Providing Health Care to Undocumented Residents:
Program details and lessons learned from three California county health programs

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INTRODUCTION

While the number of people without health insurance has declined dramatically since the Affordable Care Act went into effect, undocumented immigrants continue to be excluded from many health coverage options under this law. In California, approximately 1.8 million individuals are projected to remain uninsured due to their immigration status.[1] Without resources to pay for costly health care, undocumented immigrants may delay care and eventually seek treatment in the emergency room or go untreated entirely.[2]

In California, 1.8 million individuals are projected to remain uninsured due to their immigration status.

Undocumented adults in California are generally eligible for only emergency and pregnancy-related services through Medi-Cal, the state's Medicaid program, though undocumented children and those granted deferred action may be eligible for full-scope Medi-Cal. Many of California's counties provide primary and preventive health care services to low-income undocumented residents through safety-net programs.[3] These programs are of interest to advocates and policymakers in other states who are looking for local solutions to offer non-emergency health services to undocumented immigrants. This report profiles three county programs that offer health care services to undocumented residents and aims to serve as a resource for designing and implementing similar programs elsewhere across the nation. It is based on interviews with county program staff, statewide informants, provider organizations, consumer advocacy groups, and published reports and documents gathered in June and July of 2016.

This report will present a brief history, basic enrollment and eligibility information, and available cost and revenue data for each of the highlighted county health care programs, and then describe lessons learned about building provider networks, engaging in outreach and enrollment, and evaluating the program.

METHODS

The majority of California counties provide at least some care for undocumented immigrants. We chose to profile Healthy San Francisco (HSF) in San Francisco and My Health LA (MHLA) in Los Angeles, due to their relative success in providing health care to large numbers of undocumented residents in metropolitan areas, the range of services offered, the improved systems of care coordination, and their history as established programs. We chose to profile the County Medical Services Program (CMSP) that serves 35 rural counties as a contrast to HSF and MHLA; CMSP has only recently started providing limited non-emergency health care to undocumented residents, and coordinates care in a large, mostly rural geographic area.

To prepare this report, we consulted with county program officials, provider organizations, consumer advocacy groups, health policy organizations, one health care foundation, and out-of-state advocates, and reviewed published reports and documents. For more details, see Appendix A.

PROGRAM DETAILS

BACKGROUND

California's Safety Net

For decades, the responsibility of providing care to the uninsured has been assigned to counties in California. Since 1933, California's Welfare and Institutions Code Section 17000 has required that counties make available a safety net to individuals who have no other recourses for their health care needs.[4] However, interpretation of this obligation varies widely among counties, including whether or not undocumented individuals are included in this responsibility. Even so, California has made much progress toward an inclusive safety net; currently 47 out of 58 counties provide at least some primary care and other non-emergency services to undocumented immigrants.[5]

Interpretation of the obligation to provide a safety net varies widely among counties, including whether or not undocumented individuals are included.

Counties have created safety net programs to provide more efficient and coordinated care to uninsured residents. These services are delivered through an array of safety net providers including Federally Qualified Health Centers (FQHCs), public hospitals, private hospitals and clinics, community health centers, and other facilities. Previously the uninsured interacted with a host of safety net providers with different eligibility requirements, enrollment systems, costs, and types of services offered, creating significant challenges in accessing care. County safety net programs streamline eligibility and enrollment, and make transparent the program costs and services available. However, the range of services covered under these programs varies significantly by county. For instance, whereas an undocumented person in Healthy San Francisco can access primary, preventive, specialty, behavioral, and hospital care, the same individual in Napa County (part of County Medical Services Program) would only be eligible for emergency care and, through a pilot program for some in certain income ranges, a limited amount of primary care and prescription drug coverage. These programs do not provide insurance, but rather access to care. As a result, enrollment in the programs does not count as "minimum essential coverage" for purposes

of avoiding the ACA tax penalties for uninsurance. These programs also generally do not pay for health care services provided outside county borders.

In addition to the county-based safety net system, California's undocumented residents with incomes below certain thresholds are eligible for restricted-scope Medi-Cal for emergencies and pregnancy-related services. Importantly, the Affordable Care Act (ACA) has expanded this program since 2014 through increasing the income eligibility for Medi-Cal programs, including restricted-scope coverage, to 138% of the federal poverty level (FPL), and expanding eligibility to childless adults. The state recently extended eligibility for full-scope Medi-Cal to undocumented children and youth under age 19. The coverage for children was accomplished through a multi-year campaign by advocates and legislators, and went into effect on May 1, 2016.

Financing the Safety Net and Changes Post-ACA

Two important sources of revenue for California's safety net are state realignment funds and federal funds for uncompensated care. In 1991, California established funding, commonly referred to as "Realignment," through portions of vehicle licensing fees and sales tax revenues, to finance county health, mental health, and other social services programs.[6] Realignment funding is a source of financial support to safety net programs.[7] Public hospitals in California also receive federal funding for Medi-Cal and uninsured patients through Medicaid Disproportionate Share Hospital (DSH) funds and Safety Net Care Pool (SNCP) funds.[8] These funds are designed to support hospitals that serve large populations of low-income patients by helping close gaps in coverage or uncompensated care, for services provided to these persons.

As a result of expanding eligibility for full-scope Medi-Cal, creating new options for health coverage, and other provisions, the ACA has significantly reduced the uninsured population and thus decreased their participation in safety net programs.[9] Anticipation of this led to a reassessment of health realignment funds with the intent of returning savings to the state. For 2014–2015 and after, counties must choose from one of two formulas that redistribute health realignment funds between the county and the state.[10] One of these formulas was seen as favorable to counties with public hospitals (such as San Francisco and Los Angeles) that continue to provide care to large numbers of low-income and uninsured patients post-ACA.[11] These changes resulted in a significant decline in revenue for CMSP as further described in the following section.

A new Global Payment Program incentivizes health care in settings beyond emergency care and removes restrictions on care to undocumented persons.

