09
EVCHC-WEST COVINA CLINIC	2,947	2004	68%	7,126	3.14
FAMILY HEALTH-BELL GARDENS	3,438	2407	70%	9,737	3.72
FAMILY HEALTH-DOWNEY	149	110	74%	482	4.04
FAMILY HEALTH-HAWAIIAN GARDENS	497	331	67%	1,203	3.29
FAMILY HEALTH-MAYWOOD	6	1	17%	1	1.09
GARFIELD HEALTH CENTER	331	229	69%	963	4.16
HARBOR COMMUNITY CLINIC	887	581	66%	2,771	4.44
HARBOR COMMUNITY CLINIC-DON KNABE PEDIATRIC	27	9	33%	40	2.13
HERALD CHRISTIAN HEALTH CENTER	405	129	32%	370	1.64

Medical Home	Total Enrolled	Unique Participants Seen	% of Participants Seen	Total Participant Visits	Visit Per Participant Per Year (Annualized)
JWCH-BELL GARDENS	2,107	1420	67%	6,355	4.02
JWCH-BELL SHELTER	1	1	100%	7	21.00
JWCH-DOWNTOWN WOMEN'S CENTER	2	0	0%	0	0.00
JWCH-NORWALK	1,395	937	67%	4,177	3.90
JWCH-PATH	260	171	66%	607	3.31
JWCH-WEINGART	637	430	68%	1,742	3.88
JWCH-WEINGART 2	1	1	100%	4	9.60
JWCH-WESLEY BELLFLOWER	1,451	944	65%	3,586	3.49
JWCH-WESLEY DOWNEY	261	207	79%	749	5.81
JWCH-WESLEY LYNWOOD	1,673	1154	69%	4,233	3.44
KEDREN COMMUNITY CARE CLINIC	182	96	53%	758	8.41
KHEIR CLINIC	1,684	1139	68%	6,542	5.72
KHEIR-WILSHIRE CLINIC	27	13	48%	46	5.36
LA CHRISTIAN-EXODUS ICM	17	7	41%	46	6.07
LA CHRISTIAN-GATEWAY AT PERCY VILLAGE	15	2	13%	3	0.73
LA CHRISTIAN-JOSHUA HOUSE	578	359	62%	1,202	2.91
LA CHRISTIAN-PICO ALISO	1,381	987	71%	2,786	2.77
LA CHRISTIAN-TELECARE SERVICE AREA 4	2	1	50%	5	3.53
LA CHRISTIAN-WORLD IMPACT	14	12	86%	39	4.88
LOS ANGELES LGBT CENTER	11	3	27%	5	2.73
MISSION CITY-HOLLYWOOD	55	30	55%	110	3.28
MISSION CITY-INGLEWOOD	32	15	47%	60	4.34
MISSION CITY-MONROVIA	12	7	58%	30	4.34
MISSION CITY-NORTH HILLS	4,555	2974	65%	12,369	3.69
MISSION CITY-NORTHRIDGE	709	460	65%	1,774	3.77
MISSION CITY-ORANGE GROVE	8	5	63%	22	5.28

Medical Home	Total Enrolled	Unique Participants Seen	% of Participants Seen	Total Participant Visits	Visit Per Participant Per Year (Annualized)
MISSION CITY-PACOIMA MIDDLE SCHOOL	328	211	64%	819	3.18
MISSION CITY-PARTHENIA	6	3	50%	15	3.75
MISSION CITY-PRAIRIE	9	6	67%	28	5.01
NEV-CANOGA PARK	1,114	746	67%	2,651	2.62
NEV-HOMELESS	28	4	14%	8	0.71
NEV-MACLAY HC FOR CHILDREN	12	7	58%	16	1.59
NEV-PACOIMA	2,500	1384	55%	4,124	1.86
NEV-PEDIATRIC HLTH AND WIC CENTER	143	70	49%	178	1.80
NEV-SAN FERNANDO	3,647	1885	52%	5,425	2.17
NEV-SAN FERNANDO HIGH SCHOOL TEEN HC	11	7	64%	21	2.29
NEV-SANTA CLARITA	824	418	51%	1,134	1.57
NEV-SUN VALLEY	1,776	1113	63%	3,734	2.41
NEV-VALENCIA	1,442	801	56%	2,433	1.84
NEV-VAN NUYS ADULT	448	292	65%	1,150	4.16
PEDIATRIC AND FAMILY-EISNER PEDIATRIC AND FAMILY	5,778	3676	64%	11,368	2.25
POMONA COMMUNITY-HOLT	1,100	813	74%	2,869	3.39
QUEENSCARE-EAGLE ROCK	662	524	79%	2,178	3.72
QUEENSCARE-EAST THIRD STREET	2,075	1344	65%	4,747	3.20
QUEENSCARE-EASTSIDE	1	1	100%	1	2.40
QUEENSCARE-ECHO PARK	2,209	1554	70%	5,094	3.16
QUEENSCARE-HOLLYWOOD	1,777	1294	73%	4,483	3.38
SAMUEL DIXON-CANYON COUNTRY HC	206	121	59%	331	2.05
SAMUEL DIXON-NEWHALL	202	95	47%	265	1.95
SAMUEL DIXON-VAL VERDE	39	17	44%	48	1.69
SOUTH BAY-CARSON	298	180	60%	625	2.89
SOUTH BAY-GARDENA	1,453	955	66%	4,352	3.74

