Interim Evaluation Report on California's Low Income Health Program (LIHP)

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Interim Evaluation Report on California's Low Income Health Program

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Interim Evaluation Report on California's Low Income Health Program

Executive Summary

In November 2010, the Centers for Medicare and Medicaid Services (CMS) approved California's "Bridge to Reform" §1115 Medicaid waiver for the Low Income Health Program (LIHP). LIHP is an optional, locally funded, federally reimbursed health care coverage program for low-income individuals that builds upon the success of the state's previous demonstration program, the Health Care Coverage Initiative (HCCI). Ten California counties participated in HCCI from 2007 to 2010, significantly expanding health care coverage in those areas. Under LIHP, these 10 "legacy counties"[1] officially launched local LIHPs on July 1, 2011. Eight other California counties and the County Medical Services Program (CMSP), a consortium of 35 counties, have also implemented local LIHPs. As of March 2013, two more counties had launched their programs.

Standard eligibility requirements for the program are citizenship status, age, income, county residency, and not being pregnant. These criteria were established by the California Department of Health Care Services (DHCS) and CMS. Local LIHPs administer the programs locally and are able to select an income criteria lower than the maximum of 200 percent of the Federal Poverty Level (FPL). Among LIHPs, income eligibility limits range from 25- 200 percent FPL.

LIHP Coverage Expansion

LIHP enrollment has increased steadily since July 2011. By the end of the first program year, more than 680,946 individuals had enrolled in LIHP, surpassing the initial enrollment projection of 512,000 individuals by the program's end in December 31, 2013. Ninety-four percent of

[1] A "legacy county" refers to any of the counties that participated in the previous Health Care Coverage Initiative demonstration waiver program (2007-2010): Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura.

current enrollees are projected to be eligible for the Medi-Cal Expansion in 2014, while 6 percent are expected to be eligible for subsidies in California's Health Benefit Exchange, Covered California.[2] Various efforts by each local LIHP contributed to the program enrollment's surpassing the state's initial projection.

The majority of LIHP enrollees to date have been between the ages of 45 and 64 (55 percent). Almost one-third of LIHP enrollees (30 percent) were Latino, 20 percent of LIHP enrollees speak a primary language other than English, and 91 percent of LIHP enrollees had incomes at or below 133 percent FPL. Approximately 34 percent of enrollees had at least one of five common chronic conditions: diabetes, asthma/chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF)/cardiovascular disease (CAD), dyslipidemia, and hypertension.

Access to Care

For this report, access to care of LIHP enrollees was measured by utilization of health services. The total volume of outpatient services and emergency room visits increased over the first three quarters of the program, reflecting the continuous growth in enrollment from Quarter 1 to Quarter 3 (July 1, 2011, through March 31, 2012).

To account for differences in the size of the population of LIHP enrollees, the rates of utilization were also measured as service per 1,000 active enrollees per month. These comparisons showed the following:

- The rate of outpatient services ranged from 2,195 in Quarter 1 to 1,745 in Quarter 3.
- The rate of ER visits ranged from 175 in Quarter 1 to 141 in Quarter 3.
- The rate of hospitalizations ranged from 46 in Quarter 1 to 32 in Quarter 3.
- The proportion of active enrollees who used behavioral health services ranged from 2.2 percent in Quarter 1 to 2.0 percent in Quarter 3.
- The proportion of active enrollees who used both behavioral and medical services ranged from 0.9 percent in Quarter 1 to 0.8 percent in Quarter 3.

These rates do not show conclusive trends, as they do not account for differences in patient characteristics and chronic conditions. However, the data do suggest a trend toward more outpatient care and away from high-cost emergency services. In addition, these rates may be influenced by pent-up demand for care among new LIHP enrollees.

[2] UCLA projections based on LIHP enrollment data as of December 31, 2012. For a detailed description of methodology, please see Appendix A: Available Data and Methods.

Quality of Care

All legacy LIHPs had established several structural measures of quality improvement activities. Nine of the ten legacy LIHPs had established evidence-based clinical guidelines for diabetes, and six had electronic diabetes registries. Fewer had established registries for other common chronic conditions. New LIHPs had also begun these processes.

Some LIHPs indicated that they measured the following processes of care:

- Riverside tracked and documented diabetes indicators such as low-density lipoprotein (LDL) and HbA1c test completion rates; annual retinal exam rates.
- San Mateo tracked mammogram and flu shot rates. San Mateo also reported that approximately 70 percent of the enrollees had a second behavioral health follow-up visit within 14 days of initial treatment, and 55 percent of enrollees had a third and fourth follow-up visit within 30 days of a second behavioral health treatment.
- San Diego tracked beta-blocker treatment for those diagnosed with acute myocardial infarction; smoking cessation assistance; and rates of follow-up within seven days following a hospitalization related to mental illness.

Conclusions

By March 2013, 19 LIHPs were operating in California, covering 53 counties. As of December 31, 2012, 680,946 low-income individuals had enrolled in the program since its inception. This enrollment exceeded the projections for the program, most likely due to innovative efforts initiated at the local level. Such efforts included community outreach and partnerships, effective use of IT systems, increased efficiency, cost control measures, staff training, and successful retention and redetermination efforts.

The interim data on utilization of outpatient services, behavioral health services, and emergency room visits indicated an increase in the volume of services provided during the program. However, it is premature to discern the reliability of trends in these utilization patterns due to significant limitations in the availability of data for all participating LIHPs, the rapid growth in enrollment, and changes to newly implemented LIHPs in this time period. Self-reported quality of care data indicated the progress of LIHPs in establishing data systems and benchmarks for tracking quality performance measures and quality improvement efforts.

Overall, available data indicate that the program is succeeding in preparing California for the upcoming transition of a significant portion of the state's population to coverage under Medi-Cal and Covered California. The final LIHP evaluation will provide a comprehensive overview of the successes and challenges of the program during the two and a half years of program operation.

Introduction

Background and Program Description

In November of 2010, California's "Bridge to Reform" §1115 Medicaid waiver was approved by the Centers for Medicare and Medicaid Services (CMS). The waiver expanded Medi-Cal managed care for seniors and persons with disabilities, allowed new pilot projects in the California Children's Services program, approved new quality improvement and patient safety programs for public hospitals through Delivery System Reform Incentive Payments, and created the Low Income Health Program (LIHP) to provide health care to underinsured or uninsured nonelderly adults in California.

LIHP is an expanded, optional, locally funded, federally reimbursed health care coverage program for low-income individuals that is administered at the local level. Local LIHPs receive 50 percent of their overall program spending in federal reimbursement funds through the waiver administered by California's Department of Health Care Services (DHCS). LIHP includes two main program components, distinguished by family income eligibility levels: Medicaid Coverage Expansion (MCE), for those living at or below 133 percent of the Federal Poverty Level (FPL); and the Health Care Coverage Initiative (HCCI), for those with incomes of 133-200 percent FPL. When the Affordable Care Act (ACA) begins on January 1, 2014, the Special Terms and Conditions (STCs) of the waiver will require the transition of LIHP enrollees into available coverage options in California. Currently enrolled MCE beneficiaries will be transitioned from their local LIHPs to Medi-Cal, while HCCI enrollees will be referred to Covered California, the state health benefit exchange.

To be eligible for LIHP, individuals must meet all of the following eligibility criteria:

- U.S. citizen or satisfactory immigration status
- Between the ages of 19 and 64
- County resident
- Family income within the range established by the local LIHP, up to and including 200 percent FPL
- Not be eligible for the Medi-Cal program
- Not be pregnant

Income eligibility criteria are set by local LIHP administrators. Depending on availability of resources, local governments implementing LIHPs may elect to limit enrollment by establishing

thresholds for income below the allowable maximum. However, LIHPs cannot select higher FPL eligibility limits (i.e., above 133-200 percent FPL) without covering lower FPL limits.

LIHP provides access to covered health care services in one of two ways: through the existing safety net health care system within the local LIHP service area, or through an expanded network of providers built upon the existing system for meeting indigent care expectation (Section 17000 of the California Welfare and Institutions Code).

LIHPs are required to include:

- A defined provider network and the assignment of enrollees to a medical home
- A benefit package that includes a comprehensive set of services, including primary and preventive care services, hospital services, pharmacy, and specialty care
- Coordination of care
- Monitoring of quality of care indicators

The goal of LIHP is to shift low-income uninsured or underinsured individuals from more costly episodic care to a more coordinated system of care, thereby improving their access to care, quality of care, and overall health.

LIHP builds upon the previous HCCI demonstration waiver program, which was scheduled to end August 31, 2010 but was extended through October 31, 2010. This HCCI demonstration program was operated by 10 counties and provided an opportunity for expansion of health care coverage for local governmental entities that opted to participate. Beginning on September 1, 2007, the previous HCCI program extended health care coverage to eligible low-income uninsured adults who were otherwise ineligible for Medi-Cal and other public health care programs in 10 selected counties. The participating counties were Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. These counties, known as "legacy counties" under the LIHP demonstration, continued and expanded the original HCCI programs during the transition period (November 1 – June 30, 2011) to meet the new LIHP requirements that began on July 1, 2012.

LIHP enrollees are either transitioned into the program from the previous HCCI demonstration waiver program or are newly enrolled. Those who were transitioned into the program are categorized as "existing" enrollees, whether they are in the MCE or HCCI program component of LIHP. Those who are new to LIHP are categorized as "new" enrollees, regardless of whether they are in the MCE or HCCI program component. Only four of the 10 legacy counties opted to keep income eligibility criteria at up to 200 percent FPL, and they are thus the only local LIHPs that can have new HCCI enrollees.

The University of California, Los Angeles Center for Health Policy Research (UCLA) was selected to conduct an independent evaluation of LIHP. The evaluation monitors the progress of the LIHP demonstration project in four areas:

1. Outreach, enrollment, retention, and transition strategies
2. Coverage expansion
3. Access to and quality of care
4. Care delivery system redesign in anticipation of ACA implementation in 2014

The primary goal of the evaluation is to provide information to various stakeholders on the impacts of LIHP in each of these areas. Rigorous evaluation of LIHP relies on continuous data collection, cleaning, and management by the LIHPs. UCLA offers ongoing training and technical assistance related to variable development, data collection, and data transmission to local LIHP administrators. In addition, UCLA provides quarterly performance dashboards for each LIHP that include summary data on enrollment, demographics of enrollees, and service utilization, enabling individual LIHPs to monitor and compare their progress.

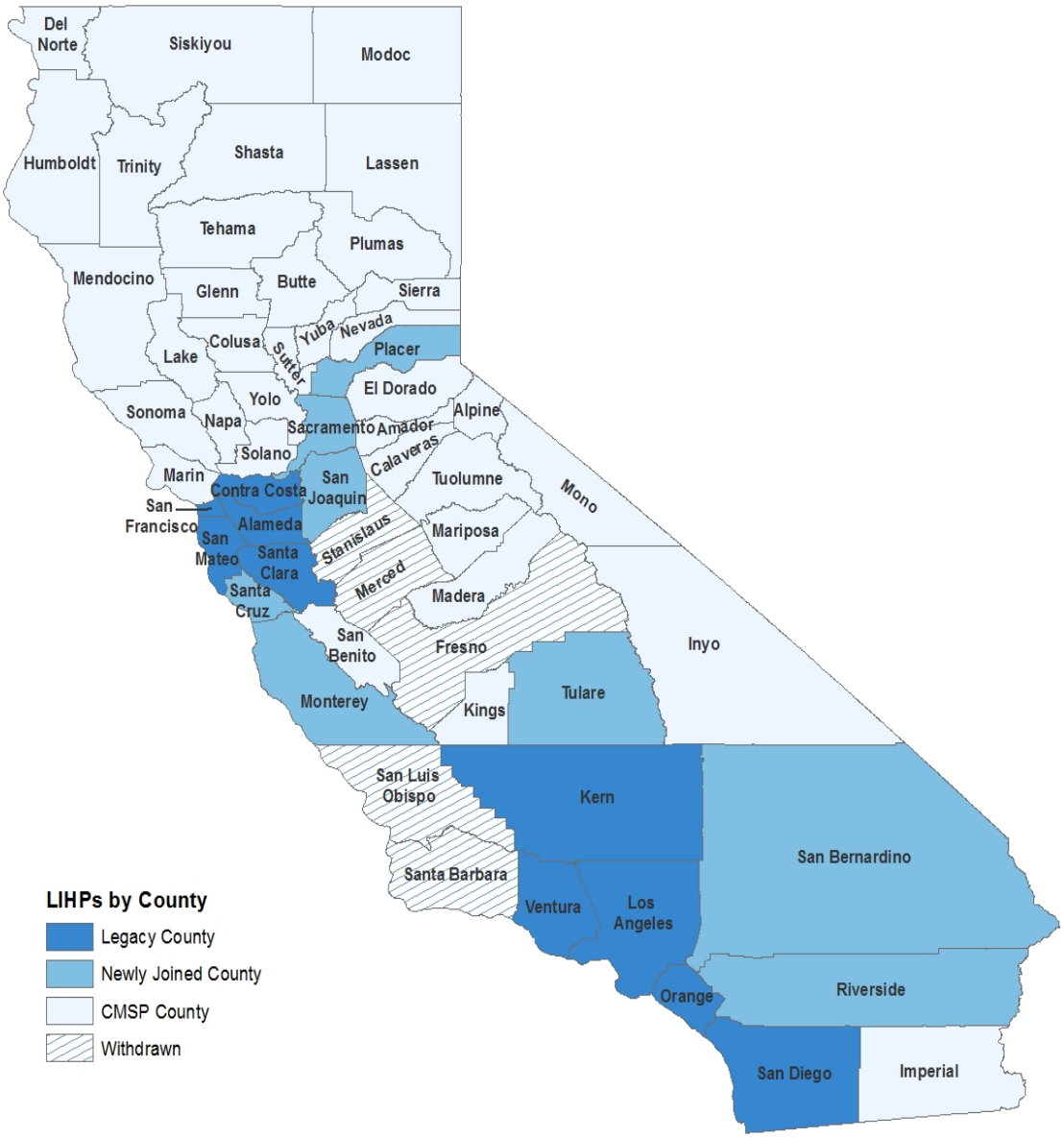
Implementation Process and Program Components

Local LIHPs were implemented from July 2011 until March 2013. The 10 legacy counties comprised the first cohort to implement local LIHPs, in July 2011 (Exhibit 1). In January 2012, Riverside, San Bernardino, and Santa Cruz counties launched local LIHPs. The County Medical Services Program (CMSP), which was a consortium of 34 California counties, also launched at that time.[3] San Joaquin County began operation of its local LIHP in June 2012. CMSP added Yolo County to its LIHP on July 1, 2012, bringing the consortium up to 35 county members. Placer County implemented its local LIHP on August 1, 2012, and Sacramento County implemented on November 1, 2012. Monterey and Tulare, the last two anticipated LIHP counties, began implementation in March 2013. No further LIHP implementation is anticipated, and the LIHP demonstration will end on December 31, 2013.

Local LIHPs have indicated that the variations in LIHP implementation were determined by resources and other considerations, including competing priorities, budget issues, and challenges in contracting with providers, all of which contributed to different implementation dates.

[3]The County Medical Services Program (CMPS) includes 35 rural counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo (joined on July 1, 2012), and Yuba.