Furthermore, DSH and SNCP payments were scheduled either to be reduced or to disappear entirely after full implementation of the ACA.[12] However, through California's Section 1115 Medicaid Waiver titled "California's Medi-Cal 2020 Demonstration," DSH

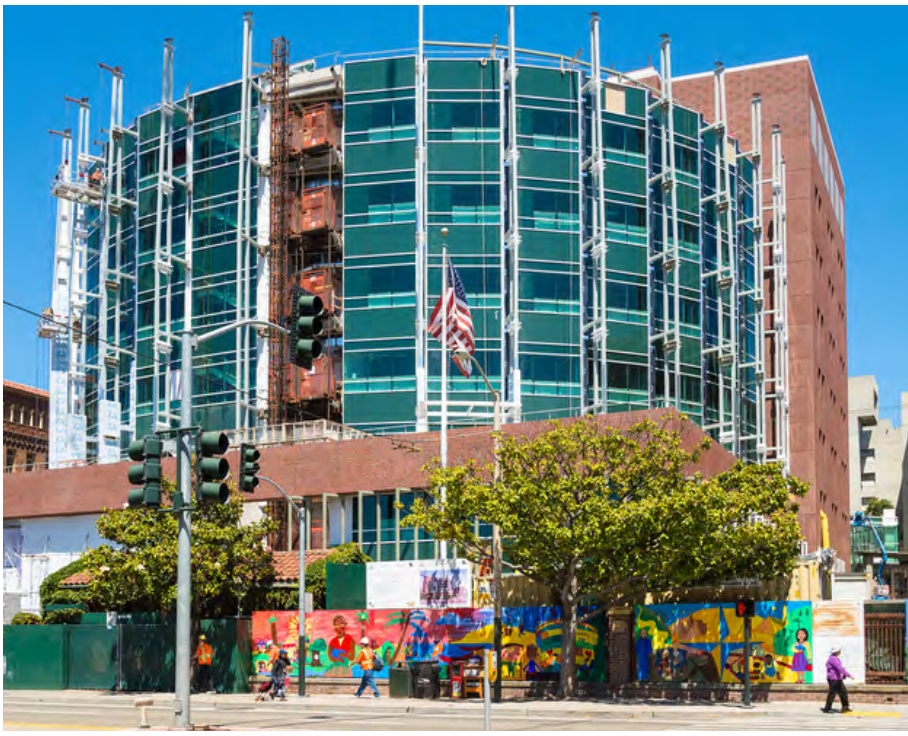
and SNCP revenue will now be reorganized under a new Global Payment Program, which incentivizes health care in settings beyond emergency care and removes restrictions on care to undocumented persons.[13] Though no new funding for uncompensated care is established through GPP, one advocate explained that the result of preserving DSH funding through California's Medi-Cal 2020 Demonstration was significant. This waiver is effective December 30, 2015, through December 31, 2020.[14]

HISTORY AND BASIC PROGRAM INFORMATION

The following section details HSF, MHLA, and CMSP program history, changes, and provider network information. A summary of program details is provided at the end of the section.

HEALTHY SAN FRANCISCO (HSF)

HSF: Background



Healthy San Francisco (HSF) has been recognized nationally as a model program for providing comprehensive and coordinated health care for the uninsured. In 2006, San Francisco established the Health Care Security Ordinance (HCSO), which requires employers to make health care contributions on behalf of their employees, either by subsidizing employer-sponsored health insurance or contributing funds toward health care costs.[15] A portion of these funds was used to establish the program and continues to fund HSF.[16]

Participants of HSF have a one-time enrollment per 12-month benefit period, access to a medical home for primary and preventive services, and a designated site for specialty care and emergency services. In particular, the concept of a medical home (such as a community clinic) has been important in the program design of HSF: a regular place for primary health care that improves efficiency of the safety net and patient care. Each HSF participant can choose a medical home that fits their cultural and linguistic needs and is in a

convenient location.[17] When a medical home no longer has capacity, an HSF participant will be able to select from the remaining available medical homes. This helps monitor capacity at medical homes.[18] Additionally, by having assigned specialty care and emergency service locations, patients will have more streamlined access to these services and providers will be able to refer these patients back to their medical home for follow up care.[19]

The San Francisco Department of Public Health (SFDPH) administers HSF and pays each medical home per person enrolled in HSF per month. This amount is determined by a negotiated rate that takes into consideration the range of services that a provider offers, the provider's available resources for uncompensated care, and the business circumstances of each medical provider. Providers may also charge a point of service fee to HSF participants that is determined by the provider.[20] To be eligible for the program, an individual must have an income of below 500% FPL, be a resident of San Francisco, be uninsured for over or equal to 90 days, not be eligible for Medi-Cal and Medicare, and be at least 18 years of age.[21] HSF does not ask applicants for their immigration status. Citizens and many lawfully present immigrants in San Francisco who are uninsured and have an income below 138% FPL are eligible for Medi-Cal and therefore ineligible for HSF. As of January 2016, HSF policies allow for individuals who are eligible for subsidized Covered CA coverage to enroll in or continue with Healthy SF provided they meet other eligibility criteria. All participants who are eligible for Covered CA but enroll or remain in Healthy SF are asked to sign a Health Insurance Option Acknowledgment Form stating that they have been advised of their insurance options and the potential penalties for remaining uninsured.[22] Participants pay quarterly participant fees based on a sliding scale ranging from $0 to $450, and point of services fees at the time services are received ranging from $0 to $200 on a sliding scale depending on service type.[23]

Furthermore, Healthy SF participants are screened for restricted-scope Medi-Cal and are encouraged to enroll.[24] Restricted-scope Medi-Cal eligibility does not affect an individual's eligibility to enroll in HSF.[25] Since HSF is not insurance, emergency Medi-Cal is the primary payor for eligible services to individuals enrolled in both Healthy SF and restricted Medi-Cal.[26]

HSF: Post-ACA

HSF has seen some changes as a result of the ACA. The number of participants has significantly decreased due to new eligibility for Medi-Cal and increased access to private health plans. The peak of the program was reached in September 2013 with 65,650 participants;[27] in the subsequent year it fell by 51% and in 2014–2015 the program had 15,380 active participants.[28] HSF representatives shared that a present challenge for HSF is being able to manage a program that has to consider all the different options the uninsured may potentially be eligible for and having HSF

A challenge for HSF is managing a program that must consider all the options the uninsured may be eligible for, and having rules that are in sync with other program rules.

program rules that are in sync with other program rules. They describe that as a result, HSF needs to continually have discussions about program eligibility, income limits, participant fees, and other program aspects. They continually have to catch up to the changing health care landscape for the uninsured.