Medical Home	Total Enrolled	Unique Participants Seen	% of Participants Seen	Total Participant Visits	Visit Per Participant Per Year (Annualized)
SOUTH BAY-INGLEWOOD	1,676	1163	69%	4,270	3.11
SOUTH BAY-REDONDO BEACH	860	537	62%	2,018	3.00
SOUTH CENTRAL FAMILY HC	2,271	1745	77%	8,129	4.44
SOUTH CENTRAL-HUNTINGTON PARK	704	448	64%	1,880	4.44
SOUTHERN CALIFORNIA-EL MONTE CLINIC	450	274	61%	996	4.77
SOUTHERN CALIFORNIA-PICO RIVERA	285	163	57%	625	4.51
ST. JOHN'S-COMPTON	4,684	2940	63%	12,301	3.42
ST. JOHN'S-DOMINGUEZ	3,326	2146	65%	8,363	3.12
ST. JOHN'S-DOWNTOWN LOS ANGELES-MAGNOLIA	5,198	3041	59%	10,143	2.44
ST. JOHN'S-DR. KENNETH WILLIAMS	7,750	4659	60%	16,136	2.76
ST. JOHN'S-HYDE PARK	1,041	599	58%	2,029	2.59
ST. JOHN'S-LINCOLN HEIGHTS	678	469	69%	2,041	3.84
ST. JOHN'S-LOUIS FRAYSER	2,257	1124	50%	3,215	1.76
ST. JOHN'S-MANUAL ARTS	998	614	62%	2,475	3.56
ST. JOHN'S-MOBILE UNIT 1	74	57	77%	181	4.30
ST. JOHN'S-RANCHO DOMINGUEZ	1,789	1153	64%	4,674	3.46
ST. JOHN'S-WARNER TRAYNHAM	957	700	73%	2,360	3.95
ST. JOHN'S-WASHINGTON	814	549	67%	2,178	3.88
TARZANA-LANCASTER	758	393	52%	1,695	3.06
TARZANA-PALMDALE	446	250	56%	1,291	3.89
THE ACHIEVABLE FOUNDATION	24	13	54%	37	2.64
THE CHILDREN'S CLINIC-CESAR CHAVEZ ELEMENTARY SCHOOL	335	250	75%	953	3.43
THE CHILDREN'S CLINIC-FAMILY HC BELLFLOWER	235	173	74%	652	3.45
THE CHILDREN'S CLINIC-FAMILY HC CENTRAL LB	615	418	68%	1,328	2.75
THE CHILDREN'S CLINIC-FAMILY HC WESTSIDE	554	388	70%	1,497	3.23