Exhibit 1: LIHP Implementation Status by County

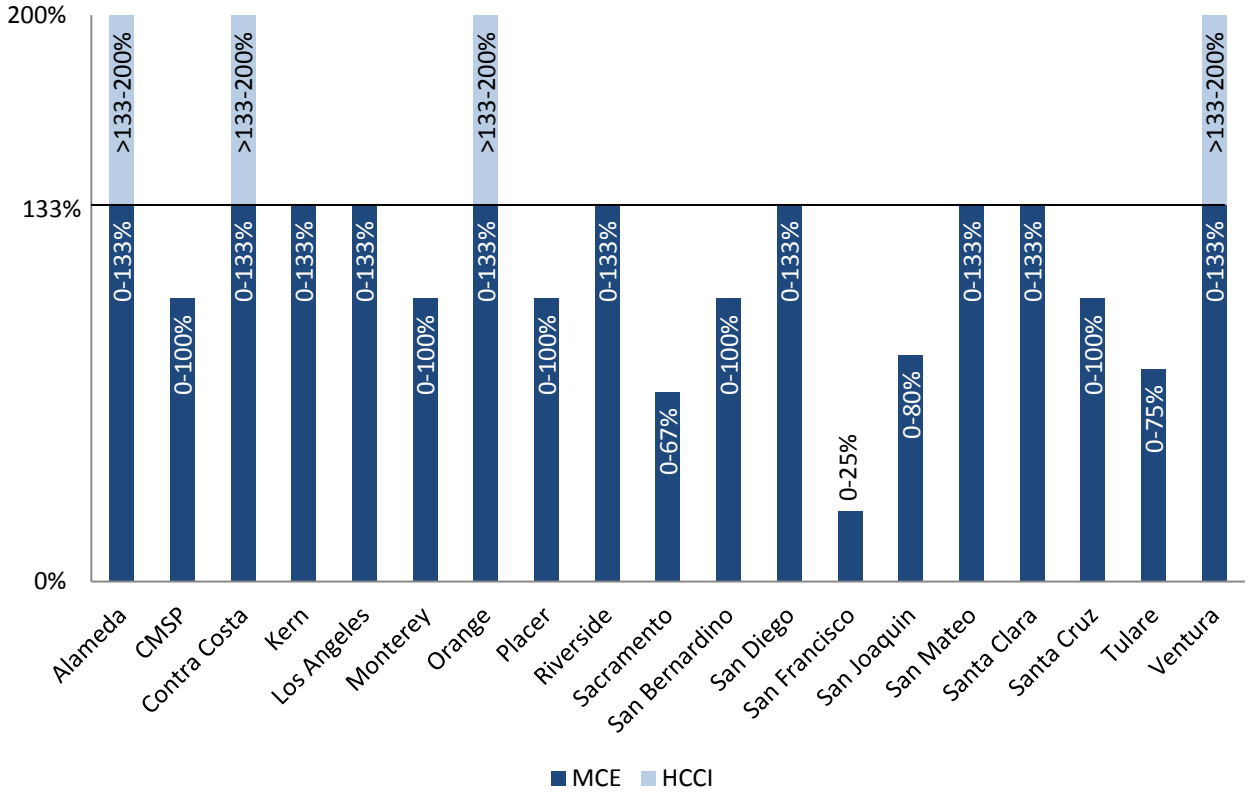


Source: Low Income Health Program contracts with California Department of Health Care Services.

Income Eligibility Criteria

Exhibit 2 demonstrates the various FPL limits by MCE and HCCI program components. Currently, only four LIHPs are enrolling individuals in the HCCI program who have incomes above 133 percent FPL to 200 percent FPL. Four counties have FPL limits below 100 percent and as low as 25 percent (San Francisco). Five LIHPs limit enrollment to 100 percent of FPL, and the remaining six LIHPs chose 133 percent FPL levels. Santa Clara County and Kern County increased their enrollment income eligibility levels to 133 percent FPL early in 2013.

Exhibit 2: Federal Poverty Level Limits by Local Low Income Health Program (LIHP)



Source: Low Income Health Program contracts with the California Department of Health Care Services.

Core Benefits Under LIHP

Under LIHP, all enrollees are entitled to a core benefits package (Exhibit 3). MCE enrollees are entitled to additional core benefits, including mental health and limited medical transportation.

Exhibit 3: Low Income Health Program Core Benefits

MCE and HCCI Core Benefits	Additional Core Benefits for MCE
i. Medical equipment and supplies ii. Emergency care services iii. Acute inpatient hospital services iv. Laboratory services v. Outpatient hospital services vi. Physical therapy vii. Physician services viii. Prescription and limited nonprescription medications ix. Prosthetic and orthotic appliances and devices x. Radiology	i. Minimum mental health services ii. Prior authorized nonemergency medical transportation when medically necessary

Source: Low Income Health Program contracts provided by the California Department of Health Care Services.

Network Structure

The provider networks across all LIHPs vary due to inherent differences in local delivery systems prior to LIHP. Available data as of June 2012 demonstrated that there were close to 5,000 primary care providers in the LIHP network throughout the state (Exhibit 4). CMSP had the highest volume of providers (1,326) across the 35 counties that are within the consortium. The majority of primary care physicians in LIHP networks were in family or general internal medicine. There were 196 hospitals in LIHP provider networks (Exhibit 4), including 95 in the CMSP network.

Exhibit 4: Number of Primary Care Providers and Hospitals in the LIHP Network by Local LIHP

Local LIHP	Number of Primary Care Providers in Network	Number of Hospitals in Network
Alameda	236	2
CMSP (County Medical Services Program)	1,326	95
Contra Costa	137	7
Kern	117	2
Los Angeles	569	7
Orange	716	25
Riverside	47	10
San Bernardino	166	2

Local LIHP	Number of Primary Care Providers in Network	Number of Hospitals in Network
San Diego	1,032	28
San Francisco	132	2
San Joaquin	38	2
San Mateo	144	7
Santa Clara	169	1
Santa Cruz	23	4
Ventura	68	2
Total	**4,920**	**196**

Source: Low Income Health Program Network Provider lists (Deliverable #3) as of June 2012.

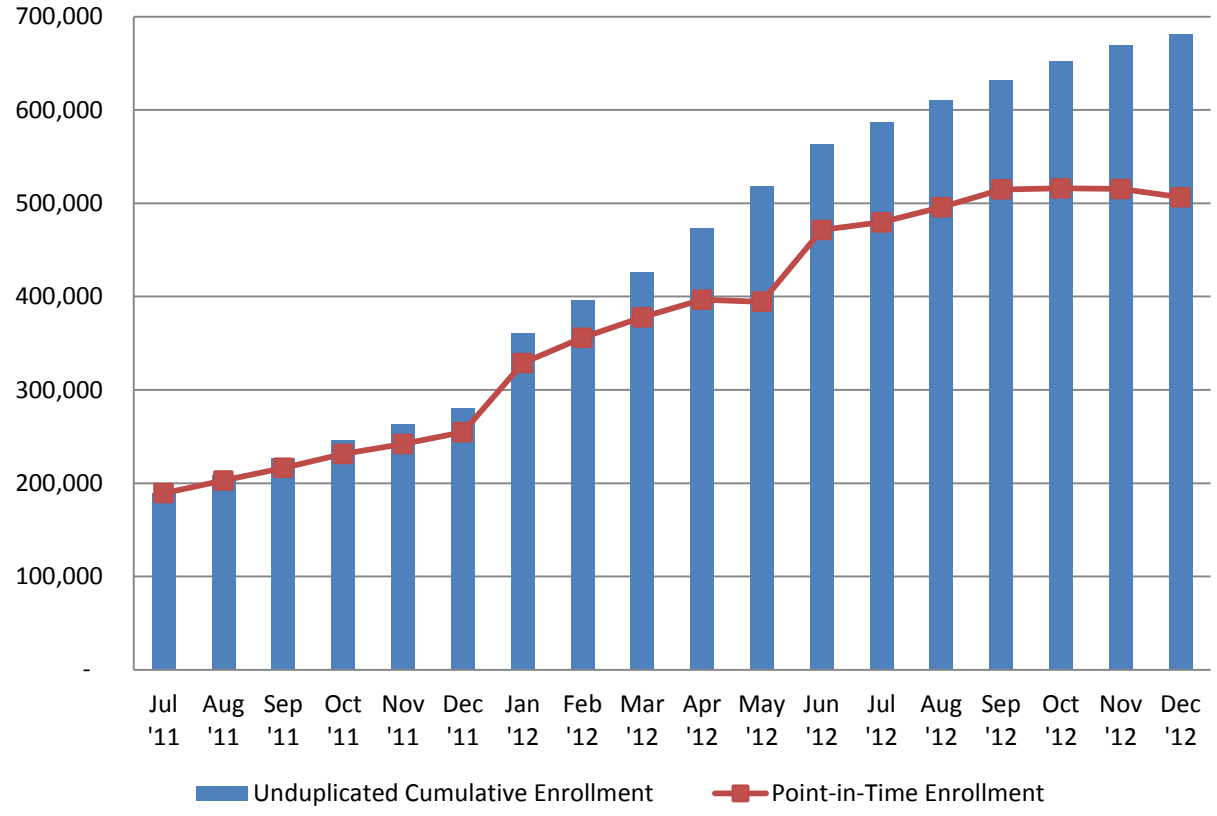
Data and Methods

Individual-level data for the analyses in this report are received on a quarterly basis from local LIHPs. However, due to the staggered implementation process of LIHP, not all data date to the July 2011 official start of the program. Furthermore, because data are still being collected, this report only provides descriptive analyses and does not offer any statistical analyses. For more information on data availability and methods, please see Appendix A: Available Data and Methods.

LIHP Coverage Expansion and Characteristics of Enrollees

LIHP enrollment has increased steadily since the beginning of the program. By the end of the first program year, 680,946 individuals had been enrolled in LIHP, including individuals who were enrolled at any point and those who disenrolled during the program operation period (Exhibit 5). In the first six months of LIHP, enrollment grew by an average of 8 percent each month. This growth reflects an expansion of enrollment in the legacy counties operating during this period. In January 2012, enrollment grew by 21 percent from the previous month, due to the launch of LIHP in three new counties and CMSP. The increase in enrollment continued through December 2012.

Exhibit 5: Monthly Unduplicated Cumulative and Current Enrollment as of December 31, 2012

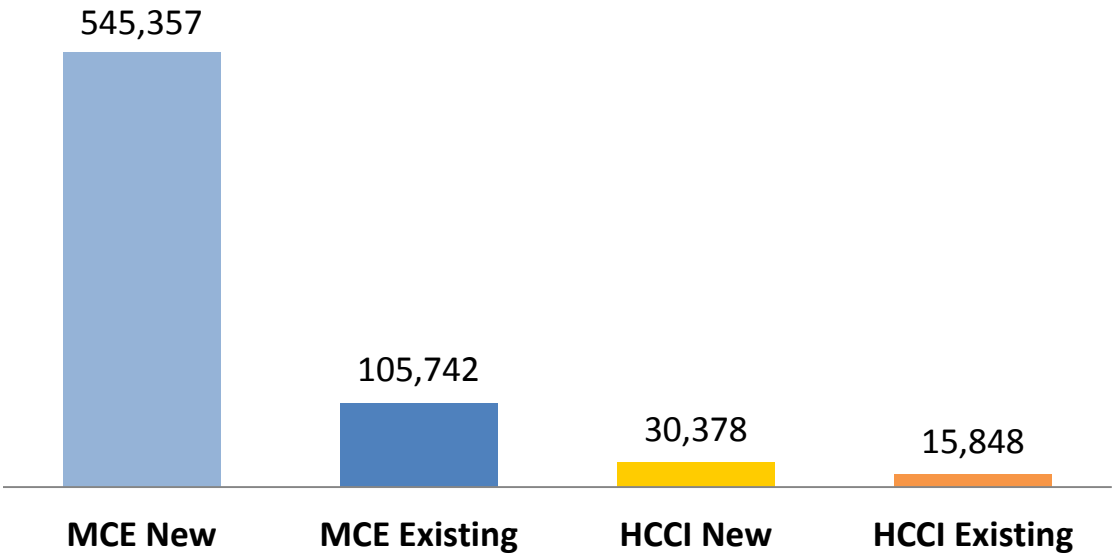


Notes: (1) Ten LIHPs were active from July 2011 through December 2011. Four additional LIHPs, including the County Medical Services Program (CMSP), launched in January 2012. San Joaquin launched in June 2012, Placer in August 2012, and Sacramento in November 2012. (2) Unduplicated cumulative enrollment data by local LIHP can

be found in Appendix B, Exhibit 1. (3) Monthly point-in-time enrollment by local LIHP can be found in Appendix B, Exhibit 2.
Source: UCLA analysis of Low Income Health Program enrollment data.

LIHP enrollees were predominantly MCE new enrollees (545,357; Exhibit 6). The second largest group was MCE existing enrollees, those who were at or below 133 percent FPL and who had enrolled prior to the start of LIHP under the HCCI demonstration waiver. The low number of HCCI enrollees reflects the limited number of local LIHPs that have implemented the HCCI component of the LIHP. Again, these proportions reflect the determination of income eligibility limits by local LIHPs based on their own policy decisions and available resources.

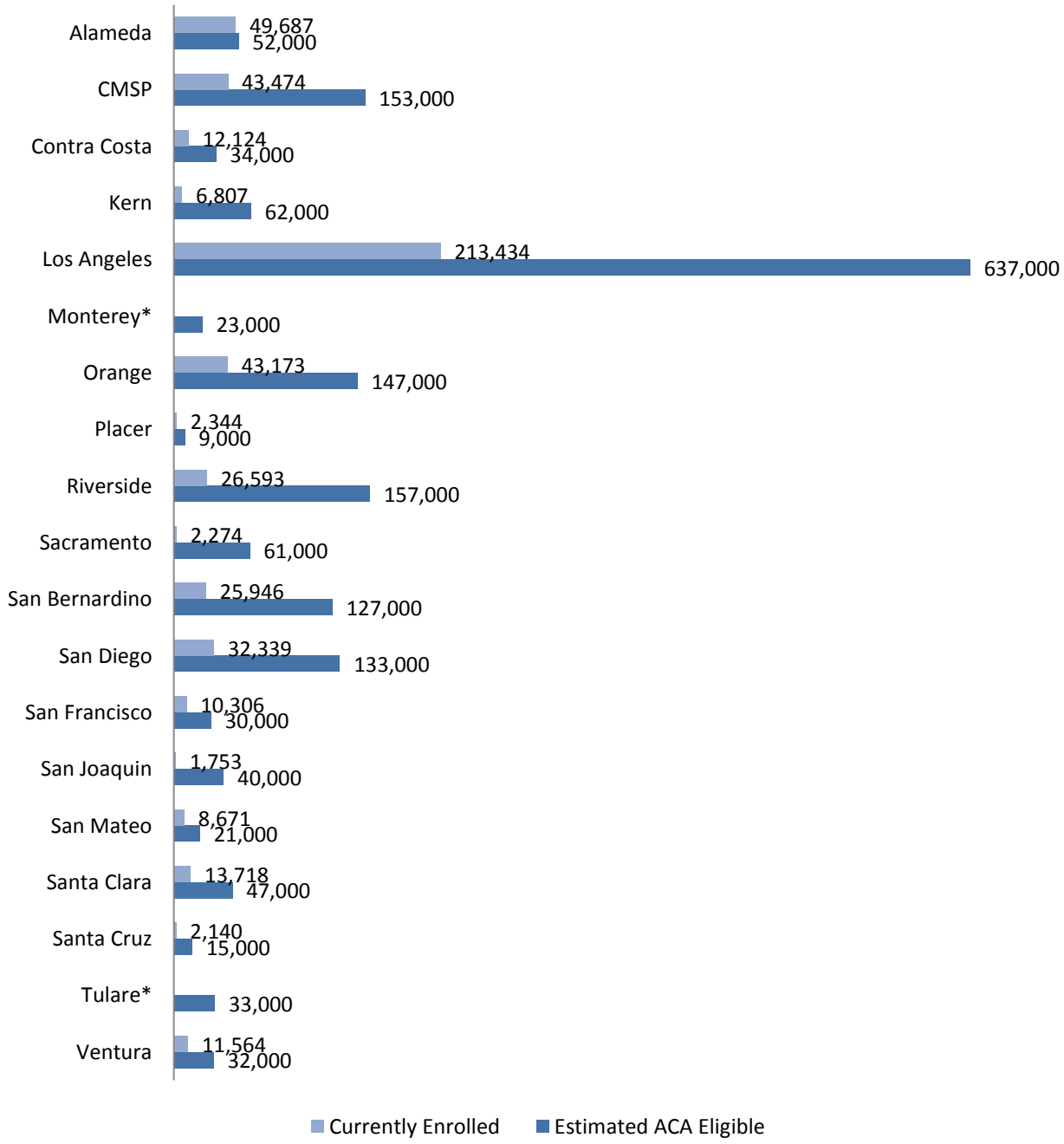
Exhibit 6: Cumulative Total of Unduplicated Enrollees in Each Program Component, as of December 31, 2012



Source: UCLA analysis of Low Income Health Program enrollment data.