HSF: Provider Network

The HSF provider network currently includes 33 community clinics/medical homes, one public hospital, one public skilled-nursing facility, and five not-for-profit hospitals facilities.[29] Incentives for these providers to participate in HSF and the other programs profiled will be discussed below, but it is important to note that with a decrease in participants and changes in the health care landscape due to ACA implementation, two medical homes and one affiliated hospital opted to leave HSF in FY 2014–15.[30] HSF staff suspect that these few providers that left may face different business priorities in the post-ACA environment and have concluded that they no longer have a business case to remain as part of the HSF provider network. However, two additional sites were added to the HSF network, which resulted in the same number of medical homes but one fewer participating hospital at the end of FY 2014–15.[31]

MY HEALTH LA (MHLA)

MHLA: Background

Launched on October 1, 2014, My Health LA (MHLA) emerged from previous iterations of Los Angeles County's health care access programs for the uninsured dating back to the late 1990s. With over 145,000 participants,[32] My Health LA serves a large number of uninsured LA residents and is possibly the largest source of county-level care to undocumented immigrants nationwide. Similar to HSF, the program structure of MHLA centers around a designated medical home with coordinated access to specialty care and hospital services. Los Angeles County Department of Health (LACDHS) administers MHLA and reimburses medical homes through capitation payments. This means that each medical home receives a set payment (in this case $32) per MHLA patient per month at a set rate as in HSF. Program benefits include primary, preventive, specialty, and hospital services.[33] All specialty and hospital services are offered through LACDHS facilities (LA County hospitals); MHLA does not cover hospital services at non-LACDHS facilities.[34] Primary health care at medical homes under MHLA is free.[35] Specialty, urgent care, diagnostic, emergency, and inpatient services are offered at LACDHS facilities also at no cost to MHLA participants.[36] Though not considered a program benefit, MHLA participants can receive dental care in select medical homes that offer the service. LA County sets aside a certain portion of MHLA funding to reimburse medical homes for dental services through fee-for-service payments.[37] To be eligible for MHLA, an individual must have an income of not more than 138% FPL, be a Los Angeles County resident, be uninsured, not be eligible for health insurance, and be 19 years and older.[38] MHLA does not ask

applicants for their immigration status. Legal residents in Los Angeles County who are uninsured and have an income below 138% FPL are eligible for full-scope Medi-Cal and therefore ineligible for MHLA.[39] The benefit term is for 12 months and individuals can renew their participation annually.

Similar to HSF, individuals on restricted Medi-Cal are eligible for MHLA since restricted Medi-Cal is not health insurance. If a MHLA participant has a condition (emergency or pregnancy) and presents at a LACDHS facilities, then LACDHS can seek to bill services under restricted Medi-Cal.[40]

MHLA: Post-ACA

Hundreds of thousands in Los Angeles County have gained health coverage under the ACA, though there remains a smaller yet still sizeable number of uninsured persons in LA.[41] Though MHLA was launched after full implementation of the ACA, the program builds on the infrastructure and provider networks from LA County's previous health care access programs, including the county's Low Income Health Program, an early expansion of Medi-Cal, called Healthy Way LA. Program staff indicated the following were key changes from previous iterations of the program: 1) a capitation payment model as opposed to the previous fee-for-service payment for providers; 2) a new web-based enrollment system (One-e-App); and 3) the ability for participants to choose a medical home. As a MHLA staff described, capitation payments improve the timeliness of payments to providers. The number of MHLA participants per medical home can easily be obtained through the One-e-App web-based enrollment system. MHLA staff explained that previously, the program used paper applications which made it difficult to have data on who was enrolled and in which locations. This staffer describes that real-time enrollment data through the One-e-App was a "real game changer." Moreover, to improve system efficiency, each MHLA participant now has the ability to choose a desired medical home but must remain in the same location during the 12-month period. Previously participants would be able to visit multiple locations for primary care in a year.

MHLA: Provider Network

The MHLA network includes 196 medical homes composed of non-profit community based clinics, eight urgent care centers, and LACDHS facilities for hospital and emergency care.[42] MHLA built upon the existing provider network from previous program iterations. MHLA representatives did not express concerns about maintaining provider participation in the network. However, because the county does not contract with outside providers, clinics reported that access to specialty care and hospital services can be limited for those who live far away from or have difficulty reaching specific LACDHS sites. When building a network, some flexibility for contracting additional providers could improve access, especially for patients who cannot readily access main facilities.

CALIFORNIA MEDICAL SERVICES PROGRAM (CMSP)

CMSP: Background

County Medical Services Program (CMSP) is a multi-county safety net program created in 1983 to help meet the medical needs of adults in rural counties left out of public coverage options. CMSP operates under the policy and fiscal responsibility of the CMSP Governing Board. Members of the Governing Board include ten county officials and one non-voting state representative.[43] There are 35 participating counties mostly concentrated in Northern California. CMSP is administered through third-party contracts that handle medical, dental, and pharmacy benefit reimbursements to providers.[44] In contrast to MHLA and HSF, CMSP uses a fee-for-service payment model for providers.[45]

CMSP's level of benefits depends on a person's immigration status. Citizens, lawfully present immigrants, and certain U.S. nationals aged 21 through 64, who have incomes at or below 300% FPL, reside in one of the participating counties, and meet requirements for an asset test are eligible for CMSP.[46] To receive benefits, participants with incomes over 138% FPL must pay a calculated "Share of Cost" (SOC) in the month they receive services.[47] The "Standard Benefit" provides an array of primary, specialty, and emergency services to citizens and other qualifying immigrants but provides only emergency services to undocumented residents.[48] The benefit period is for six months and participants may re-enroll in CMSP to continue their participation.[49]

Undocumented residents historically received only emergency services from CMSP. Those who meet the Medi-Cal income eligibility limit are expected to receive emergency services through restricted Medi-Cal, and therefore eligibility for CMSP among the undocumented is restricted to those with incomes from 139% to 300% FPL.[50] A new pilot program gives undocumented persons access to additional primary care benefits, as described in the next section.

CMSP: Post-ACA

CMSP has undergone significant changes post-ACA, including enrollment and revenue decline, eligibility and participant fee changes, and the creation of a pilot program for primary care coverage. Enrollment went from a peak of 83,600 participants in 2013 to roughly 700 participants in 2015.[51] An average of 60 to 70 persons are enrolled in CMSP per month.[52] An estimated 15 to 18% of 2015 CMSP Standard Benefit participants were undocumented and received emergency-only coverage.[53] This decline in enrollment had consequences to the provider network that will be described in the following section. In addition, CMSP realignment revenue was reduced from $250 million at peak enrollment to $30 million dollars; the State of the California took most of the money back under the new safety net funding formulas.[54] While CMSP enrollment and revenue has significantly declined, CMSP has substantial reserve funds and in 2015–2016 budgeted program expenses were well under $30 million.[55] The Governing Board held a strategic planning meeting in June 2015 that led to a series of temporary program changes that include enhancements to program eligibility (i.e., increasing income eligibility limit from 200% to 300% FPL) and a considerable reduction in fees charged to participants.[56] These changes are taking place under a two-year pilot period that started on May 1, 2016. The Governing Board also rolled out a Primary Care Benefit for a two-year pilot period to supplement services available under the CMSP Standard Benefit. This new benefit enables CMSP participants, including undocumented persons, to receive three free doctor visits and pharmacy coverage for up to $1,500.[57] CMSP plans to evaluate these program changes through utilization data to determine their impact.[58]

A CMSP Governing Board member explained that undocumented persons with incomes at or below 138% FPL are eligible for emergency services under restricted Medi-Cal and the program does not take responsibility for primary care or preventive services for these individuals. Several advocates interviewed believe the program can be more inclusive; one advocate expressed CMSP "[leaves] the poorest of the poor out for reasons that [don't] make any sense." However, a CMSP representative shared that there is an interest in evaluating current program utilization for undocumented persons and making incremental changes to expand access accordingly. An advocate also described some technical challenges for CMSP in administering benefits as a supplement to restricted Medi-Cal.