Medical Home	Total Enrolled	Unique Participants Seen	% of Participants Seen	Total Participant Visits	Visit Per Participant Per Year (Annualized)
THE CHILDREN'S CLINIC-INTERNATIONAL ELEM SCHOOL	4	2	50%	2	2.40
THE CHILDREN'S CLINIC-LB MULTI-SERVICE CTR HOMELESS	3	1	33%	4	1.71
THE CHILDREN'S CLINIC-NORTH LB HAMILTON MIDDLE SCHOOL	929	689	74%	2,220	2.97
THE CHILDREN'S CLINIC-S. MARK TAPER	2,429	1605	66%	5,026	2.62
THE CHILDREN'S CLINIC-VASEK POLAK	1,202	767	64%	2,544	2.79
THE LA FREE-BEVERLY	1,502	1093	73%	4,892	4.26
THE LA FREE-HOLLYWOOD-WILSHIRE	4,504	3031	67%	12,246	3.55
THE LA FREE-S. MARK TAPER	982	634	65%	2,854	3.94
THE NECC-CALIFORNIA FAMILY CARE	1,138	814	72%	2,333	2.36
THE NECC-COMMUNITY MEDICAL ALLIANCE	894	653	73%	2,411	3.16
THE NECC-ELIZABETH	43	16	37%	25	1.33
THE NECC-FOSHAY	293	216	74%	825	3.63
THE NECC-GAGE	311	199	64%	625	2.96
THE NECC-GRAND	242	153	63%	570	3.50
THE NECC-HARBOR CITY	496	320	65%	1,208	2.92
THE NECC-HAWTHORNE	72	39	54%	84	1.57
THE NECC-HIGHLAND PARK	713	497	70%	1,765	2.93
THE NECC-WILMINGTON	1,004	596	59%	1,760	2.17
THE NECC-WOMEN'S HEALTH CENTER	107	51	48%	123	1.84
THE-LENNOX	57	33	58%	102	4.29
THE-RUTH TEMPLE	1,874	1171	62%	4,112	2.90
UMMA	1,341	965	72%	3,521	3.13
UMMA-FREMONT WELLNESS CENTER	348	231	66%	954	3.21
UNIVERSAL COMMUNITY	154	83	54%	312	3.33
UNIVERSAL HEALTH	10	0	0%	0	0.00

Medical Home	Total Enrolled	Unique Participants Seen	% of Participants Seen	Total Participant Visits	Visit Per Participant Per Year (Annualized)
VALLEY-NORTH HILLS WELLNESS CENTER	996	690	69%	2,179	4.17
VALLEY-NORTH HOLLYWOOD	5,690	3952	69%	13,910	3.22
VENICE-COLEN	785	506	64%	1,623	2.66
VENICE-ROBERT LEVINE	242	145	60%	474	2.45
VENICE-SIMMS/MANN	1,755	1193	68%	4,641	3.08
VENICE-VENICE	2,029	1312	65%	5,268	3.19
WATTS-CRENSHAW	9	4	44%	8	5.05
WATTS-WATTS	1,692	1023	60%	3,245	2.88
WESTSIDE FAMILY HEALTH CENTER	380	265	70%	892	3.14
WILMINGTON COMMUNITY CLINIC	2,531	1682	66%	6,382	3.13
All Medical Homes	**179,367**	**116,168**	**61%**	**441,702**	**3.44**

APPENDIX 3
Avoidable Emergency Room (AER) Visit – Diseases

Avoidable Emergency Room Diseases	Unique Participants	AER Visits	% of AER Visits
Other headache syndromes	679	723	36.70%
Dorsalgia	395	425	21.57%
Headache	151	159	8.07%
Encounter for general examination	84	88	4.47%
Acute upper respiratory infections of multiple or unspecified sites	81	82	4.16%
Conjunctivitis	71	71	3.60%
Acute Pharyngitis	61	63	3.20%
Urinary tract infection, site not specified	56	58	2.94%
Acute bronchitis	38	38	1.93%
Encounters of administrative purposes	34	38	1.93%
Cystitis	29	29	1.47%
Follow up examination	29	29	1.47%
Hematuria	25	25	1.27%
Inflammatory disease of cervix, vagina & vulva	23	23	1.17%
Candidiasis	22	22	1.12%
Suppurative Otitis Media	20	20	1.02%
Pruritus	15	15	0.76%
Special examinations	15	15	0.76%
Chronic sinusitis	11	11	0.56%
Dermatophytosis	10	10	0.51%
Chronic pharyngitis & nasopharyngitis	9	9	0.46%
Obstructive and reflux uropathy	8	8	0.41%
Other specified pruritic conditions (hiemalis, senilis, Winter itch)	5	5	0.25%
Chronic disease of tonsils & adenoids	2	2	0.10%
Acariasis	1	1	0.05%
Eccrine sweat disorders	1	1	0.05%
Total	**1,875**	**1,970**	**100.00%**