The proportions of currently enrolled LIHP enrollees who will be eligible for the Medi-Cal Expansion or for Covered California are 94 percent and 6 percent, respectively (data not shown). Exhibit 7 displays the proportion of the eligible population in each local LIHP if the maximum allowable FPL limit of 200 percent were implemented, as well as the proportion of individuals enrolled in LIHPs as of December 31, 2012. UCLA estimated the total eligible population using small area estimation (SAE) methodology. A detailed description of this methodology can be found in Appendix A: Available Data and Methods. The size of the eligible population does not account for potential uptake by currently insured individuals who may be eligible for Medi-Cal or Covered California after implementation of the ACA. The lower income eligibility thresholds in some LIHPs have translated to lower enrollment and fewer eligible enrollees who would transition seamlessly from LIHP to ACA coverage.

Exhibit 7: LIHP Current Enrollment and Estimated ACA-Eligible Population, per Local LIHP, as of December 31, 2012



Notes: (1) Monterey and Tulare launched local LIHPs in March 2013, and therefore no enrollment data are available. (2) Detailed information on UCLA's SAE methodology can be found in the Small Area Estimation section of Appendix A: Available Data and Methods.
Sources: UCLA Small Area Estimation (SAE) and analysis of Low Income Health Program enrollment data.

Successful Outreach, Enrollment, and Retention Strategies

Outreach and enrollment efforts within each local LIHP contributed to the program enrollment's surpassing the state's initial projection. Moreover, LIHPs successfully retained enrollees to maintain the overall volume of enrollment in LIHP. Outreach and enrollment efforts have included the following:

- Partnering of LIHPs with service providers, county-based organizations, and advocacy groups to reach out to the eligible population.
- Using information technology (IT) systems (e.g., webinars, video conferencing, online training) to train workers in the program's eligibility requirements and covered benefits, which proved to be a low-cost and innovative way to train a large, dispersed workforce.
- Setting up kiosks at service provider venues to screen for eligibility, creating an electronic application for LIHP, placing outreach and eligibility workers in high-volume settings, and using available IT systems to verify documentation for eligibility determinations.
- Using automated phone calls, mailing of notifications, and prepopulated applications to redetermine and renew enrollees, along with Web-based renewal options.

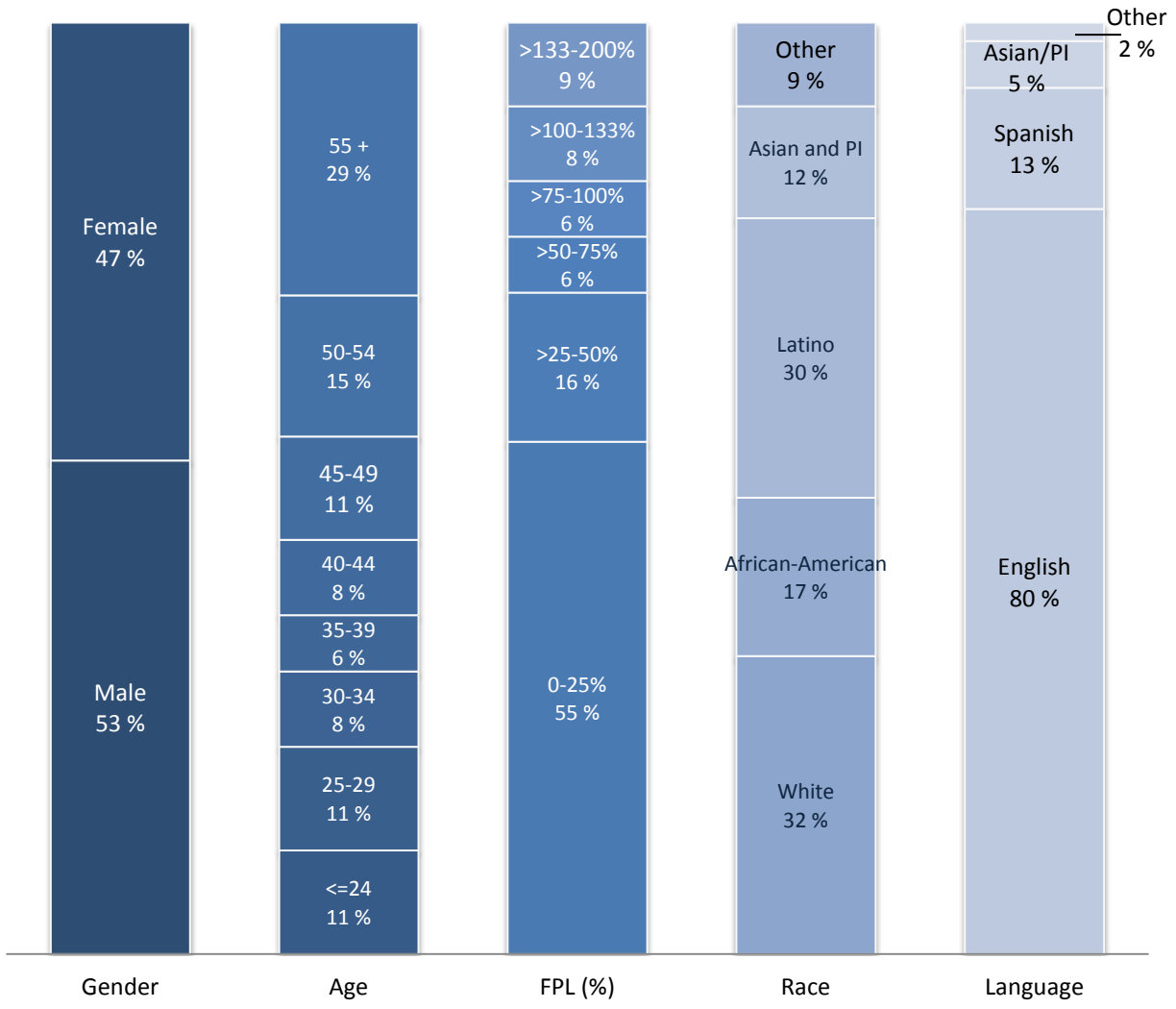
The outreach and enrollment efforts of LIHPs are documented in the UCLA publication *Successful Strategies for Increasing Enrollment in California's Low Income Health Program (LIHP)*.[4]

Sociodemographic Characteristics

The sociodemographic characteristics demonstrate that LIHP enrollees tended to be older, varied in race/ethnicity, primarily English-speaking, and with family incomes at or below 133 percent FPL. Fifty-five percent of LIHP enrollees were between the ages of 45 and 64 (Exhibit 8). According to the available data, almost one-third of LIHP enrollees (30 percent) were Latino, 20 percent of LIHP enrollees spoke a primary language other than English, and 91 percent of LIHP enrollees had an income at or below 133 percent FPL. Approximately half were female. Sociodemographic characteristics by local LIHP are displayed in Appendix B, Exhibit 4 through Appendix B, Exhibit 11.

[4]Meng YY, Cabezas L, Roby DH, Pourat N, and Kominski GF. Successful Strategies for Increasing Enrollment in California's Low Income Health Program (LIHP). Los Angeles, CA: UCLA Center for Health Policy Research, September 2012. Available at: http://healthpolicy.ucla.edu/publications/Documents/PDF/lihppolicynotesep2012.pdf

Exhibit 8: Sociodemographic Characteristics of LIHP Enrollees as of December 31, 2012



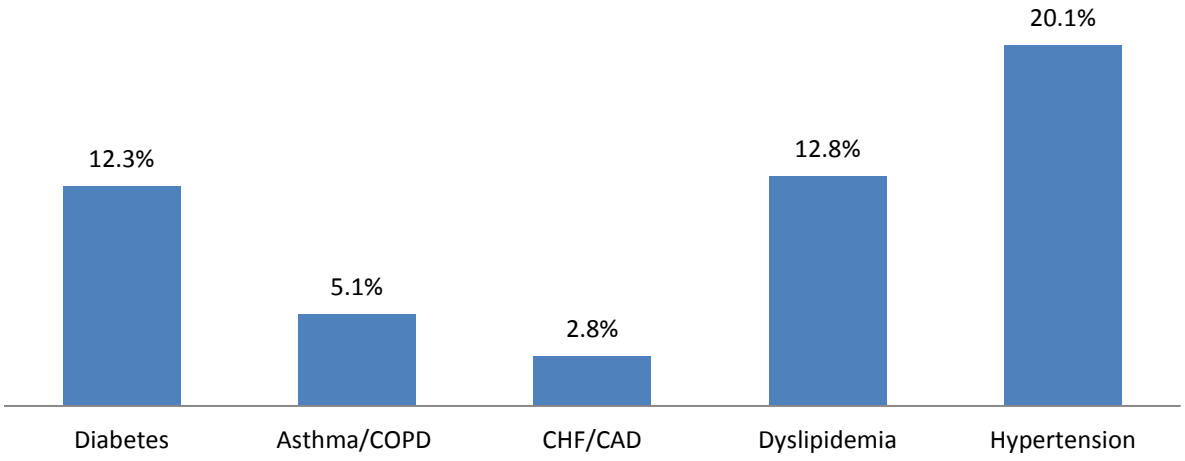
Notes: (1) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (2) For "Race," Asian includes Native Hawaiian, "PI" is for Pacific Islander, and "Other" includes American Indian or Alaska Native.
Source: UCLA analysis of Low Income Health Program enrollment data.

Chronic Conditions

More than one-third of LIHP enrollees had some type of chronic illness. Approximately 34 percent of LIHP enrollees had at least one of five considered chronic conditions – diabetes, asthma/chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF)/cardiovascular disease (CAD), dyslipidemia, and hypertension (Exhibit 9). Twenty percent of enrollees had one of these conditions, 12.7 percent had two to three, and 1.1 percent had

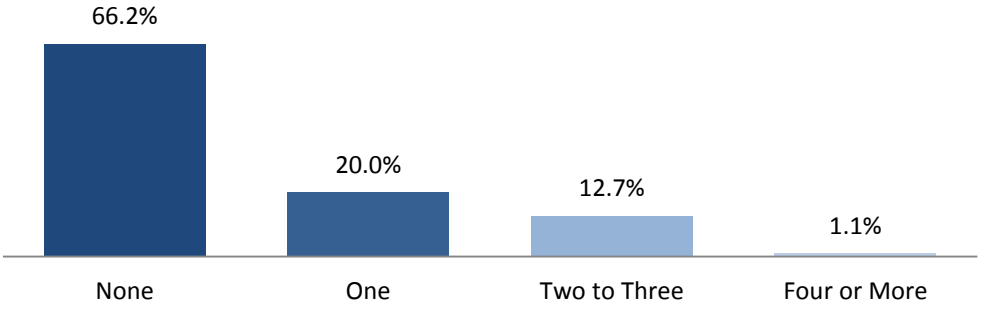
four or more (Exhibit 10). The prevalence of each condition by each LIHP is displayed in Appendix B, Exhibit 14 and Appendix B, Exhibit 15.

Exhibit 9: Chronic Disease Prevalence Among LIHP Enrollees, by Condition, as of December 31, 2012.



Note: According to UCLA Diagnosis Methodology, data are among five chronic conditions investigated.
Source: UCLA analysis of Low Income Health Program claims data.

Exhibit 10: Chronic Disease Prevalence Among LIHP Enrollees, by Number of Conditions, as of December 31, 2012



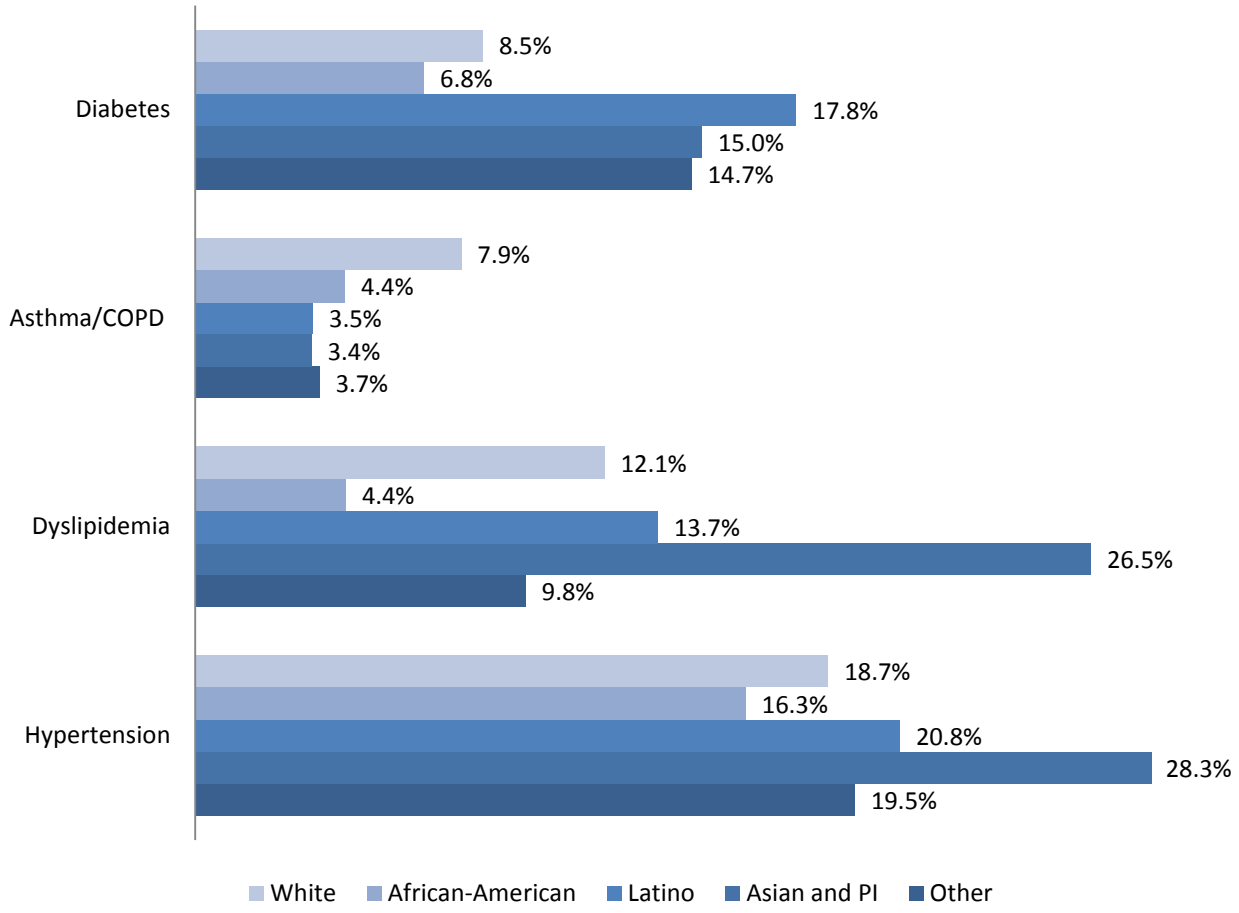
Note: According to UCLA Diagnosis Methodology, data are among five chronic conditions investigated.
Source: UCLA analysis of Low Income Health Program claims data.

Analysis of Characteristics of LIHP Enrollees

This section documents the variation in the prevalence of these chronic conditions by race/ethnicity. Approximately 12 percent of all LIHP enrollees had diabetes. The prevalence of diabetes was 17.8 percent among Latinos, and 8.5 percent and 6.8 percent among Whites and African-Americans, respectively (Exhibit 11). Asthma/COPD prevalence was 5.1 percent among all LIHP enrollees. The prevalence was 3.5 percent among Latinos, 3.4 percent among Asian-Americans/Pacific Islanders, and 7.9 percent among Whites.

Approximately 12.8 percent of LIHP enrollees had a diagnosis of dyslipidemia. Approximately 4.4 percent of African-Americans and 26.5 percent of Asian-Americans/Pacific Islanders had a diagnosis of dyslipidemia. Hypertension prevalence among LIHP enrollees overall was 20.1 percent. More than one-quarter (28.3 percent) of Asian-Americans/Pacific Islanders had hypertension, compared to 20.8 percent of Latinos and 18.7 percent of Whites. Data on these characteristics by local LIHP can be found in Appendix B, Exhibit 16 through Appendix B, Exhibit 25.