CMSP: Provider Network

Since April 2014, CMSP has contracted with Advanced Medical Management (AMM) to administer medical and dental benefits and MedImpact Health Systems to administer pharmacy benefits.[59] Previously, CMSP contracted with Anthem Blue Cross to administer program benefits. AMM contracts with a range of providers on behalf of CMSP and reimburses them at rates comparable to or higher than Medi-Cal rates.[60] A CMSP representative described that at the peak of the pre-ACA system, Anthem Blue Cross had contracts on behalf of CMSP with 300 clinics, over 100 hospitals, and over 14,000 providers. Yet following implementation of the ACA, CMSP providers previously contracted under Anthem Blue Cross were less interested in re-contracting with CMSP under the new AMM contract because of the significant decrease in patient volume. CMSP staff hope the new Primary Care Benefit, which took effect May 1, 2016, will encourage more providers to participate in CMSP. For these providers, patient volume is an important consideration for continuing to participate in the CMSP provider network.

Referrals and ongoing provider shortages were also identified as significant issues for CMSP participants. A community clinic consortium representative noted the waiting period for specialty appointments in one rural county is around half a year for Medi-Cal patients and suggested that it looks worse for CMSP patients. On doctor shortages, another representative commented, "there [aren't] even enough doctors to see commercial patients, much less Medi-Cal patients, much less CMSP patients." To help alleviate this issue, the CMSP Governing Board approved a multi-million dollar project to recruit and retain health care providers.

Table 1. Summary of Program Details[61]

	Healthy San Francisco	My Health LA	California Medical Services Program Standard Benefit *(eligibility, fees, and benefit term listed apply from 5/1/16 to end of 2-year pilot)*	California Medical Services Program Primary Care Benefit *(a 2-year pilot program beginning 5/1/16)*
Eligibility	» Up to 500% FPL » SF resident » Uninsured for ≥ 90 days » Not eligible for public insurance programs such as Medi-Cal and Medicare » Age 18 yrs +	» Up to 138% FPL » LA County resident » Uninsured » Not eligible for health insurance » Age 19 yrs +	» Undocumented persons with income 138% to 300% FPL » Legal residents eligible up to 300% FPL » Above 138% FPL asset test required » Resident of participating 35 rural counties » Not eligible for Medi-Cal or Covered California » Age 21–64 yrs	Participants with a monthly Share of Cost for their CMSP Standard Benefit are also eligible for the CMSP Primary Care Benefit.
Fees for participants	Quarterly participant fees (range from $0–$450 on sliding scale) and point of service fees (range from $0–$200) based on sliding scale and vary by service type.	Primary health care under MHLA is free. Specialty, urgent care, diagnostic, emergency, and inpatient services offered at LACDHS facilities at no cost to MHLA participants.	A monthly "Share of Cost" (SOC) for participants above 138% FPL (given program eligibility, SOC applies to all undocumented participants).	No fees for medical services; $5 copay for pharmacy services.
Benefit term	12 months	12 months	6 months	6 months
Benefits	» Primary and preventive care » Specialty care » Emergency care » Urgent care » Ambulatory services » Hospital care » Pharmacy » Mental health services » Alcohol and drug treatment » Lab tests » Family planning » Durable medical equipment	» Primary care and health screenings » Specialty care at LACDHS facilities » Hospital and emergency care at LACDHS hospitals » Prescription medicines » Laboratory services and tests » Other related health care services	Undocumented members only eligible for services that address an emergency condition. Legal residents eligible for a range of primary, specialty, and emergency health care services as listed on CMSP website.	Coverage for up to three primary care or specialty care visits, preventive services, specified lab and diagnostic tests, and prescription medications. Up to $1,500 pharmacy per benefit period.
Enrollment cap	None	146,000 persons	None	None

(continued)

Table 1. Summary of Program Details (continued)

	Healthy San Francisco	My Health LA	California Medical Services Program Standard Benefit *(eligibility, fees, and benefit term listed apply from 5/1/16 to end of 2-year pilot)*	California Medical Services Program Primary Care Benefit *(a 2-year pilot program beginning 5/1/16)*
Number of enrollees	14,404 (as of August 1, 2016)	145,670 (as of July 31, 2016)	Information not available. (For CY 2015 an estimated 60–70 persons including legal and undocumented residents enrolled on a monthly basis with a total of 700 participants.)	Information not available.
Delivery structure	San Francisco Department of Public Health (SFDPH) administers the program. HSF participants enroll at their selected medical home for primary care and preventive services. Specialty and hospital services available at county hospital and five not-for-profit hospitals.	LA County Department of Health Care Services (LACDHS) administers the program. Participants enroll at their selected medical home for primary care and preventive services. Specialty and hospital services available at LACDHS facilities.	CMSP contracts Advanced Medical Management (AMM) to administer the program. AMM establishes contracts with hospitals, clinics, and private setting for health care services.	Uses existing CMSP Standard Benefit network.
Provider compensation mechanism	SFDPH pays each medical home per person enrolled in HSF per month at a negotiated rate that can differ by provider organization. Providers are able to bill other eligible payors (i.e., restricted Medi-Cal for eligible persons).	LACDHS pays each medical home (primary care sites) $32 per person enrolled in MHLA per month ($28 for primary services, $4 for pharmacy). Though not offered as a benefit of MHLA, in FY 2014–2015 LACDHS set aside $5 million to reimburse medical homes that offer dental services to MHLA patients on fee-for-service payments. LACDHS continues to allocate a portion of revenue to cover dental services. Providers are able to bill other eligible payors (i.e., restricted Medi-Cal for eligible persons).	CMSP reimburses contracted providers on a fee-for-services model at rates comparable to or higher than Medi-Cal.	Uses existing CMSP Standard Benefit provider compensation mechanism.