APPENDIX 4
Primary Care Expenditures for MHLA Community Partners FY 2015-16

COMMUNITY PARTNER	TOTAL CP MHLA REIMBURSEMENT
ALL FOR HEALTH, HEALTH FOR ALL, INC.	$ 244,640
ALL INCLUSIVE COMMUNITY HEALTH CENTER	$ 93,824
ALTAMED HEALTH SERVICES CORPORATION	$ 3,176,192
APLA HEALTH AND WELLNESS CENTER	$ 35,904
ARROYO VISTA FAMILY HEALTH FOUNDATION	$ 1,454,080
ASIAN PACIFIC HEALTH CARE VENTURE, INC.	$ 913,792
ANTELOPE VALLEY COMMUNITY CLINIC	$ 419,168
BARTZ-ALTADONNA COMMUNITY HEALTH CENTER	$ 103,136
BIENVENIDOS COMMUNITY HEALTH CENTER	$ 409,376
BENEVOLENCE INDUSTRIES, INCORPORATED	$ 125,888
CENTRAL CITY COMMUNITY HEALTH CENTER, INC.	$ 509,984
CENTRAL NEIGHBORHOOD HEALTH FOUNDATION	$ 470,528
COMMUNITY HEALTH ALLIANCE OF PASADENA	$ 834,752
CHINATOWN SERVICE CENTER	$ 55,200
CLINICA MSR. OSCAR A. ROMERO	$ 1,816,352
COMPLETE CARE COMMUNITY HEALTH CENTER, INC.	$ 34,272
COMPREHENSIVE COMMUNITY HEALTH CENTERS, INC.	$ 845,056
EL PROYECTO DEL BARRIO, INC.	$ 1,855,360
EAST VALLEY COMMUNITY HEALTH CENTER, INC.	$ 1,994,336
FAMILY HEALTH CARE CENTERS OF GREATER LOS ANGELES, INC.	$ 1,191,136
GARFIELD HEALTH CENTER, INC.	$ 88,800
HARBOR COMMUNITY CLINIC	$ 246,624

COMMUNITY PARTNER	TOTAL CP MHLA REIMBURSEMENT
HERALD CHRISTIAN HEALTH CENTER	$ 86,688
JWCH INSTITUTE, INC.	$ 2,178,976
KEDREN COMMUNITY CARE CLINIC	$ 34,624
KOREAN HEALTH, EDUCATION, INFORMATION & RESEARCH (KHEIR)	$ 442,688
LOS ANGELES CHRISTIAN HEALTH CENTERS	$ 552,256
LOS ANGELES LGBT CENTER	$ 704
MISSION CITY COMMUNITY NETWORK, INC.	$ 1,592,192
NORTHEAST VALLEY HEALTH CORP.	$ 3,737,696
PEDIATRIC AND FAMILY MEDICAL CENTER, DBA EISNER PEDIATRIC & FAMILY MEDICAL CENTER	$ 1,941,504
POMONA COMMUNITY HEALTH CENTER	$ 325,440
QUEENSCARE HEALTH CENTERS	$ 1,923,840
SAMUEL DIXON FAMILY HEALTH CENTER, INC.	$ 125,120
SOUTH BAY FAMILY HEALTH CARE	$ 1,316,000
SOUTH CENTRAL FAMILY HEALTH CENTER	$ 866,432
SOUTHERN CALIFORNIA MEDICAL CENTER, INC.	$ 133,376
ST. JOHN'S WELL CHILD AND FAMILY CENTER, INC.	$ 8,702,400
TARZANA TREATMENT CENTER, INC.	$ 340,064
THE ACHIEVABLE FOUNDATION	$ 5,376
THE CHILDREN'S CLINIC, SERVING CHILDREN AND THEIR FAMILIES	$ 1,917,600
THE LOS ANGELES FREE CLINIC, DBA SABAN COMMUNITY CLINIC	$ 2,043,584
THE NORTHEAST COMMUNITY CLINIC	$ 1,658,624
THE CLINIC INC.	$ 553,888
UNIVERSITY MUSLIM MEDICAL ASSOCIATION, INC. (UMMA)	$ 545,344
UNIVERSAL COMMUNITY HEALTH CENTER	$ 37,312