Exhibit 11: Chronic Disease Prevalence Among LIHP Enrollees, by Race/Ethnicity, as of December 31, 2012



Notes: (1) Asian includes Native Hawaiian. (2) "PI" is for Pacific Islander. (3) Other includes American Indian or Alaska Native.
Source: UCLA analysis of Low Income Health Program enrollment and claims data.

Access to Care

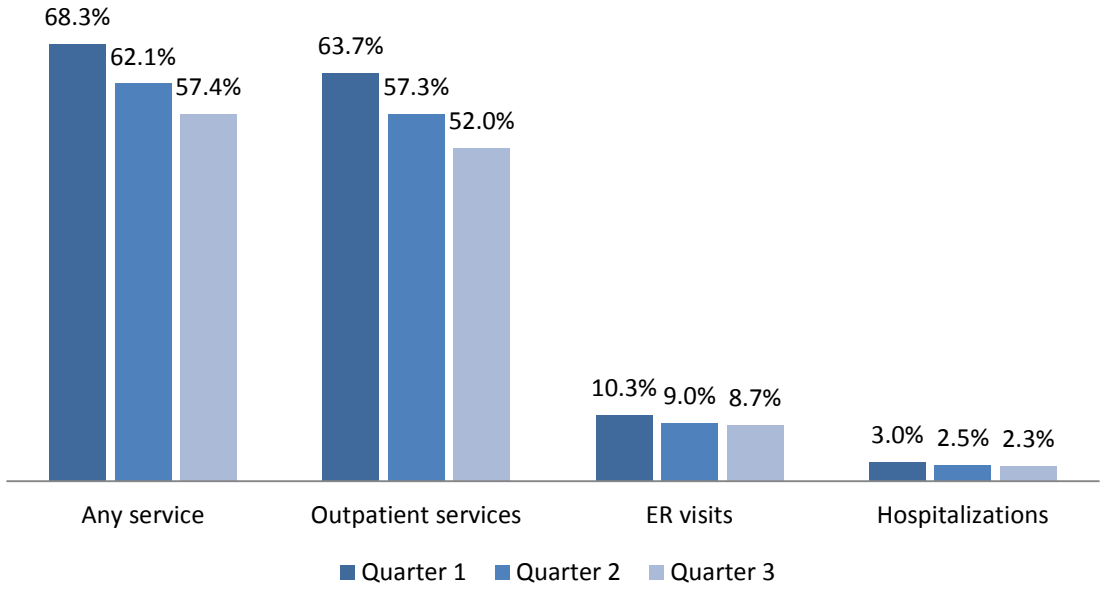
Access to care under LIHP was assessed by utilization of services during the program by active enrollees, defined as enrollees with at least one claim for any service (see Appendix A: Available Data and Methods). Utilization is reported for the program overall, and utilization for each LIHP is reported in Appendix B, Exhibit 26 through Appendix B, Exhibit 30. Services examined include outpatient services, behavioral health services, emergency room visits, and hospitalizations. Rates reported throughout this section are subject to change due to the lag in receipt of claims data.

The utilization data presented in this section include the first three quarters of LIHP. The majority of the data are therefore from the 10 legacy counties that had active programs since the beginning of the LIHP demonstration in July 2011. Later data for legacy counties and data for LIHPs that began operations more recently are not included because of limited data availability and lags in claims data.

Proportion of Enrollees Who Were "Active Users"

The proportion of active enrollees for the first three quarters of 2011 is displayed in Exhibit 12. The data indicate a range in service use from 68.3 percent of enrollees in Quarter 1 to 57.4 percent of enrollees in Quarter 3. Variations in the proportion may be the result of a changing population as outreach and enrollment strategies improve and expand. The enrolled population may also be relatively healthier as pent-up demand decreases among newly insured enrollees.

Exhibit 12: Proportion of Enrollees Who Were Active Users, by Service Type, LIHP, as of March 31, 2012

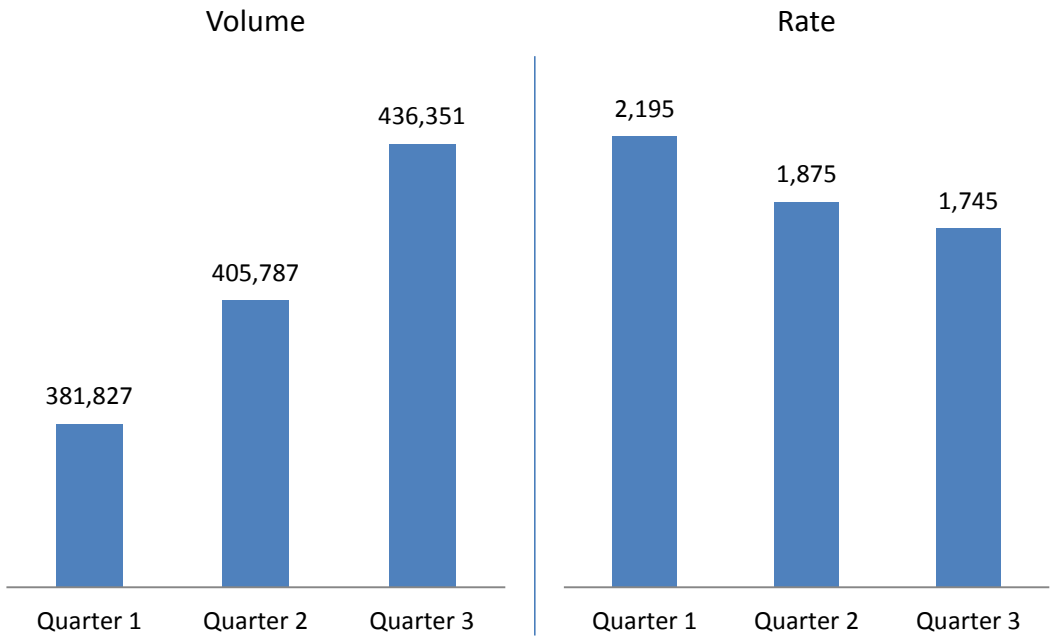


Note: Utilization data are for the 10 legacy counties: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. Data on active users of behavioral health are reported separately in Appendix B, Exhibit 26 through Appendix B, Exhibit 28.
Source: UCLA analysis of Low Income Health Program enrollment and claims data.

Outpatient Services

The total volume of outpatient services provided over the first three quarters of LIHP is displayed in Exhibit 13. A steady growth in the number of outpatient services in this time frame is consistent with the growth in enrollment in LIHP. Exhibit 13 also shows the rate of outpatient services measured as number of services per 1,000 active enrollees per month, which ranged from 2,195 in Quarter 1 to 1,745 in Quarter 3.

Exhibit 13: Total Volume and Rate (Number per 1,000 Active Enrollees per Month) of Outpatient Services by Quarter, LIHP, as of March 31, 2012

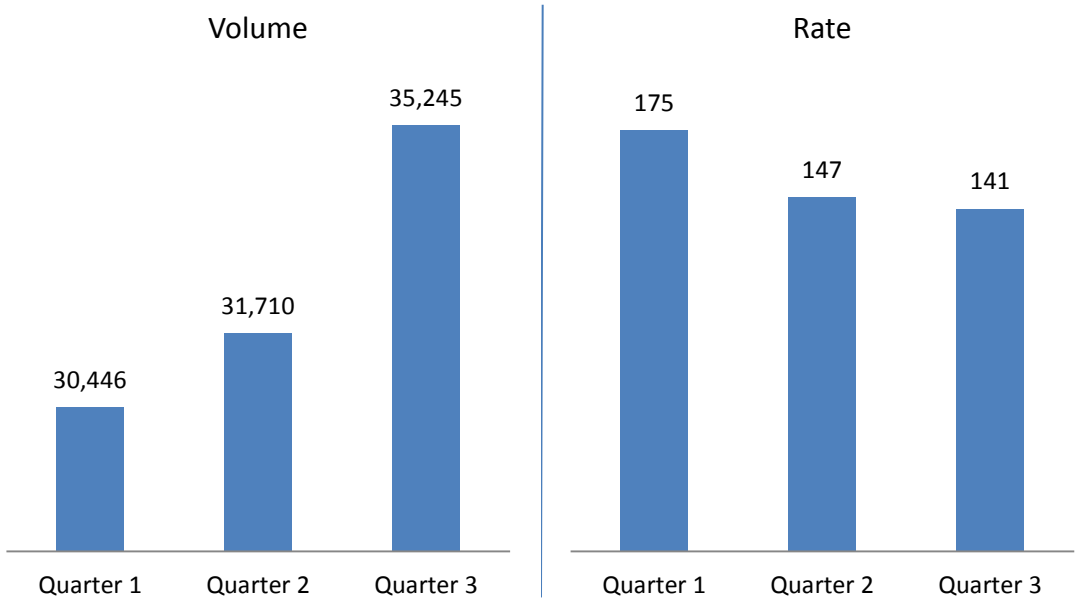


Note: Outpatient services are displayed for the 10 legacy counties: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura.
Source: UCLA analysis of Low Income Health Program enrollment and claims data.

Emergency Room Visits

The total volume and the rate of ER visits (the number of visits per 1,000 active enrollees per month) are displayed in Exhibit 14. The frequency of ER visits is influenced by demographics, chronic conditions, and other characteristics that are not examined in this report.

Exhibit 14: Total Volume and Rate (Number per 1,000 Active Enrollees per Month) of Emergency Room Visits by Quarter, LIHP, as of March 31, 2012

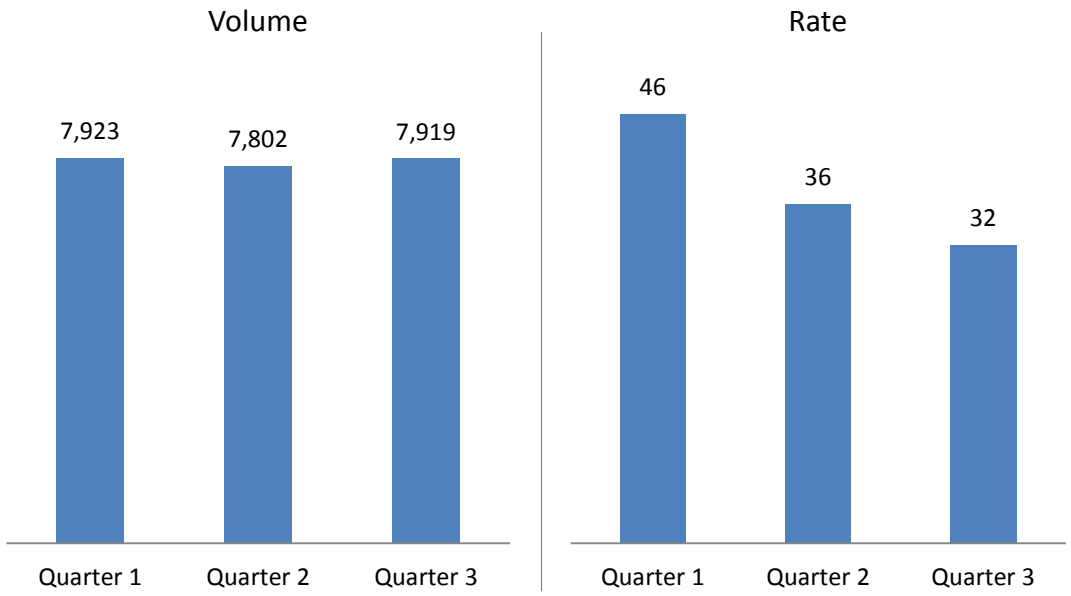


Note: Emergency room data are displayed for the 10 legacy counties: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura.
Source: UCLA analysis of Low Income Health Program enrollment and claims data.

Hospitalizations and Inpatient Days

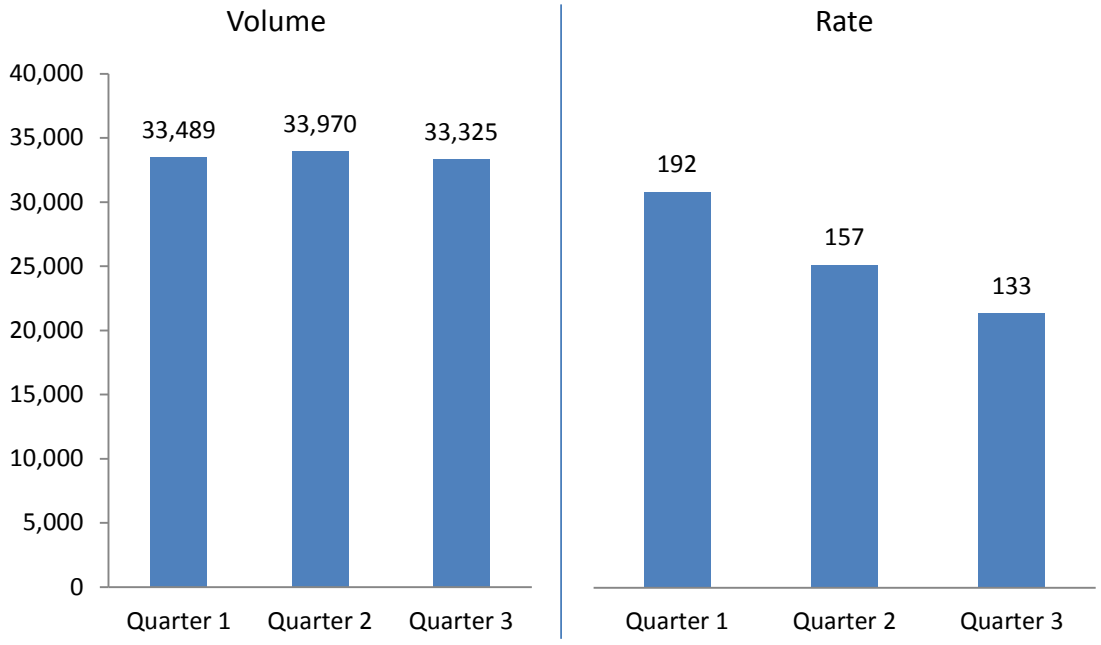
Exhibit 15 shows the total volume and the rate of hospitalizations (the number per 1,000 active enrollees per month), which ranged from 46/1,000 enrollees in Quarter 1 to 32/1,000 enrollees in Quarter 3. The total number of inpatient days ranged from 33,489 in Quarter 1 to 33,325 in Quarter 3, with rates ranging from 192/1,000 enrollees to 133/1,000 enrollees, respectively (Exhibit 16).

Exhibit 15: Total Volume and Rate (Number per 1,000 Active Enrollees per Month) of Hospitalizations by Quarter, LIHP, as of March 31, 2012



Note: Hospitalization data are displayed for the 10 legacy counties: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura.
Source: UCLA analysis of Low Income Health Program enrollment and claims data.

Exhibit 16: Total Volume and Rate (Number per 1,000 Active Enrollees per Month) of Inpatient Days by Quarter, LIHP, as of March 31, 2012



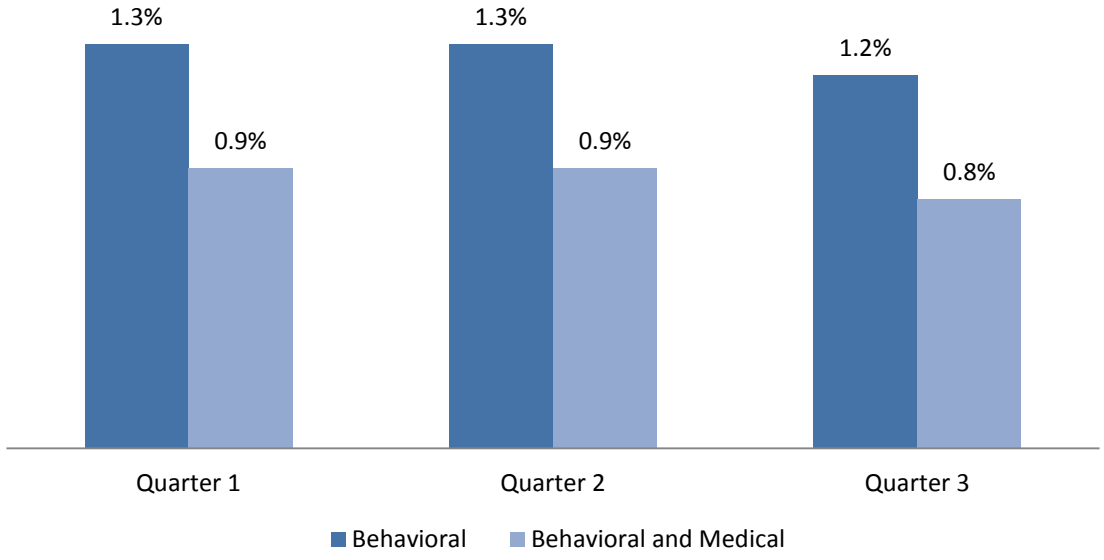
Note: Data on inpatient days are displayed for the 10 legacy counties: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura.
Source: UCLA analysis of Low Income Health Program enrollment and claims data.