PROGRAM COSTS

Table 2. HSF & MHLA Expenditures (FY 2014-15); CMSP Budgeted Expenditures (FY 2015-16)[62]

	Healthy San Francisco (FY 2014–2015)	My Health LA (FY 2014–2015) *Expenditures listed only include primary care (including pharmaceutical services) and dental services*	California Medical Services Program (Budgeted Expenditures for FY 2015–2016)
Administration	$1,106,340	Not available	$1,307,000 (budgeted)
Behavioral health	$4,875,860	Not available	Not applicable
Health care services	$95,296,180 » $79,109,151 in expenditures by SFDPH to medical homes and two hospitals (SF General and UCSF). » $16,185,656 in expenditures by private medical homes and nonprofit charity care expenditures (i.e., private hospitals).	$29,175,055 in expenditures by LACDHS to medical homes. » $27,370,321 for primary care (including pharmaceutical services). » $1,804,734 for dental services. (Does not include cost of specialty care, emergency department expenses, or other hospital services.)	$6,400,000 in budgeted net expenditures by CMSP for all health care services provided to CMSP participants (undocumented CMSP participants in FY 2015–2016 were only eligible for emergency care).
Eligibility and enrollment	$349,616 (One-e-App eligibility and enrollment technology)	Not available	$1,764,000 (budgeted)
Other: legal, consultants, contractors, data marts, misc.	Not applicable	Not applicable	$790,000 (budgeted)
Other: provider relations, IT infrastructure, customer service, and other related fees	$5,364,773 These services are performed by a Third Party Administrator (San Francisco Health Plan).	Not applicable	Not applicable
Total expenditures (from available information; dollar amounts for all of MHLA program costs are not available and thus these unknown figures are listed as "not available" in table)	$102,115,537 » $85,929,881 paid by SFDPH. » $12.13 million paid by hospital charity care that was not compensated by SFDPH. » $4.06 million paid by private medical homes that was not compensated by SFDPH.	$29,175,055 paid by LACDHS. This total only includes expenditures for primary care (including pharmaceutical services) and dental services.	$10,261,000 (budgeted)
Member months	230,568 in FY 2014–2015	786,521 in FY 2014–2015	Approximately 780 member months in FY 2015–2016.
Participant per month (PPPM) expenditure from available program costs (total expenditures/ member months)	$443 ($373 SFDPH PPPM expenditure).	$34.80 (does not include specialty, emergency, or other hospital program costs).	Since CMSP uses a fee-for-service payment model, per participant per month estimates is not applicable here.

Expenditures for HSF, MHLA, and CMSP in the chart are from the most recent fiscal year reported; FY 2014–2015 for HSF and MHLA, and FY 2015–2016 for CMSP. Expenditures are grouped into the following categories: administration, behavioral health, health care services, eligibility and enrollment, and other. Some categories may not be applicable to all programs and are thus listed as "not applicable." Dollar amounts for all of MHLA program costs are not available and thus these unknown figures are listed as "not available" in the table. Furthermore, we consolidated some categories from the original CMSP budget to fit our table. Due to these inconsistencies across programs, this table is not meant to compare "apples to apples." The aim of this table is to present information available from each program in an easy to read format.

For HSF, of the total $95,296,180 in expenditures for health care services, $79,109,151 was paid by the San Francisco Department of Public Health (SFDPH) and $16,185,656 was paid by private medical homes ($4,060,000) and nonprofit hospitals ($12,130,000). This is due to the cost of services exceeding SFDPH payments for HSF patients in private medical homes. The same may be true for community clinics and other HSF medical homes but these expenses are not reported. To cover the costs of care not compensated by SFDPH, one HSF network provider described that medical homes may have access to charity care dollars, fundraising dollars, federal grant funding (i.e., FQHCs receive grants under Section 330 of the Public Health Service Act), and other financial resources.

Not-for-profit hospitals in the HSF network receive no funding from SFDPH for services to HSF participants and use their charity care dollars to cover expenses. Of the total $102,115,537 in expenditures for HSF, $85,929,881 was paid for by SFDPH, and $16,185,656 was paid for by hospital charity care and private medical homes. The total per participant per month (PPPM) expenditure was calculated by dividing the total expenditures for HSF by the participant months, which totals to $443. By taking only expenditures by SFDPH into the calculation, the PPPM expenditure by SFDPH is $372.

MHLA estimates health care expenditures to be $29,175,055 for primary care (including pharmaceutical services) and dental services. Of the health care expenditures, $27,370,321 was paid to medical homes for primary care (including pharmaceutical services) through fee-for-service payments ($16,293,595) and grant funding ($11,0756,736). Since MHLA made a switch in provider compensation method in 2015, payments for part of the year were paid as fee-for-service (October 1, 2014 through March 31, 2015), while the remainder of the year was paid as grant funding (April 1, 2015 through June 30, 2015). The remaining $1,804,734 was paid to medical homes that offered dental services through fee-for-service payments. There are no estimates available for specialty care, emergency department, and other hospital services to MHLA participants at LACDHS facilities, and thus these costs are not included in the health care expenditures estimate. There are also no estimates available for administration, behavioral, and eligibility and enrollment expenditures. Thus the PPPM estimate for MHLA does not take into account total program expenses.

For CMSP, only budgeted amounts for FY 2015–2016 are available. These include: $10,261,000 for health care, $1,764,000 for enrollment and outreach, $1,307,000 for administration, and $790,000 for legal, consultants, contractors, data marts, and miscellaneous items. A CMSP Administrative Officer reported that, as of June 30, 2016, 2016 expenditures for FY 2015–2016 were just under $6.3 million. Roughly two-thirds of this amount, or about $4.2 million, was spent on health care benefit costs and one-third was spent on overall CMSP administration. These numbers are still not complete as expenditures for FY 2015–2016 will continue to come in for several more months. Furthermore, there were significant changes in eligibility for CMSP implemented on May 1, 2016, thus, these expenditures only reflect costs for participants previously eligible for CMSP.

HSF, MHLA, AND CMSP FUNDING SOURCES

Table 3. Funding sources to cover costs for HSF & MHLA (FY 2014–2015) & CMSP (FY 2015–16)

	Healthy SF (FY 2014–2015)	My Health LA (FY 2014–2015)	California Medical Services Program (FY 2015–2016)
Participant fees & point of services	$2,496,768 Due to a higher income eligibility for HSF, participant fees and point of services fees are collected on a sliding scale.	$0 No participant fees and point of service fees.	A participant's Share of Cost is offset from the payment to provider and is not calculated as revenue to CMSP.
County controlled funds (come from a mix of federal, state, and local resources) allocated to indigent care programs	$67,350,789	$61,000,000 » $56 million for primary care (including pharmaceutical services) » $5 million for MHLA dental services Note that $56 million for primary care (including pharmaceutical services) and $5 million for MHLA dental services were allocated for two programs: (1) former Healthy Way LA–Matched for the time period July 1, 2014 to September 30, 2014, and (2) existing MHLA program from October 1, 2014, to June 30, 2015	$43,500,000 » $30 million–realignment revenue » $7.5 million–Path2Health Federal Match » $500,000–outreach and enrollment grant » $1 million–interest » $4.5 million–other revenue/ recoveries
Other: employer health care expenditure	$16,082,324	Not applicable	Not applicable
Total funding sources	$85,929,881	$61,000,000 *Excludes funding for administrative costs, hospital and specialty care, behavioral health, eligibility and enrollment; only includes revenue that covers payments made to medical homes*	$43,500,000