COMMUNITY PARTNER	TOTAL CP MHLA REIMBURSEMENT
VALLEY COMMUNITY HEALTHCARE	$ 1,859,552
VENICE FAMILY CLINIC	$ 1,520,864
WATTS HEALTHCARE CORP.	$ 433,344
WESTSIDE FAMILY HEALTH CENTER	$ 109,248
WILMINGTON COMMUNITY CLINIC	$ 783,040
GRAND TOTAL	**$ 52,686,176**

APPENDIX 5
Dental Expenditures by Community Partner FY 2015-16

ANTELOPE VALLEY COMMUNITY CLINIC	$ 32,750.00
APLA HEALTH & WELLNESS	$ 16,081.00
ARROYO VISTA FAMILY HEALTH FOUNDATION	$ 103,389.00
BENEVOLENCE INDUSTRIES	$ 38,438.00
BIENVENIDOS CHILDREN'S CENTER, INC.	$ 1,468.00
CHILDREN'S DENTAL FOUNDATION	$ 64,079.35
CHINATOWN SERVICE CENTER	$ 20,549.00
CLINICA MSR. OSCAR A. ROMERO	$ 94,038.00
COMMUNITY HEALTH ALLIANCE OF PASADENA	$ 117,728.00
COMPREHENSIVE COMMUNITY HEALTH CENTER	$ 103,295.00
EAST VALLEY COMMUNITY HEALTH CENTER	$ 134,743.00
EL PROYECTO DEL BARRIO	$ 180,329.00
HERALD CHRISTIAN HEALTH CENTER	$ 37,701.00
JWCH INSTITUTE, INC.	$ 122,559.54
LOS ANGELES CHRISTIAN HEALTH CENTERS	$ 142,716.14
MISSION CITY COMMUNITY NETWORK, INC.	$ 438,019.00
NORTHEAST VALLEY HEALTH CORPORATION	$ 626,600.00
PEDIATRIC & FAMILY MEDICAL CENTER dba EISNER PEDIATRIC & FAMILY MEDICAL CENTER	$ 259,573.00
QUEENSCARE FAMILY CLINICS	$ 448,165.00
SOUTH BAY FAMILY HEALTH CARE CENTER	$ 60,293.00
ST. JOHN'S WELL CHILD AND FAMILY CENTER, INC.	$ 1,000,202.00
THE LOS ANGELES FREE CLINIC, dba SABAN COMMUNITY CLINIC	$ 423,129.00
VALLEY COMMUNITY CLINIC	$ 139,017.00
VENICE FAMILY CLINIC	$ 72,965.00
WATTS HEALTHCARE CORPORATION	$ 98,494.04
TOTAL	**$ 4,776,321.07**

Appendix 6
Data Source and Submission

Following the same procedure as last year, this year's source data came from DHS' Enterprise Patient Data Repository (EPDR) which includes all medical and pharmacy services, as well as membership and demographic data reports which are run from the One-e-App system as well as all DHS services provided to the MHLA program participants. This includes inpatient, emergency, urgent care and outpatient care services. The data being reported includes all services provided to the MHLA participants between July 1, 2015 and June 30, 2016.

MHLA's One-e-App (OEA) database program is a web-based eligibility and enrollment system. OEA 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, makes referrals to Restricted (Emergency) Medi-Cal Program, and provides the data to DHS. The OEA system is maintained by a contract vendor, Social Interest Solutions (SIS). The MHLA Program Office works with SIS to maintain data integrity.

The OEA system uploads its daily data to DHS' Patient Management System (PMS) which in turn uploads to the DHS clinical data warehouse, the EPDR. The EPDR integrates clinical, utilization, financial and managed care data into one well-defined and rigorously maintained database system that enables timely and accurate reporting of clinical, operational and financial data. The EPDR is a vital component of DHS' patient integrated electronic health record (EHR) that is utilized at all DHS facilities.

The EPDR is a very large and complex system requiring multiple specialized skill sets in order to maintain end-user functionality and reliable availability. The EPDR transforms data into meaningful information by a team of health facility staff, Health Services Administration informaticists, analysts and information technology staff.