Behavioral Health Services

Some counties provided mental health services under the previous HCCI, but a core set of mental health services is a new requirement for MCE LIHP enrollees. Some local LIHPs also provide services to HCCI enrollees and more extensive mental health services and substance abuse services generally, though these are not requirements. Information presented here is limited to those LIHPs that submitted behavioral health utilization data. Additional data are expected in upcoming quarters as more processed claims are received.

Exhibit 17 shows that the proportion of active enrollees who had used any behavioral health services ranged from 1.3 percent to 1.2 percent in the program's first three quarters. The total claims submitted for these services were 1,711; 2,055; and 3,865 in quarters 1, 2, and 3, respectively (data not shown). In addition, the proportion of active users who used both behavioral and medical health services ranged from 0.9 percent to 0.8 percent in the first three quarters. These proportions corresponded to 1,247; 1,402; and 2,506 in quarters 1, 2, and 3, respectively (data not shown).

Exhibit 17: Proportion of Active Enrollees Who Used Behavioral Health Services and Proportion Who Used Behavioral *and* Medical Health Services by Quarter, LIHP, as of March 31, 2012



Note: Data represent the four local LIHPs – Alameda, Contra Costa, Kern, and Los Angeles – for which sufficient behavioral health claims data were available. Other LIHPs either did not submit behavioral health claims data or had fewer than five "active user" enrollees in a given period.
Source: UCLA analysis of Low Income Health Program enrollment and claims data.

Quality of Care

In accordance with their DHCS contracts, LIHPs agree to report on quality of care and to address any needed improvements during the program. Specific quality measures are not identified in STCs or LIHP contracts, and LIHPs have flexibility in selection and implementation of quality improvement activities.

For this report, quality of care is assessed based on the structure of the delivery system, process of care delivery, and patient outcomes. At the time of this report, some data on the structural measures, including health IT, chronic disease registries, and clinical guideline development, were available. Additionally, some LIHPs also submitted self-reported data on process measures, such as receipt of timely preventive services and chronic disease performance indicators that provide insight into how local LIHPs are confronting quality-of-care issues. These data are included in this section. However, outcome measures were not available at the time of this report and thus are not included.

Structural Measures

The 10 legacy LIHPs that had HCCI programs had established several structural measures of quality of care at the local level by the beginning of LIHP. Eight legacy LIHPs had a partially electronic health information system, and the same number were using data on utilization patterns and clinical outcomes to plan and implement quality improvement efforts. Nine of the 10 legacy LIHPs had established evidence-based clinical guidelines for diabetes, and six had electronic diabetes registries. Fewer had established registries for other common chronic conditions.[5]

Other LIHPs had also begun to implement structural quality improvements at the time of this report. The San Bernardino LIHP launched a pilot electronic referral system in early 2012 and was close to implementing software to facilitate providers' ability to coordinate services and review enrollee utilization data. These health IT improvements were to augment San Bernardino's existing capacity to monitor utilization trends, patient satisfaction, and grievance monitoring for the physical and behavioral health benefits in the program.

Process of Care Measures

Several LIHPs reported tracking process performance indicators.

[5]Pourat N, Salce E, Davis AC, Hilberman D. *Achieving System Integration in California's Health Care Safety Net.* Los Angeles, CA: UCLA Center for Health Policy Research, September 2012.

Riverside County LIHP began tracking and documenting the Healthcare Effectiveness Data and Information Set (HEDIS) for comprehensive diabetes process measures from its launch in January 2012, with a 90th percentile goal. Riverside collects low-density lipoprotein (LDL) and HbA1c test completion rates, and it also identifies the proportion of LIHP enrollees with diabetes who receive an annual retinal exam (Appendix B, Exhibit 31).

San Mateo County also tracks some HEDIS comprehensive diabetes process measures, as well as the proportions of females over age 50 who had a mammogram in the past 24 months and of enrollees over age 50 who had received a flu shot. In the behavioral health arena, San Mateo uses HEDIS measures to assess seven- and 30-day outpatient follow-up (target 75th and 90th percentile, respectively) after psychiatric hospital discharge. Based on a review of national performance on longer-term follow-up metrics, San Mateo also tracks progress toward established goals of 70 percent of second follow-up visits occurring within 14 days of an initial treatment visit, and 55 percent of third and fourth follow-up visits occurring within 30 days of a second treatment visit. San Mateo has achieved or fallen just short of both goals in all four quarters of Program Year 1 (Appendix B, Exhibit 32 and Appendix B, Exhibit 33). San Mateo County Behavioral Health and Recovery Services also collect data on substance abuse and mental health services overlap, and on substance abuse service use by Medi-Cal Expansion enrollees.

The San Diego County LIHP used a range of benchmarks from national Medicaid percentiles and the California statewide collaborative Right Care Initiative, among others, to establish goals (Appendix B, Exhibit 34). San Diego also used a collaborative process involving the county's quality improvement committee and health centers to consider current performance in calibrating the aforementioned benchmarks. San Diego collects data on treatment, medication, and general care for enrollees with diabetes, hypertension, asthma, and cardiovascular conditions, including beta-blocker treatment for those diagnosed with acute myocardial infarction. It also tracks smoking cessation assistance and the HEDIS behavioral health measure of a seven-day follow-up after a hospitalization related to mental illness.

These LIHPs collect quality-of-care data at the clinic level. Riverside and San Diego collect data for LIHP enrollees specifically, and San Mateo aggregates data for all beneficiaries, regardless of program affiliation. The ability to collect data at the clinic level allows these LIHPs to better target their quality improvement efforts.

Future Analyses

Findings in this interim report are based on program-to-date data and are limited by data availability, lags in claims processing, and transmission of data to UCLA by LIHPs. Indicators of LIHP progress by the end of the first program year are not representative of all local programs operating due to variations in launch dates, rapid changes in enrollment and the subsequently changing demographics, and health status of enrollees. The final LIHP evaluation report will account for many of these data limitations. To the degree possible, plans for further analyses include:

- Examining how county or program networks were strengthened and expanded to meet the needs of LIHP.
- Evaluation of additional services available to MCE and HCCI enrollees that were not available through previous HCCI programs or county indigent care programs; examination of how these services are being utilized and coordinated.
- Examining increased access to care for the target population in the MCE and HCCI programs; additional analysis on how the volume of services provided changed during the program implementation period.
- Comprehensive analysis of the utilization of medical and behavioral health services, including visits to primary and specialty care providers, emergency room visits followed by discharge, and hospitalizations for enrollees with chronic conditions.
- Size and structure of provider networks in LIHP, and enrollee utilization of different providers within the network.
- Patient adherence to medical home assignment when seeking care; whether medical home providers were able to expand services to better support self-management of chronic illnesses.
- Changes in rates of use of outpatient services, emergency room visits, and hospitalizations, with specific focus on whether the MCE and HCCI programs were able to reduce avoidable ER visits and hospitalizations over the program period.
- Improvements in enrollee's health status as assessed through clinical measures.
- Changes in rates of use of preventive services (e.g., cancer screenings, well exams, and immunizations) as a result of the new services available through LIHP.

- Trends in quality of care as indicated by process measures available in claims data, such as cancer screening and self-assessed health.

- Self-reported data on health care service and administrative expenditures and trends in reimbursements for services during LIHP.

Summary and Conclusions

By March 2013, 19 LIHPs were operating in California, covering 53 counties. As of December 2012, 680,946 low-income individuals had been enrolled in the program since its inception. This enrollment exceeded the projections for the program, most likely due to innovative efforts initiated at the local level, including community outreach and partnerships, effective use of IT systems, increased efficiency, cost-control measures, staff training, and successful retention and redetermination efforts. The LIHP provider network included close to 5,000 primary care providers and almost 200 hospitals statewide.

The interim data on utilization of outpatient services, behavioral health services, and emergency room visits indicated an increase in the volume of services provided during the program. However, it is premature to attempt to discern the reliability of trends in these utilization patterns due to significant limitations in the availability of data for all participating LIHPs, the rapid growth in enrollment, and changes to newly implemented LIHPs in this time period. The current patterns of utilization are likely to be complicated by the potential pent-up demand for care on the part of previously uninsured enrollees, as well as by demographic characteristics and the health status of enrollees. Self-reported quality of care data indicated progress of LIHPs in establishing data systems and benchmarks for tracking quality performance measures and quality improvement efforts. Chronic disease registries and electronic health information systems were frequently available, and additional emphasis on population health management was reported.

Overall, available data indicate that the program is succeeding in preparing California for the upcoming transition of a significant portion of the state's population toward coverage under Medi-Cal and Covered California. The final LIHP evaluation will provide a comprehensive overview of the successes and challenges of the program during its two and a half years of operation.

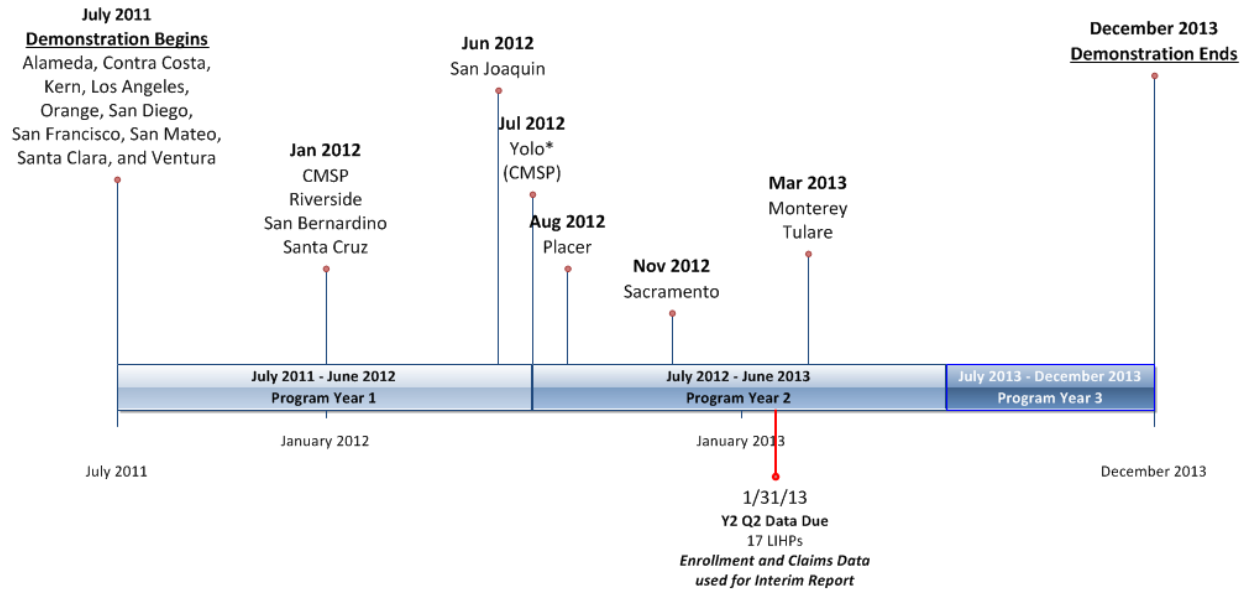
Appendices

Appendix A: Available Data and Methods

Data

The data for the analyses included in this report are received on a rolling basis from LIHPs. The phased implementation of LIHP has affected the timing of data delivery from local LIHPs. Legacy counties were able to submit claims and enrollment data from the beginning of LIHP implementation in July 2011 (Appendix A, Exhibit 1). Counties with newer LIHPs began providing data as early as January 2012 (CMSP, Riverside, San Bernardino, and Santa Cruz) and as late as June 2012 (San Joaquin). Therefore, the analysis for Program Year (PY) 1, Quarters (Q) 1 and 2 includes data for the 10 legacy counties only. Claims and enrollment data for the 10 legacy counties and seven LIHPs that launched in 2012 are demonstrated in PY 1 Q3-4 and PY2 Q1-2 data (except for utilization data, which account for the 10 legacy counties only).

Appendix A, Exhibit 1: LIHP Implementation and Data Delivery Timeline



Notes: (1) Yolo joined CMSP on July 1, 2012. Implementation dates are current as of March 31, 2013. (2) Data delivery dates were established by UCLA for evaluation purposes.
Source: Low Income Health Program contracts with Department of Health Care Services.

Methods

Monthly Cumulative Enrollment Figures

The unduplicated cumulative enrollment numbers by month for the entire LIHP program were calculated for this report. When cumulative enrollment was reported quarterly rather than monthly, the unduplicated cumulative total for those months was estimated. In these instances, the net increase in cumulative enrollment between consecutive quarters was divided into three equal parts representing each month in that quarter. For example, an increase of 900 enrollees from Quarter 1 to Quarter 2 was assumed to be an increase of 300 enrollees per month during Quarter 1.

Small Area Estimation

The estimates of the size of the adult population potentially eligible for LIHP in each area were based on small area estimation (SAE) methodology using the 2007 and 2009 California Health Interview Survey (CHIS) and the American Community Survey (ACS). SAE analysis was not needed for the combined CMSP counties, because the direct estimate using CHIS 2009 was stable and reliable.

The SAE methodology was developed by UCLA and has been validated over the past 10 years. SAE is a design-oriented and model-based synthetic estimation method that uses CHIS and ACS data to build models predicting variables of interest in smaller geographic areas included in CHIS. Predicted values for the variables of interest in CHIS data are calculated and then aggregated to derive the final estimates for the desired small area of interest. For the SAEs reported in this brief, the model was based on CHIS 2007 and 2009 data, accounting for year-to-year differences. The model parameter estimates were then applied to decennial U.S. Census population data from ACS, representing the population from which the CHIS 2009 survey was drawn. The variance for the estimates was derived through the bootstrapping method. Confidence intervals and coefficients of variation of the final estimates were also calculated and presented.

Chronic Conditions

The prevalence of five of the most common chronic conditions, using the ninth revision of the International Classification of Diseases (ICD-9) diagnostic codes, was calculated. An enrollee was considered to have the specific chronic condition if s/he had at least one claim with specific ICD-9 diagnostic codes. The three-digit root of the ICD-9 codes was used in the absence of the complete code (Appendix A, Exhibit 2). Enrollees were assigned multiple chronic conditions if claims had codes for more than one condition.

Appendix A, Exhibit 2: ICD-9 Diagnostic Codes for the Five Most Chronic Conditions

Condition	ICD-9 Diagnostic Codes
Diabetes	250, 357.2, 362.0, 366.41
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	492, 493, 496
Congestive Heart Failure (CHF)/ Coronary Artery Disease (CAD)	428, 410, 411, 412, 413, 414
Hypertension	401, 402, 403, 404
Dyslipidemia	272

Federal Poverty Level

FPL calculations in this report were consistent with the 2012 poverty guidelines issued in the Federal Register by the Department of Health and Human Services (DHHS). FPL values were calculated using family size and monthly or annual income and were grouped into the following categories: 0-25%, >25-50%, >50-75%, >75-100%, >100-133%, and >133-200%.

Data reporting problems may have led to inaccuracies in FPL data. Multiple counties reported missing or erroneous values in the "monthly/annual income" and "family size" variables used to calculate FPL. Additionally, some counties inconsistently listed "null" or "zero" values. Furthermore, some legacy counties continued to report FPL levels used under the HCCI demonstration, which were different from FPL levels mandated by LIHP for MCE and HCCI.