Funding sources for HSF in FY 2014–2015 included $2,496,768 in point of services and participant fees, $67,350,789 in county-controlled funds, and $16,082,324 in employer health care expenditures under the San Francisco employer mandate to contribute to an employee's health care costs. Businesses with 20 or more employees and non-profits with 50 or more employees are required to pay at least $1.76 per hour per employee, and up to $2.64 per hour per employee for larger employers (rates are as of January 2017 and increase each year with inflation). For employees not offered or not eligible for employer-sponsored health insurance, the required health care contribution can be contributed toward the "city option." San Francisco workers whose employers contribute to the city option are enrolled in Healthy San Francisco, if eligible, or receive a Medical Reimbursement Account which can be spent on eligible health care expenses, including health insurance premiums.[63] Additionally, though not considered a revenue for HSF, private medical homes used own resources to cover $4,058,997 in net expenditures for HSF participants not compensated by SFDPH. Furthermore, hospitals used charity care funding to cover $12,126,659 in expenditures for HSF participants not compensated by SFDPH.

Funding sources for MHLA in FY 2014–2015 only included funds allocated for provider payments. According to the MHLA FY 2014–2015 annual report, the Los Angeles County Board of Supervisors allocated $56 million for the provision of primary care (including pharmaceutical services) for medical homes. Of this allocation, a total of $27,370,321 was spent by the medical homes from October 1, 2014 to June 30, 2015 for MHLA. The remainder was allocated for the Healthy Way LA–Matched program from July 1, 2014, to September 30, 2014. In addition, $5 million was allocated for dental services for both MHLA participants from October 1, 2014, to June 30, 2015, and Healthy Way LA–Matched participants from July 1, 2014, to September 30, 2014.

Funding sources for CMSP in FY 2015–2016 were $43,500,000 in county-controlled funds which includes: $30 million in realignment revenue from the state, $7.5 million in Path2Health Federal Match (Path2Health is an early Medi-Cal expansion program that operated pre-ACA), $500,000 in an outreach and enrollment grant, $1 million in interest, and $4.5 million in other revenue. A CMSP participant's Share of Cost is offset from the payment to provider and is not calculated as revenue for CMSP. Furthermore, though not listed in the chart, CMSP has $232,739,036 in reserve funds which were rolled over from previous years.

LESSONS LEARNED

In this section of the report, we describe lessons learned by policymakers and stakeholders in these three counties. Based on feedback from individuals outside California on what would be helpful in developing a new program in their regions, we focused on three questions:

1. What has motivated providers to participate?
2. How have counties approached outreach and enrollment and what has been most effective?
3. What information should be collected in developing and evaluating a program?

WHAT HAS MOTIVATED PROVIDERS TO PARTICIPATE?

County programs for the uninsured require sufficient participation from providers to be effective. All three programs had an existing provider network to use as they developed or modified programs to focus on the undocumented uninsured. The following section outlines incentives for providers to continue to participate in the county programs profiled.

A. Providers who already serve the uninsured can receive financial support.

An advocate explained that "folks are going to show up at [providers'] doors anyways because of section 17000 obligations, charity care, EMTALA [the Emergency Medical Treatment and Labor Act]." Many similarly agreed that for providers who already—as part of their missions or responsibility—serve the uninsured, participation in county programs is a net plus. Additionally, a HSF representative explains that for nonprofit hospitals to maintain their 501(c)3 status, and thus keep certain tax benefits, they must invest in the community through community benefit requirements. Some of these hospitals see HSF participation as a good way to meet this requirement. For FQHCs, as one person described, "[they're] already seeing this population so they can now receive some financial support to serve or expand those they could see." FQHCs and other providers for underserved communities can gain more resources to fulfill their mission. Notably, no one interviewed expressed profit-making as an incentive for providers.

B. Providing infrastructure is a more efficient way to take care of the uninsured.

A HSF representative noted that "folks who are coming in the door, are coming in regardless, but now [HSF is] adding more structure and better funneling systems which makes sense for everyone." A provider representative explains that infrastructure under HSF helps improve care coordination for uninsured patients. As an example, this individual described a new E-referral triage system in their clinics for specialty care which facilitates

communication between primary care providers and specialists for more efficient referral protocols: specialists triage their referrals, recommending that some patients come in for a visit and suggesting tests or other appropriate follow up care through a primary care provider for others. As a result, the backlog for specialty care has improved for their patients. Though HSF did not directly incentivize this quality improvement measure, it creates infrastructure for uninsured patients to benefit from system improvements when linked to a medical home. As the provider representative elaborates, "We don't separate HSF [patients] from Medi-Cal managed care [patients]; even though HSF is not health insurance, [HSF patients] are becoming part of a system that centers around a medical home." Several county program representatives also describe that use of the One-e-App technology system in HSF and MHLA facilitates eligibility screening and enrollment, utilization analysis, and provider compensation (i.e., by having accurate data on number of members enrolled per medical home for capitation payments).

> "We don't separate HSF patients from Medi-Cal managed care patients; even though HSF is not health insurance, these patients are becoming part of a system that centers around a medical home.
>
> *— HSF provider representative*

C. Providing a medical home reduces avoidable emergency room visits.

MHLA representatives believe that improving access to a medical home reduces emergency-related visits considered "avoidable." From October 1, 2014, to June 30, 2015, approximately 16% of ED visits by MHLA patients were considered avoidable; the top reasons for these visits were headaches, urinary tract infections, and backaches. MHLA will be able to monitor trends in avoidable ER visits in subsequent years. HSF representatives similarly believe improving access to primary care decreases unnecessary ED utilization. The HSF annual report describes that in FY 2014–2015 HSF saw a decrease in ED utilization per member per year (PMPY) to 0.1 PMPY from the previous year of 0.2 PMPY. The trend was most pronounced among participants who were newly enrolled (0.26 PMPY to 0.15 PMPY) or re-enrolled (0.36 PMPY to 0.18 PMPY). County representatives explained that the approach of reducing preventable ED visits is both cost-effective and improves patient outcomes. In the words of an advocate, "These health care programs are a more humane way of providing care to the uninsured." CMSP is expecting to analyze service utilization including ED visits by undocumented participants in the primary care benefit pilot program to understand how well new changes in the program are working.

> "These health care programs are a more humane way of providing care to the uninsured.
>
> *— Health advocate*

HOW HAVE COUNTIES APPROACHED OUTREACH AND ENROLLMENT, AND WHAT HAS BEEN MOST EFFECTIVE?

Health programs face unique considerations engaging in outreach and enrollment of the undocumented uninsured. The following section provides thematic findings on outreach and enrollment practices among counties profiled.