Utilization

All utilization data were reported for "active users," defined as the number of unique enrollees with at least one claim in the claims data for the given quarter.

The proportions of active users who had used outpatient or behavioral health services, had visited emergency rooms, and had been hospitalized were calculated. Rates of outpatient service use, emergency room visits, and hospitalizations per 1,000 active enrollees by quarter were also calculated.

The proportion of enrollees who were active users was calculated by dividing the number of enrollees using a particular service during a quarter by the total number of enrollees in LIHP during the quarter. Rates of utilization per 1,000 active enrollees were calculated by dividing the number of services per quarter by the number of active users and multiplying the result by 1,000 to reflect the "per 1,000" element of the measure.

Appendix B: Supplemental Findings and Analyses

Appendix B, Exhibit 1: Monthly Unduplicated Cumulative Enrollment by LIHP, as of December 31, 2012

Local LIHP	Jul '11	Aug '11	Sep '11	Oct '11	Nov '11	Dec '11	Jan '12	Feb '12	Mar '12	Apr '12	May '12	Jun '12	Jul '12	Aug '12	Sept '12	Oct '12	Nov '12	Dec '12
Alameda	22,690	25,315	27,825	30,131	32,103	34,286	39,222	42,651	45,746	48,463	51,097	53,548	55,725	58,218	60,267	62,525	64,293	66,147
CMSP	-	-	-	-	-	-	46,592	52,532	58,226	63,545	68,553	73,541	79,462	84,342	88,272	91,788	93,229	93,305
Contra Costa	12,487	13,255	13,951	14,561	15,134	15,595	16,240	16,802	17,471	18,079	18,658	19,149	19,553	20,057	20,482	21,004	21,424	21,725
Kern	6,783	7,090	7,414	7,705	7,913	8,079	8,307	8,584	8,893	9,201	9,561	9,869	10,216	10,570	10,873	11,160	11,397	11,658
Los Angeles	65,233	74,627	84,021	93,046	102,071	111,096	120,215	129,335	138,454	164,438	190,422	216,406	221,381	226,356	231,331	236,305	241,280	246,255
Orange	35,480	37,311	39,014	40,784	42,482	43,986	45,766	47,475	49,355	51,107	52,892	54,556	56,249	57,949	59,457	61,051	62,276	62,769
Placer	-	-	-	-	-	-	-	-	-	-	-	-	-	1,247	1,617	1,946	2,216	2,443
Riverside	-	-	-	-	-	-	7,997	15,312	16,700	17,907	19,128	20,910	22,311	23,632	24,854	26,127	27,060	27,693
Sacramento	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,662	2,287
San Bernardino	-	-	-	-	-	-	4,370	7,221	10,380	16,058	18,888	21,456	23,808	25,783	27,672	29,240	30,288	30,663
Santa Clara	6,115	6,554	6,930	7,410	7,911	8,454	9,028	9,690	10,459	11,242	12,029	12,750	13,484	14,257	14,951	15,741	16,336	16,886
Santa Cruz	-	-	-	-	-	-	851	1,154	1,366	1,601	1,764	1,947	2,102	2,271	2,386	2,440	2,440	2,440
San Diego	13,372	15,321	17,404	19,904	22,039	24,091	26,394	28,459	30,608	32,638	34,744	36,854	38,851	40,932	42,719	44,718	46,075	46,642
San Francisco	10,801	11,462	12,137	12,869	13,247	13,639	14,076	14,466	14,882	15,334	15,716	16,078	16,422	16,758	17,023	17,360	17,632	17,886
San Joaquin	-	-	-	-	-	-	-	-	-	-	-	-	199	662	980	1,176	1,442	1,753
San Mateo	8,059	8,500	8,891	9,266	9,579	9,932	10,255	10,632	10,966	11,334	11,741	12,116	12,489	12,862	13,189	13,572	13,882	14,119
Ventura	8,269	8,755	9,213	9,664	10,113	10,509	10,994	11,491	12,055	12,526	13,034	13,558	14,129	14,676	15,088	15,574	15,984	16,275
Total	**189,289**	**208,190**	**226,800**	**245,340**	**262,592**	**279,667**	**360,307**	**395,804**	**425,561**	**473,473**	**518,227**	**562,738**	**586,381**	**610,572**	**631,161**	**651,727**	**668,916**	**680,946**

Notes: (1) "-" denotes that the local LIHP was not operating at that point in time. (2) Data for Los Angeles County are self-reported.
Source: UCLA analysis of Low Income Health Program enrollment data.

Appendix B, Exhibit 2: Monthly Point-in-Time Enrollment by LIHP, as of December 31, 2012

Local LIHP	Jul '11	Aug '11	Sep '11	Oct '11	Nov '11	Dec '11	Jan '12	Feb '12	Mar '12	Apr '12	May '12	Jun '12	Jul '12	Aug '12	Sept '12	Oct '12	Nov '12	Dec '12
Alameda	22,690	24,221	25,734	27,041	28,056	29,622	34,176	37,012	39,002	40,794	42,476	44,002	44,711	46,096	46,895	48,169	48,956	49,687
CMSP	-	-	-	-	-	-	46,592	47,655	49,343	51,048	52,667	54,241	55,874	57,083	56,846	56,564	52,344	43,474
Contra Costa	12,487	12,797	12,836	12,966	12,925	12,974	12,968	12,985	12,958	12,928	12,886	12,717	12,358	12,229	12,038	12,225	12,254	12,124
Kern	6,783	6,968	6,696	6,619	6,451	6,266	6,104	5,994	6,001	6,079	6,260	6,357	6,472	6,673	6,623	6,677	6,700	6,807
Los Angeles	65,233	73,680	83,689	94,131	101,506	110,345	117,447	127,317	137,557	142,862	129,628	198,020	198,373	204,878	218,719	214,432	213,101	213,434
Orange	35,480	36,156	36,682	37,250	37,714	38,037	38,542	39,094	39,731	40,381	41,163	41,840	42,424	43,015	43,533	44,006	44,063	43,173
Placer	-	-	-	-	-	-	-	-	-	-	-	-	-	1,247	1,594	1,910	2,161	2,344
Riverside	-	-	-	-	-	-	7,997	15,278	16,332	17,489	18,696	20,465	21,854	23,042	24,114	25,239	26,065	26,593
Sacramento	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,662	2,274
San Bernardino	-	-	-	-	-	-	4,370	7,204	10,302	15,673	18,234	20,440	22,361	23,880	25,285	26,330	26,817	25,946
Santa Clara	6,115	6,365	6,538	6,817	7,178	7,619	8,129	8,639	9,269	9,926	10,556	11,140	11,745	12,206	12,622	13,153	13,478	13,718
Santa Cruz	-	-	-	-	-	-	851	1,145	1,330	1,549	1,678	1,839	1,953	2,079	2,167	2,197	2,167	2,140
San Diego	13,372	15,125	16,419	18,488	20,074	21,621	23,269	25,084	26,977	28,739	30,559	29,947	31,064	32,134	32,867	33,286	33,356	32,339
San Francisco	10,801	10,900	10,862	10,979	10,765	10,688	10,727	10,658	10,675	10,796	11,009	11,149	10,943	10,771	10,628	10,471	10,455	10,306
San Joaquin	-	-	-	-	-	-	-	-	-	-	-	345	199	662	980	1,176	1,442	1,753
San Mateo	8,059	8,138	8,180	8,210	8,184	8,193	8,097	8,051	8,123	8,118	8,202	8,268	8,315	8,426	8,520	8,659	8,723	8,671
Ventura	8,269	8,548	8,688	8,859	9,076	9,266	9,505	9,769	10,071	10,234	10,445	10,657	10,970	11,224	11,284	11,460	11,590	11,564
Total	**189,289**	**202,898**	**216,324**	**231,360**	**241,929**	**254,631**	**328,774**	**355,885**	**377,671**	**396,616**	**394,459**	**471,427**	**479,616**	**495,645**	**514,715**	**515,954**	**515,334**	**506,347**

Notes: (1) "-" denotes that the local LIHP was not operating at that point in time. (2) Data for Los Angeles County are self-reported.
Source: UCLA analysis of Low Income Health Program enrollment data.

Appendix B, Exhibit 3: LIHP Current Enrollment and Estimated ACA-Eligible Population, as of December 31, 2012

LIHP	Current FPL	Currently Enrolled (as of December 31, 2012)	Estimated Potential Eligible Population at 200% FPL (95% Confidence Interval)
Alameda	200%	49,687	52,000 (26,000 - 77,000)
County Medical Services Program (CMSP)	100%	43,787	153,000 (142,000 - 177,000)
Contra Costa	200%	12,124	34,000 (16,000 - 51,000)
Kern	133%	6,807	62,000 (35,000 - 90,000)
Los Angeles	133%	213,434	637,000 (490,000 - 783,000)
Monterey	100%	N/A	23,000 (12,000 - 33,000)
Orange	200%	43,173	147,000 (78,000 - 216,000)
Placer	100%	2,344	9,000 (4,000 - 14,000)
Riverside	133%	26,593	157,000 (88,000 - 225,000)
Sacramento	67%	2,274	61,000 (28,000 - 94,000)
San Bernardino	100%	25,946	127,000 (70,000 - 184,000)
San Diego	133%	32,339	133,000 (101,000 - 166,000)
San Francisco	25%	10,306	30,000 (15,000 - 45,000)
San Joaquin	80%	1,753	40,000 (21,000 - 58,000)
San Mateo	133%	8,671	21,000 (10,000 - 32,000)
Santa Clara	133%	13,718	47,000 (23,000 - 71,000)
Santa Cruz	100%	2,140	15,000 (8,000 - 23,000)
Tulare	75%	N/A	33,000 (18,00 - 47,000)
Ventura	200%	11,564	32,000 (16,000 - 48,000)

Sources: The estimated number of ACA-eligible individuals is based on small area estimation using the 2007 and 2009 California Health Interview Survey (CHIS) data, with the exception of CMSP, which used the CHIS 2009 direct estimate. The methodology for these estimates can be found in Data Sources and Methods. Current enrollment

estimates are based on enrollment data submitted to UCLA by operating Low Income Health Programs as of March 31, 2012. Methods used to develop small area estimates can be found in Appendix A: Available Data and Methods.

Appendix B, Exhibit 4: Sociodemographic Characteristics of LIHP Enrollees: Number of Enrollees by Age, as of December 31, 2012

	Age							
Local LIHP	**<25**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55 +**
Alameda	7,150	7,544	6,011	4,713	5,684	7,485	9,124	18,436
Contra Costa	1,730	2,723	2,055	1,466	1,807	2,607	3,248	6,089
CMSP	12,139	13,151	9,796	7,055	8,613	11,292	13,082	18,177
Kern	966	1,139	929	683	931	1,565	1,952	3,493
Los Angeles	27,448	22,022	17,186	13,485	16,421	23,085	30,966	62,821
Orange	5,609	6,310	4,016	3,226	4,468	6,323	9,205	23,612
Placer	229.0	245.0	195.0	194.0	242.0	340.0	455.0	543.0
Riverside	2,376	2,624	2,033	1,574	2,068	3,299	4,682	9,035
Sacramento	187	231	205	143	214	292	428	587
San Bernardino	3,725	3,094	2,444	1,962	2,480	3,768	4,992	8,198
Santa Clara	1,120	1,534	1,238	933	1,200	1,715	2,477	6,669
Santa Cruz	203	254	215	170	223	287	376	712
San Diego	4,407	4,762	3,710	2,950	3,736	5,351	7,466	14,226
San Francisco	1,362	2,130	1,736	1,408	1,727	2,101	2,372	5,050
San Joaquin	170	184	118	98	148	238	313	484
San Mateo	1,212	1,653	1,195	868	1,025	1,534	1,950	4,682
Ventura	1,586	1,712	1,180	977	1,243	1,771	2,406	5,400
LIHP Total	**71,619**	**71,312**	**54,262**	**41,905**	**52,230**	**73,053**	**95,494**	**188,214**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 5: Sociodemographic Characteristics of LIHP Enrollees: Percentage of Enrollees by Age, as of December 31, 2012

	Age							
Local LIHP	**<25**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55 +**
Alameda	10.8	11.4	9.1	7.1	8.6	11.3	13.8	27.9
Contra Costa	8.0	12.5	9.5	6.7	8.3	12.0	14.9	28.0
CMSP	13.0	14.1	10.5	7.6	9.2	12.1	14.0	19.5
Kern	8.2	9.7	7.9	5.8	7.9	13.3	16.6	29.7
Los Angeles	12.9	10.3	8.1	6.3	7.7	10.8	14.5	29.4
Orange	8.9	10.1	6.4	5.1	7.1	10.1	14.7	37.6
Placer	9.4	10.0	8.0	7.9	9.9	13.9	18.6	22.2
Riverside	8.5	9.4	7.3	5.6	7.4	11.8	16.8	32.4

Sacramento	8.2	10.1	9.0	6.3	9.4	12.8	18.7	25.7
San Bernardino	12.1	10.1	7.9	6.4	8.1	12.3	16.2	26.7
Santa Clara	6.6	9.1	7.3	5.5	7.1	10.2	14.7	39.5
Santa Cruz	8.3	10.4	8.8	7.0	9.1	11.8	15.4	29.2
San Diego	9.4	10.2	8.0	6.3	8.0	11.5	16.0	30.5
San Francisco	7.6	11.9	9.7	7.9	9.6	11.7	13.3	28.2
San Joaquin	9.7	10.5	6.7	5.6	8.4	13.6	17.9	27.6
San Mateo	8.6	11.7	8.5	6.1	7.3	10.9	13.8	33.2
Ventura	9.7	10.5	7.2	6.0	7.6	10.9	14.8	33.1
LIHP Total	**11.0**	**11.0**	**8.4**	**6.5**	**8.1**	**11.3**	**14.7**	**29.0**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 6: Sociodemographic Characteristics of LIHP Enrollees: Number of Enrollees by Gender and Race/Ethnicity, as of December 31, 2012

	Gender		Race/Ethnicity					
Local LIHP	**Male**	**Female**	**White**	**African-American**	**Asian/PI**	**Latino**	**Other**	**Unavailable**
Alameda	35,067	31,080	12,215	19,926	16,126	10,563	2,955	4,362
Contra Costa	11,165	10,562	8,980	4,088	2,277	4,507	1,860	15
CMSP	54,118	39,187	61,478	6,151	3,170	16,313	3,647	2,415
Kern	6,232	5,544	4,607	974	310	4,594	72	1,219
Los Angeles	117,901	95,532	31,103	54,763	11,266	83,433	32,869	
Orange	30,189	32,580	16,019	1,166	17,552	16,301	2,743	8,988
Placer	1,342	1,095				210	2,223	
Riverside	14,059	13,764	7,918	2,445	856	8,946	945	6,764
Sacramento	1,257	1,030	918	418	327	279	345	
San Bernardino	16,168	14,584	14,588	4,864	1,102	7,369	202	2,627
Santa Clara	8,208	8,678	4,161	852	5,353	5,222	1,111	187
Santa Cruz	1,374	1,066	1,354	56	34	539	19	438
San Diego	24,997	21,645	14,513	4,571	2,697	9,948	1,893	13,020
San Francisco	10,869	7,030	5,595	4,091	4,265	2,923	885	140
San Joaquin	850	903	624	256	343	495	35	
San Mateo	7,364	6,755	4,267	219	3,205	5,001	182	1,245
Ventura	7,820	8,491	4,320	299	860	6,951	405	3,476
LIHP Total	**348,980**	**299,526**	**192,660**	**105,139**	**69,743**	**183,594**	**52,391**	**44,906**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 7: Sociodemographic Characteristics of LIHP Enrollees: Percentage of Enrollees by Gender and Race/Ethnicity, as of December 31, 2012

	Gender		Race/Ethnicity					
Local LIHP	**Male**	**Female**	**White**	**African-American**	**Asian/PI**	**Latino**	**Other**	**Unavailable**
Alameda	53.0	47.0	18.5	30.1	24.4	16.0	4.5	6.6
Contra Costa	51.4	48.6	41.3	18.8	10.5	20.7	8.6	0.1
CMSP	58.0	42.0	65.9	6.6	3.4	17.5	3.9	2.6
Kern	52.9	47.1	39.1	8.3	2.6	39.0	0.6	10.4
Los Angeles	55.2	44.8	14.6	25.7	5.3	39.1	15.4	
Orange	48.1	51.9	25.5	1.9	28.0	26.0	4.4	14.3
Placer	54.9	44.8				8.6	91.0	
Riverside	50.4	49.4	28.4	8.8	3.1	32.1	3.4	24.3
Sacramento	55.0	45.0	40.1	18.3	14.3	12.2	15.1	
San Bernardino	52.6	47.4	47.4	15.8	3.6	24.0	0.7	8.5
Santa Clara	48.6	51.4	24.6	5.0	31.7	30.9	6.6	1.1
Santa Cruz	56.3	43.7	55.5	2.3	1.4	22.1	0.8	18.0
San Diego	53.6	46.4	31.1	9.8	5.8	21.3	4.1	27.9
San Francisco	60.7	39.3	31.3	22.9	23.8	16.3	4.9	0.8
San Joaquin	48.5	51.5	35.6	14.6	19.6	28.2	2.0	
San Mateo	52.2	47.8	30.2	1.6	22.7	35.4	1.3	8.8
Ventura	47.9	52.1	26.5	1.8	5.3	42.6	2.5	21.3
LIHP Total	**53.8**	**46.2**	**29.7**	**16.2**	**10.8**	**28.3**	**8.1**	**6.9**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 8: Sociodemographic Characteristics of LIHP Enrollees: Number of Enrollees by Language, as of December 31, 2012

	Language				
Local LIHP	**English**	**Spanish**	**Asian/PI**	**Other**	**Unavailable**
Alameda	50,955	4,657	4,593	5,942	
Contra Costa	19,224	1,985	44	278	
CMSP	87,314	5,112	252	527	
Kern	9,534	1,731	67	28	371
Los Angeles	163,301	38,166	7,924	3,940	
Orange	42,009	9,047	947	10,658	
Placer	2,368	35	15	15	
Riverside	23,273	4,501	51		49
Sacramento	1,987	60	71	139	

San Bernardino	26,898	3,454	105	288	
Santa Clara	12,223	1,127	46	3,187	
Santa Cruz	2,204	230			
San Diego					
San Francisco	14,376	1,061	40	2,348	
San Joaquin	1,481	102		169	
San Mateo	10,994	2,166	255	598	69
Ventura	12,189	4,122			
LIHP Total	**480,330**	**77,556**	**14,412**	**28,122**	**500**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 9: Sociodemographic Characteristics of LIHP Enrollees: Percentage of Enrollees by Language, as of December 31, 2012

	Language				
Local LIHP	**English**	**Spanish**	**Asian/PI**	**Other**	**Unavailable**
Alameda	77	7	6.9	9	
Contra Costa	88.5	9.1	0.2	1.3	
CMSP	93.6	5.5	0.3	0.6	
Kern	81	14.7	0.6	0.2	3.2
Los Angeles	76.5	17.9	3.7	1.8	
Orange	66.9	14.4	1.5	17	
Placer	96.9	1.4	0.6	0.6	
Riverside	83.5	16.1	0.2		0.2
Sacramento	86.9	2.6	3.1	6.1	
San Bernardino	87.5	11.2	0.3	0.9	
Santa Clara	72.4	6.7	0.3	18.9	
Santa Cruz	90.3	9.4			
San Diego					
San Francisco	80.3	5.9	0.2	13.1	
San Joaquin	84.5	5.8		9.6	
San Mateo	77.9	15.3	1.8	4.2	0.5
Ventura	74.7	25.3			
LIHP Total	**74.1**	**12.0**	**2.2**	**4.3**	**0.1**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 10: Sociodemographic Characteristics of LIHP Enrollees: Number of Enrollees by FPL, December 31, 2012

	FPL						
Local LIHP	**Below 25%**	**>25-50%**	**>50-75%**	**>75-100%**	**>100-133%**	**>133-200%**	**Unavailable**
Alameda	24,423	15,609	4,417	4,673	6,474	10,360	
Contra Costa	3,489	8,214	1,585	1,923	2,773	3,724	
Kern	7,010	651	936	888	620	711	92
Los Angeles	108,480	1,901	122	90	93		
Orange	5,641	22,757	5,588	6,076	8,542	14,041	112
Placer	370	695	196	226	42	58	32
Riverside	19,507	1,234	1,840	2,069	2,887	125	31
Sacramento	1,589						693
San Bernardino	19,832	3,846	2,506	2,315	808	699	416
Santa Clara	13,196	757	1,059	343	464	745	131
Santa Cruz	1,498	329	330	283			
San Diego	17,450	12,364	4,640	5,101	5,912	690	
San Francisco	11,293	892	1,195	1,317	1,320	1,882	
San Joaquin	1,383	139	183	30			
San Mateo	6,793	946	1,281	1,553	2,275	1,174	57
Ventura	4,505	2,543	1,294	1,575	2,309	3,694	346
LIHP Total	**246,459**	**72,877**	**27,173**	**28,462**	**34,524**	**37,915**	**1,488**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 11: Sociodemographic Characteristics of LIHP Enrollees: Percentage of Enrollees by FPL, as of December 31, 2012

	FPL						
Local LIHP	**Below 25%**	**>25-50%**	**>50-75%**	**>75-100%**	**>100-133%**	**>133-200%**	**Unavailable**
Alameda	36.9	23.6	6.7	7.1	9.8	15.7	
Contra Costa	16.1	37.8	7.3	8.9	12.8	17.1	
Kern	59.5	5.5	7.9	7.5	5.3	6.0	0.8
Los Angeles	50.8	0.9	0.1	0.0	0.0		
Orange	9.0	36.3	8.9	9.7	13.6	22.4	0.2
Placer	15.1	28.4	8.0	9.3	1.7	2.4	1.3
Riverside	70.0	4.4	6.6	7.4	10.4	0.4	0.1
Sacramento	69.5						30.3
San Bernardino	64.5	12.5	8.1	7.5	2.6	2.3	1.4
Santa Clara	78.1	4.5	6.3	2.0	2.7	4.4	0.8
Santa Cruz	61.4	13.5	13.5	11.6			

San Diego	37.4	26.5	9.9	10.9	12.7	1.5	
San Francisco	63.1	5.0	6.7	7.4	7.4	10.5	
San Joaquin	78.9	7.9	10.4	1.7			
San Mateo	48.1	6.7	9.1	11.0	16.1	8.3	0.4
Ventura	27.6	15.6	7.9	9.7	14.2	22.6	2.1
LIHP Total	**38.0**	**11.2**	**4.2**	**4.4**	**5.3**	**5.8**	**0.3**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 12: Number of LIHP Enrollees with Chronic Disease, by Number of Conditions, as of December 31, 2012

	Number of Chronic Conditions					
Local LIHP	**0**	**1**	**2**	**3**	**4**	**5**
Alameda	47,582	10,715	5,147	2,379	314	
Contra Costa	13,215	4,200	2,467	1,488	327	30
CMSP	64,215	15,349	7,954	4,341	1,250	160
Kern	6,604	2,137	1,428	1,265	294	48
Los Angeles	158,945	42,993	10,453	999	42	2
Orange	30,590	22,930	9,899	7,152	1,918	280
Placer	2,395	33	12			
Riverside	16,334	5,402	3,538	2,143	403	54
San Bernardino	23,895	5,218	1,405	202	30	
Santa Clara	9,691	3,078	2,262	1,553	276	26
Santa Cruz	1,369	562	311	154	44	
San Diego	26,991	8,427	6,023	4,010	1,056	135
San Francisco	11,959	3,820	1,698	383	35	
San Mateo	8,492	2,435	1,699	1,247	228	18
Ventura	10,686	3,790	1,544	265	24	
Total	**432,963**	**131,089**	**55,840**	**27,583**	**6,242**	**771**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 13: Chronic Disease Prevalence Among LIHP Enrollees, by Number of Conditions, as of December 31, 2012

	Prevalence of Chronic Conditions					
Local LIHP	**0**	**1**	**2**	**3**	**4**	**5**
Alameda	71.9	16.2	7.8	3.6	0.5	
Contra Costa	60.8	19.3	11.4	6.8	1.5	0.1
CMSP	68.8	16.5	8.5	4.7	1.3	0.2

	Prevalence of Chronic Conditions					
Local LIHP	**0**	**1**	**2**	**3**	**4**	**5**
Kern	56.1	18.1	12.1	10.7	2.5	0.4
Los Angeles	74.5	20.1	4.9	0.5	0.0	0.0
Orange	42.0	31.5	13.6	9.8	2.6	0.4
Placer	98.0	1.4	0.5			
Riverside	58.6	19.4	12.7	7.7	1.4	0.2
San Bernardino	77.7	17.0	4.6	0.7	0.1	
Santa Clara	57.4	18.2	13.4	9.2	1.6	0.2
Santa Cruz	56.1	23.0	12.7	6.3	1.8	
San Diego	57.9	18.1	12.9	8.6	2.3	0.3
San Francisco	66.8	21.3	9.5	2.1	0.2	
San Mateo	60.1	17.2	12.0	8.8	1.6	0.1
Ventura	65.5	23.2	9.5	1.6	0.1	
Total	**66.2**	**20.0**	**8.5**	**4.2**	**1.0**	**0.1**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 14: Number of LIHP Enrollees with Chronic Disease, by Condition, as of December 31, 2012

	Number of LIHP Enrollees with Chronic Disease, by Condition				
Local LIHP	**Diabetes**	**Asthma/COPD**	**Dyslipidemia**	**Hypertension**	**CHF/CAD**
Alameda	6,248	2,505	7,176	12,383	1,140
Contra Costa	2,840	1,876	3,761	5,861	718
CMSP	8,188	8,552	12,472	17,992	2,876
Kern	2,039	1,097	2,535	4,002	531
Los Angeles	23,020	4,564	8,322	28,771	2,397
Orange	12,308	4,751	21,648	20,420	4,129
Placer	13	11	11	27	
Riverside	4,749	1,812	4,778	8,365	1,085
San Bernardino	3,073	787	1,296	2,999	609
Santa Clara	2,800	926	4,276	4,952	541
Santa Cruz	270	278	573	587	114
San Diego	7,752	3,674	9,668	13,604	2,704
San Francisco	1,811	852	1,626	3,672	564
San Mateo	1,961	914	3,605	3,740	356
Ventura	2,436	516	1,395	3,105	327
LIHP Total	**79,508**	**33,115**	**83,142**	**130,480**	**18,096**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 15: Chronic Disease Prevalence Among LIHP Enrollees, by Condition, as of December 31, 2012

	Prevalence of Chronic Disease, by Condition				
Local LIHP	**Diabetes**	**Asthma/COPD**	**Dyslipidemia**	**Hypertension**	**CHF/CAD**
Alameda	9.4	3.8	10.8	18.7	1.7
Contra Costa	13.1	8.6	17.3	27.0	3.3
CMSP	8.8	9.2	13.4	19.3	3.1
Kern	17.3	9.3	21.5	34.0	4.5
Los Angeles	10.8	2.1	3.9	13.5	1.1
Orange	19.6	7.6	34.5	32.5	6.6
Placer	0.5	0.5	0.5	1.1	
Riverside	17.0	6.5	17.1	30.0	3.9
San Bernardino	10.0	2.6	4.2	9.8	2.0
Santa Clara	16.6	5.5	25.3	29.3	3.2
Santa Cruz	11.1	11.4	23.5	24.1	4.7
San Diego	16.6	7.9	20.7	29.2	5.8
San Francisco	10.1	4.8	9.1	20.5	3.2
San Mateo	13.9	6.5	25.5	26.5	2.5
Ventura	14.9	3.2	8.6	19.0	2.0
LIHP Total	**12.3**	**5.1**	**12.9**	**20.2**	**2.8**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 16: Number of LIHP Enrollees with Diabetes, by Race/Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	832	1,506	1,954	1,596	327	33
Contra Costa	826	543	413	844	214	
CMSP	4,107	462	427	2,608	404	180
Kern	588	130	79	1,098	13	131
Los Angeles	1,845	2,239	1,439	12,241	5,256	
Orange	2,553	201	2,949	4,674	634	1,297
Placer						
Riverside	980	377	177	2,194	179	842

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
San Bernardino	1,359	361	132	979	19	223
Santa Clara	465	121	976	1,023	183	32
Santa Cruz	96			90		69
San Diego	1,663	646	533	2,581	289	2,040
San Francisco	245	431	610	449	65	11
San Mateo	395	35	581	790	27	133
Ventura	420	47	161	1,431	61	316
LIHP Total	**16,374**	**7,107**	**10,437**	**32,601**	**7,682**	**5,307**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 17: Diabetes Prevalence Among LIHP Enrollees, by Race/Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	6.8	7.6	12.1	15.1	11.1	0.8
Contra Costa	9.2	13.3	18.1	18.7	11.5	
CMSP	6.7	7.5	13.5	16.0	11.1	7.1
Kern	12.8	13.3	25.5	23.9	18.1	10.7
Los Angeles	5.9	4.1	12.8	14.7	16.0	
Orange	15.9	17.2	16.8	28.7	23.1	14.4
Placer						
Riverside	12.4	15.4	20.7	24.5	18.9	12.4
San Bernardino	9.3	7.4	12.0	13.3	9.4	8.5
Santa Clara	11.2	14.2	18.2	19.6	16.5	17.1
Santa Cruz	7.1			16.7		15.8
San Diego	11.5	14.1	19.8	25.9	15.3	15.7
San Francisco	4.4	10.5	14.3	15.4	7.3	7.9
San Mateo	9.3	16.0	18.1	15.8	14.8	10.7
Ventura	9.7	15.7	18.7	20.6	15.1	9.1
LIHP Total	**8.5**	**6.8**	**15.0**	**17.8**	**14.7**	**11.8**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 18: Number of LIHP Enrollees with Asthma/ COPD, by Race/ Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	581	1,038	379	349	129	29
Contra Costa	856	443	135	296	144	
CMSP	6,271	515	169	1,079	291	227
Kern	621	119	21	265		63
Los Angeles	854	1,211	186	1,496	817	
Orange	1,997	135	786	973	217	643
Placer					11	
Riverside	762	211	33	344	58	404
San Bernardino	436	135	13	139		57
Santa Clara	288	68	239	264	60	
Santa Cruz	168			42		59
San Diego	1,493	447	127	564	106	937
San Francisco	269	288	134	116	38	
San Mateo	336	27	150	293		98
Ventura	216		21	168	24	79
LIHP Total	**15,148**	**4,648**	**2,396**	**6,388**	**1,923**	**2,612**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 19: Asthma/ COPD Prevalence Among LIHP Enrollees, by Race/ Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	4.8	5.2	2.4	3.3	4.4	0.7
Contra Costa	9.5	10.8	5.9	6.6	7.7	
CMSP	10.2	8.4	5.3	6.6	8.0	8.9
Kern	13.5	12.2	6.8	5.8		5.2
Los Angeles	2.7	2.2	1.7	1.8	2.5	
Orange	12.5	11.6	4.5	6.0	7.9	7.2
Placer						
Riverside	9.6	8.6	3.9	3.8	6.1	6.0
San Bernardino	3.0	2.8	1.2	1.9		2.2
Santa Clara	6.9	8.0	4.5	5.1	5.4	
Santa Cruz	12.4			7.8		13.5