The Approach to Enrollment/Renewals Differs by Program

Stark differences were noted in enrollment and renewal strategies. In MHLA, a provider network representative describes that "outreach and enrollment is more difficult than Medi-Cal. Patients have to enroll and renew in a clinic which is not the case for Medi-Cal. The current renewal rate is 48.6%. When we started the program it was about a 70% renewal rate." The strategy of on-site enrollment and renewal for MHLA was attributed to controlling the influx of patients signing up to reserve space in the enrollment capped program for those needing care immediately. Several advocates disagreed with this strategy, noting that it restricts access to this very important program.

San Francisco makes a concerted effort to renew participants by sending mailed notices, automated and live phone calls, and email reminders. In addition, they track and report their renewal statistics and track the number re-enrollments after a period of disenrollment to identify areas for improvement. In contrast to San Francisco and Los Angeles, CMSP does not have a renewal process, though participants can re-enroll to continue health care access. This reflects CMSP's philosophy as a "payer of last resort" rather than an insurance-like program focused on providing a medical home.

Screening Eligibility for Health Insurance is Important

All counties stressed the importance of screening participants for eligibility for health insurance during time of enrollment. With the array of public and private options available as well as limited safety net resources, linking uninsured residents to health coverage is a priority for safety net programs. There also exists new opportunities for undocumented children to obtain Medi-Cal coverage. A MHLA representative noted the county is currently taking steps to facilitate transition of undocumented children to public coverage. To screen for health coverage options, MHLA and HSF use the One-e-App web-based technology. One advocate noted, however, that there is still confusion among eligibility workers on benefits for undocumented persons such as Medi-Cal for DACA recipients. The HSF annual report describes the importance of training Certified Application Assisters to ensure they are aware of all potential health care options for applicants.

Community Partners are Critical to Support Marketing and Outreach

All three programs discussed the importance of community partners (i.e., consumer advocacy groups, health foundations, and policy organizations) to supporting marketing and outreach. The support provided includes translation of marketing materials to several languages, enhancement of marketing materials, and helping spread knowledge of the program especially in marginalized communities. A MHLA consumer advocacy coalition acknowledged: "Translating materials and finding qualified bilingual staff and interpreters can be challenging and costly. However, [we] stand willing to work with [LA County] DHS to alleviate some of that burden." Community groups may be disposed and equipped to help improve entry points for the program.

More Targeted Outreach and Enrollment Strategies Needed for Under-Enrolled Groups

MHLA reported low enrollment among males (40% male vs 60% female) and low enrollment among non-Hispanic communities (6% of enrollment is non-Hispanic). An advocacy coalition noted that low enrollment numbers among communities that have demonstrated interest in the program (such as Korean residents) is as a result of not having sufficient clinics that meet their specific cultural and linguistic needs. As one advocate describes, "Many API undocumented immigrants live in San Gabriel Valley which has a huge geographic region. However, you only have 2 to 3 medical homes where people can enroll and see a doctor." Additionally, the HSF annual report cites that HSF covered an estimated 75% of the uninsured in San Francisco County prior to the ACA but only 25% post-ACA. This is likely due to the vast majority of participants becoming eligible for and enrolling in programs under the ACA. However, the low penetration rate of the remaining uninsured may reflect unique challenges reaching the post-ACA uninsured populations that meet eligibility criteria for HSF. It may also indicate that there is a need for outreach and enrollment strategies that are more carefully targeted to this group.[64]

Clear Language Around Eligibility is Important for Undocumented Immigrants

All county representatives acknowledged the importance of being forthright about eligibility for undocumented immigrants by including clear language on outreach materials. For example, a MHLA poster states: "People are welcome to apply regardless of immigration status." MHLA consumer advocates encourage direct language in-person as well; during a presentation by a MHLA representative, they explained, "The Los Angeles county 'resident' requirement was often misunderstood to refer to immigration status. Without clarification, potential applicants...may be left thinking they are ineligible because they are not green card holders [lawful permanent resident]."

Confidentiality and Safety for Undocumented Immigrants Must Be Assured

In addition to clear language around eligibility, a MHLA representative expressed the need to assure confidentiality and safety for undocumented immigrants. At the time of enrollment, MHLA enrollment workers make it clear that none of the information will be shared with immigration authorities. MHLA consumer advocates also encourage language on public facing materials that indicates participation in MHLA will not cause a person to be considered a "public charge" for immigration purposes. Undocumented immigrants fear this can be detrimental when applying to adjust their immigration status.

> "We want MHLA members to feel like they have a sense of participating in a program and feel like they are staying in touch.
>
> *— MHLA county representative*

Outreach Strategies Help Create Sense of Belonging

MHLA and HSF reported various strategies to promote a sense of belonging for patients. These include sending new member packets, program ID cards, periodic newsletters, participant handbooks, email reminders for renewal, and customer service lines. One county representative noted, "We want [MHLA members] to feel like they have a sense of participating in a program and feel like they are staying in touch." These strategies are can help promote program engagement and retention.

WHAT INFORMATION SHOULD BE COLLECTED IN DEVELOPING AND EVALUATING THE PROGRAM?

Performing a Needs Assessment

For others who are interested in developing health care programs for the uninsured, a county program staff recommended performing a needs assessment to understand where improvements can be made. This information will be crucial for program evaluations and will be specific to each county. For example:

- A needs assessment could be to determine the number of health care visits per person such as ER utilization rates. If the ER utilization rates are found to be high, a program goal could be to match ER utilization rates by program participants to Medicaid patients.
- Another assessment could be to determine how the uninsured usually receive services and which providers currently take care of them. A program goal could be to incorporate new providers that are available to care for the uninsured.

Program designers of HSF made the observation that uninsured persons in San Francisco were already utilizing the safety net through various points of entry (i.e., community health centers, private clinics, public hospitals, and clinics), and thus a goal for HSF was to improve care coordination for existing safety net users and reduce the duplication of health care services.[65] However, it is unclear the extent to which undocumented San Franciscans who lacked health insurance were participating in the safety net before the creation of HSF. Evidence generally points to less health care utilization among undocumented immigrants than US-born persons due to access barriers.[66,67] Therefore, individuals who design a health care program to serve undocumented immigrants may set different goals for these individuals than might otherwise be applicable to uninsured individuals who are already safety net users (i.e., instead of aiming to reduce duplicate services a goal could be to increase participation of undocumented immigrants in the health care system).

Evaluating Program Success

All three programs continue to evolve and use various metrics to evaluate the success of the program in meeting its goals. The following section provides thematic findings on program evaluations among the county programs profiled.

Utilization Data

Utilization data was frequently cited as important for evaluating programs. HSF and MHLA annual reports include a range of this data such as utilization by service type (outpatient/specialty, inpatient, emergency, mental health, primary care, and prescription services), by site of care, and by participant characteristics (i.e., age and chronic condition status). (See Appendix A for full list of utilization categories.) A CMSP representative shared they will be able to analyze utilization data for undocumented persons by assigning them a particular eligibility code. In particular, ER utilization rates were commonly addressed as important. Tracking utilization data makes sense since it can be used to readily assess progress, success, and areas for improvement. However, people noted challenges with obtaining accurate utilization data, such as delayed or incomplete data submitted by medical homes and on patient encounters, and medical usage underreporting since individuals can opt to use facilities and services outside the program's provider network.

Demographic and Enrollment Data

Additionally, HSF and MHLA keep track of participant demographic data. These categories include gender, age, ethnicity, income level, languages spoken, housing status (homeless or housed), and location of residence. MHLA monitors and publishes demographic and enrollment data by month on their website. Enrollment data is important to keeping track of MHLA's percentage of target enrollment by month (MHLA has a participant cap).

MHLA and HSF also publish detailed enrollment information such as completed applications, applications rejected, enrollment, disenrollment and re-enrollment rates, disenrollment by reason, re-enrollment by original disenrollment reasons, and reasons for multiple disenrollments.

Satisfaction Data

HSF and MHLA also gather satisfaction data. Both have a call center where participants can call for support. Data gathered from these calls include customer service complaints received and reason per complaint, source of complaint (e.g., medical home, specialty care site, pharmacy, and program policy), and volume of complaints. These details are included in published annual reports. Additionally, HSF distributes a Health Access Questionnaire in Spanish, English, and Chinese at point of application and renewals to capture patients' experience. All county representatives also noted mechanisms for obtaining feedback from network providers. For instance, community clinic staff are encouraged to contact MHLA program administrators directly, and if there is a common issue these are escalated more formally. MHLA also has regular meetings for various working groups on renewals and enrollment.

Financial Data

Examining the financial impact of the programs was also commonly noted as important for program evaluations. All programs report on revenues and expenditures; this information is summarized in Table 2 in the Program Costs section, above. In the HSF annual report, this information is stratified by year with information on the two previous years. However, there are no standardized reporting guidelines, so it can be difficult to compare exactly "apples to apples" across programs. Furthermore, HSF and MHLA participants may also receive health care that is billed under restricted Medi-Cal and other eligible players which can lead to underreporting of health care costs.

Suggestions on Data Improvements

Several suggestions were made to improve the evaluation data available. One advocate said they would like to see better monitoring of patient outcomes such as "aggregate data on where people are beginning and how they have improved, a better understanding of the kinds of connections you are making for people to improve their lifestyle and [information on] their ability to manage their conditions." Other improvements suggested include reporting on actual costs of services to participants, documenting customer service call details (waiting times, language spoken, and call length), and identifiers for data that make it possible to look at trends based on demographics, region, and medical home to understand where improvements in access can be made.

Advocates in Los Angeles suggest the creation of a data committee comprised of data experts, advocates, and stakeholders to help make improvements in data collection by

"evaluating what data should be collected, determining how it should be analyzed and disseminated, and ensuring that data collection and public reporting remain a priority." HSF's Health Improvement Initiatives focuses on a range of prevention and quality improvement projects including quality and utilization data reporting.

CLOSING COMMENTS

Healthy San Francisco, My Health LA, and County Medical Services Program provide three models of county programs for the uninsured. Hundreds of thousands of undocumented persons are able to access health care through these programs. While funding sources, demographics, and provider networks in other states may vary, this information is presented in order to help guide others in designing and implementing county-level programs to provide health services for undocumented persons.

Appendix A: Methods

In June and July of 2016, we reviewed published documents, reports, and articles related to HSF, MHLA, and CMSP, and conducted telephone interviews with the following individuals for the report:

- Tangerine Brigham, Director, Office of Managed Care, My Health LA, Los Angeles County Department of Health Care Services
- Amy Luftig Viste, Program Director, My Health LA, Los Angeles County Department of Health Care Services
- Reginauld Jackson, Program Officer, Office of Managed Care, San Francisco Department of Public Health
- Alice Kurniadi, Senior Health Program Planner, San Francisco Department of Public Health
- Lee D. Kemper, Policy & Planning Consultant, CMSP Governing Board
- Anthony Wright, Executive Director, Health Access California
- Betzabel Estudillo, Health Policy Coordinator, California Immigrant Policy Center
- Deborah Kelch and staff, Executive Director, Insure the Uninsured Project
- Beth Malinowski, Deputy Director of Government Affairs, California Primary Care Association
- Meaghan McCamman, Assistant Director of Policy, California Primary Care Association
- Aracely Navarro, Grassroots Advocate, California Primary Care Association
- Cynthia Carmona, Director of Government & External Affairs, Community Clinic Association of Los Angeles County
- Deena Lahn, Vice President, Policy and Advocacy, San Francisco Community Clinic Consortium
- Alison Klurfeld, Manager, Program Development Safety Net Initiatives, L.A. Care Health Plan
- Sonya Vasquez, Chief Program Officer, Community Health Councils
- Josue Chavarin, Program Associate, Prevention, The California Endowment

Additionally, we consulted with the following individuals from outside California for their knowledge on health care advocacy for undocumented immigrants in their local regions. These interviews helped guide interview questions for the report.

- Max Hadler, Health Advocacy Specialist, The New York Immigration Coalition
- Luvia Quinones, Health Policy Director, Illinois Coalition for Immigrant and Refugee Rights
- Michelle LaRue, Senior Manager, Health and Human Services, CASA
- Joshua Sharfstein, Associate Dean for Public Health Practice & Training, Johns Hopkins Bloomberg School of Public Health

Appendix B: Utilization Data Categories from Healthy San Francisco and My Health LA Reports 2014-2015

Healthy San Francisco

- Utilization of outpatient services inpatient services, ED, substance abuse services, mental health services per member per year

  Additional ED Information:

  —Reported ED services were stratified by application type (i.e., new, re-enroll, renewal)

  —ED and inpatient utilization by medical home
- Utilization of outpatient services by application type (new, re-enroll, renewal)
- Inpatient utilization rates by medical home
- Utilization by age, application type, and service type (one chart)
- Utilization by chronic disease indicator, age category, and service type (office visit, ED visit, inpatient visit)

My Health LA

- Utilization by services type (inpatient, primary care, outpatient/specialty, emergency, and prescription)
- Visit numbers for those with a chronic condition vs. without chronic condition
- LACDHS hospital utilization rate
- Avoidable emergency department visit rate (i.e., headaches, UTI, backaches)
- Inpatient hospitalization rates
- Hospital readmission rates
- Specialty care services by LACDHS facility

Endnotes

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