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
San Diego	10.3	9.8	4.7	5.7	5.6	7.2
San Francisco	4.8	7.0	3.1	4.0	4.3	
San Mateo	7.9	12.3	4.7	5.9		7.9
Ventura	5.0		2.4	2.4	5.9	2.3
LIHP Total	**7.9**	**4.4**	**3.4**	**3.5**	**3.7**	**5.8**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 20: Number of LIHP Enrollees with CAD/CHF, by Race/Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	280	369	255	161	65	
Contra Costa	321	138	98	102	59	
CMSP	1,984	166	109	435	103	79
Kern	256	55	17	173		27
Los Angeles	462	405	178	837	515	
Orange	1,392	109	787	1,082	249	510
Riverside	391	115	34	284	46	215
San Bernardino	298	91	22	129		66
Santa Clara	155	25	147	169	35	
Santa Cruz	72			17		20
San Diego	934	247	130	550	106	737
San Francisco	156	151	134	89	28	
San Mateo	135		98	85		23
Ventura	121	12	22	104	12	56
LIHP Total	**6,957**	**1,894**	**2,031**	**4,218**	**1,237**	**1,759**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 21: CAD/CHF Prevalence Among LIHP Enrollees, by Race/Ethnicity, as of June 30, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	2.3	1.9	1.6	1.5	2.2	
Contra Costa	3.6	3.4	4.3	2.3	3.2	
CMSP	3.2	2.7	3.4	2.7	2.8	3.1
Kern	5.6	5.6	5.5	3.8		2.2
Los Angeles	1.5	0.7	1.6	1.0	1.6	
Orange	8.7	9.3	4.5	6.6	9.1	5.7
Riverside						
San Bernardino	4.9	4.7	4.0	3.2	4.9	3.2
Santa Clara	2.0	1.9	2.0	1.8		2.5
Santa Cruz	3.7	2.9	2.7	3.2	3.2	
San Diego	5.3			3.2		4.6
San Francisco	6.4	5.4	4.8	5.5	5.6	5.7
San Mateo	2.8	3.7	3.1	3.0	3.2	
Ventura	3.2		3.1	1.7		1.8
Alameda	2.8	4.0	2.6	1.5	3.0	1.6
LIHP Total	**3.6**	**1.8**	**2.9**	**2.3**	**2.4**	**3.9**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 22: Number of LIHP Enrollees with Dyslipidemia, by Race/Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	1,099	1,006	3,180	1,541	329	21
Contra Costa	1,271	659	632	912	286	
CMSP	7,740	500	580	2,940	404	308
Kern	931	142	94	1,208	13	147
Los Angeles	1,023	586	784	3,994	1,935	
Orange	4,305	288	8,034	5,996	1,076	1,949
Placer						
Riverside	1,250	323	190	1,937	201	877
San Bernardino	614	128	100	349		98
Santa Clara	735	141	2,027	1,078	260	35
Santa Cruz	297			120		136

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
San Diego	2,430	667	866	2,645	468	2,592
San Francisco	297	159	768	341	55	
San Mateo	915	50	1,067	1,342	37	194
Ventura	389	18	122	682	32	152
LIHP Total	**23,296**	**4,675**	**18,454**	**25,086**	**5,115**	**6,516**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 23: Dyslipidemia Prevalence Among LIHP Enrollees, by Race/Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	9.0	5.0	19.7	14.6	11.1	0.5
Contra Costa	14.2	16.1	27.8	20.2	15.4	
CMSP	12.6	8.1	18.3	18.0	11.1	12.1
Kern	20.2	14.6	30.3	26.3	18.1	12.1
Los Angeles	3.3	1.1	7.0	4.8	5.9	
Orange	26.9	24.7	45.8	36.8	39.2	21.7
Placer						
Riverside	15.8	13.2	22.2	21.7	21.3	13.0
San Bernardino	4.2	2.6	9.1	4.7		3.7
Santa Clara	17.7	16.5	37.9	20.6	23.4	18.7
Santa Cruz	21.9			22.3		31.1
San Diego	16.7	14.6	32.1	26.6	24.7	19.9
San Francisco	5.3	3.9	18.0	11.7	6.2	
San Mateo	21.4	22.8	33.3	26.8	20.3	15.6
Ventura	9.0	6.0	14.2	9.8	7.9	4.4
LIHP Total	**12.1**	**4.4**	**26.5**	**13.7**	**9.8**	**14.5**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 24: Number of LIHP Enrollees with Hypertension, by Race/ Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	1,890	4,023	3,849	2,047	499	75
Contra Costa	2,115	1,346	749	1,229	420	
CMSP	11,092	1,240	762	3,773	686	439
Kern	1,565	361	134	1,661	29	252
Los Angeles	3,176	5,280	2,342	11,705	6,268	
Orange	4,993	437	6,212	5,855	862	2,061
Placer					24	
Riverside	2,275	888	304	2,980	327	1,591
San Bernardino	1,303	551	146	759	21	219
Santa Clara	1,032	276	1,898	1,416	297	33
Santa Cruz	295	22		119		140
San Diego	3,833	1,403	890	3,241	545	3,692
San Francisco	679	1,103	1,091	657	119	23
San Mateo	961	80	1,072	1,267	42	318
Ventura	820	88	254	1,507	68	368
LIHP Total	**36,029**	**17,098**	**19,711**	**38,219**	**10,210**	**9,213**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 25: Hypertension Prevalence Among LIHP Enrollees, by Race/ Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	15.5	20.2	23.9	19.4	16.9	1.7
Contra Costa	23.6	32.9	32.9	27.3	22.6	
CMSP	18.0	20.2	24.0	23.1	18.8	17.2
Kern	34.0	37.1	43.2	36.2	40.3	20.7
Los Angeles	10.2	9.6	20.8	14.0	19.1	
Orange	31.2	37.5	35.4	35.9	31.4	22.9
Placer					1.1	
Riverside	28.7	36.3	35.5	33.3	34.6	23.5
San Bernardino	8.9	11.3	13.2	10.3	10.4	8.3
Santa Clara	24.8	32.4	35.5	27.1	26.7	17.6
Santa Cruz	21.8	39.3		22.1		32.0

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
San Diego	26.4	30.7	33.0	32.6	28.8	28.4
San Francisco	12.1	27.0	25.6	22.5	13.4	16.4
San Mateo	22.5	36.5	33.4	25.3	23.1	25.5
Ventura	19.0	29.4	29.5	21.7	16.8	10.6
LIHP Total	**18.7**	**16.3**	**28.3**	**20.8**	**19.5**	**20.5**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 26: Volume and Rate of Emergency Room Visits (number of emergency room visits per 1,000 active enrollees per month), by Quarter, as of March 31, 2012

	Total Emergency Room Visits			Rate of Emergency Room Visits per 1,000 Active Enrollees		
Local LIHP	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**
Alameda	4,193	4,409	5,188	253.4	213.4	213.6
Contra Costa	2,981	2,911	3,251	282.4	254.7	275.1
Kern	1,058	1,052	1,038	219.1	211.3	221.4
Los Angeles	8,046	8,900	10,718	108.2	108.2	108.2
Orange	6,807	6,326	5,917	236.2	201.1	190.5
San Diego	3,013	3,626	4,326	243.1	222.2	222.2
San Francisco	1,456	1,613	1,727	174.2	175.2	182.3
San Mateo	1,768	1,676	1,748	289.9	257.9	267.1
Santa Clara	497	482	501	91.5	77.0	70.0
Ventura	627	715	831	95.5	97.0	104.4
LIHP Total	**30,446**	**31,710**	**35,245**	**175.0**	**146.6**	**141.0**

Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 27: Volume and Rate of Outpatient Services (number of outpatient services per 1,000 active enrollees per month), by Quarter, as of March 31, 2012

	Total Outpatient Services			Rate of Outpatient Services per 1,000 Active Enrollees		
Local LIHP	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**
Alameda	50,614	49,968	51,064	3,059.3	2,418.5	2,102.4
Contra Costa	21,317	21,787	22,824	2,019.4	1,906.0	1,931.6
Kern	11,454	8,790	8,644	2,372.4	1,765.3	1,843.9
Los Angeles	146,400	159,960	181,318	1,968.1	1,565.5	1,421.4
Orange	56,973	57,652	46,369	1,976.7	1,832.5	1,493.1

San Diego	29,472	37,971	47,361	975.4	942.5	1,035.0
San Francisco	32,992	33,134	34,608	3,527.0	4,125.5	5,000.1
San Mateo	4,898	3,125	3,136	5,408.8	5,098.1	5,287.7
Santa Clara	12,088	15,378	20,147	901.9	499.1	437.9
Ventura	15,619	18,022	20,880	2,378.9	2,444.9	2624.0
LIHP Total	**381,827**	**405,787**	**436,351**	**2,194.7**	**1,875.5**	**1,745.3**

Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 28: Volume and Rate of Hospitalizations (number of hospitalizations per 1,000 active enrollees per month), by Quarter, as of March 31, 2012

	Total Hospitalizations			Rate of Hospitalizations per 1,000 Active Enrollees		
Local LIHP	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**
Alameda	408	425	508	24.7	20.6	20.9
Contra Costa	657	595	537	62.2	52.1	45.4
Kern	255	218	262	52.8	43.8	55.9
Los Angeles	1,612	1,586	1,658	21.7	15.5	13.0
Orange	2,436	2,315	2,073	84.5	73.6	66.8
San Diego	1,612	1,737	1,799	130.0	106.4	92.4
San Francisco	428	423	474	51.2	46.0	50.0
San Mateo	174	155	166	28.5	23.8	25.4
Santa Clara	124	131	204	22.8	20.9	28.5
Ventura	217	217	238	33.1	29.4	29.9
LIHP Total	**7,923**	**7,802**	**7,919**	**45.5**	**36.1**	**31.7**

Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 29: Volume and Rate of Inpatient Days (number of inpatient days per 1,000 active enrollees per month), by Quarter, as of March 31, 2012

	Total Inpatient Days			Rate of Inpatient Days per 1,000 Active Enrollees		
Local LIHP	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**
Alameda	1,726	2,237	2,296	104.3	108.3	94.5
Contra Costa	1,730	1,745	1,583	163.9	152.7	134.0
Kern	1,047	976	1,331	216.9	196.0	283.9
Los Angeles	6,298	6,459	6,373	84.7	63.2	50.0
Orange	11,347	11,192	9,634	393.7	355.7	310.2
San Diego	8,203	8,598	9,081	661.9	527.0	466.5
San Francisco	1,708	1,386	1,470	207.5	153.5	163.1
San Mateo	365	334	480	59.8	51.4	73.3
Santa Clara	153	192	207	28.2	30.7	28.9
Ventura	912	851	870	138.9	115.4	109.3
LIHP Total	**33,489**	**33,970**	**33,325**	**192.4**	**157.0**	**133.3**

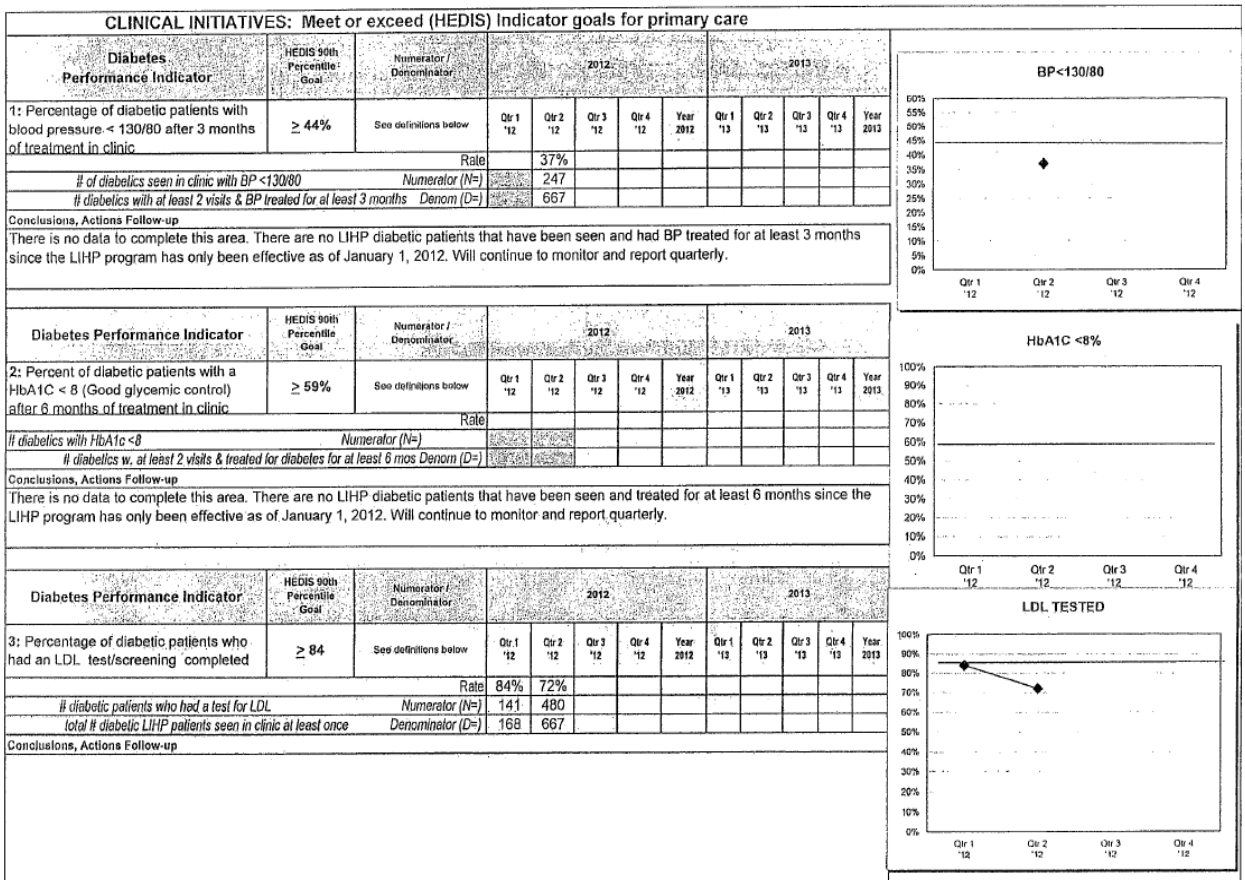
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 30: Proportion of Active Enrollees Who Used Behavioral Health Services and Proportion Who Used Behavioral *and* Medical Health Services, by Quarter, as of March 31, 2012

	"Active Users" of Behavioral Health Services			"Active Users" of Behavioral and Medical Health Services		
Local LIHP	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**
Alameda	2.3%	3.0%	2.7%	1.1%	1.3%	1.2%
Contra Costa	5.9%	6.0%	6.4%	5.5%	5.5%	6.0%
Kern	0.2%	0.2%	0.1%	0.2%	0.1%	0.1%
Los Angeles	0.3%	0.2%	0.3%	0.2%	0.2%	0.2%

Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 31: Riverside County LIHP Diabetes Performance Indicators, Quarter 2, Fiscal Year 2011-12



CLINICAL INITIATIVES: Meet or exceed (HEDIS) Indicator goals for primary care

Diabetes Performance Indicator	HEDIS 90th Percentile Goal	Numerator / Denominator	2012 Qtr 1 '12	2012 Qtr 2 '12	2012 Qtr 3 '12	2012 Qtr 4 '12	2012 Year 2012	2013 Qtr 1 '13	2013 Qtr 2 '13	2013 Qtr 3 '13	2013 Qtr 4 '13	2013 Year 2013
1: Percentage of diabetic patients with blood pressure < 130/80 after 3 months of treatment in clinic	≥ 44%	See definitions below										
		Rate		37%								
		# of diabetics seen in clinic with BP <130/80 — Numerator (N=)		247								
		# diabetics with at least 2 visits & BP treated for at least 3 months — Denom (D=)		667								

Conclusions, Actions Follow-up

There is no data to complete this area. There are no LIHP diabetic patients that have been seen and had BP treated for at least 3 months since the LIHP program has only been effective as of January 1, 2012. Will continue to monitor and report quarterly.

BP<130/80

Diabetes Performance Indicator	HEDIS 90th Percentile Goal	Numerator / Denominator	2012 Qtr 1 '12	2012 Qtr 2 '12	2012 Qtr 3 '12	2012 Qtr 4 '12	2012 Year 2012	2013 Qtr 1 '13	2013 Qtr 2 '13	2013 Qtr 3 '13	2013 Qtr 4 '13	2013 Year 2013
2: Percent of diabetic patients with a HbA1C < 8 (Good glycemic control) after 6 months of treatment in clinic	≥ 59%	See definitions below										
		Rate										
		# diabetics with HbA1c <8 — Numerator (N=)										
		# diabetics w. at least 2 visits & treated for diabetes for at least 6 mos — Denom (D=)										

Conclusions, Actions Follow-up

There is no data to complete this area. There are no LIHP diabetic patients that have been seen and treated for at least 6 months since the LIHP program has only been effective as of January 1, 2012. Will continue to monitor and report quarterly.

HbA1C <8%

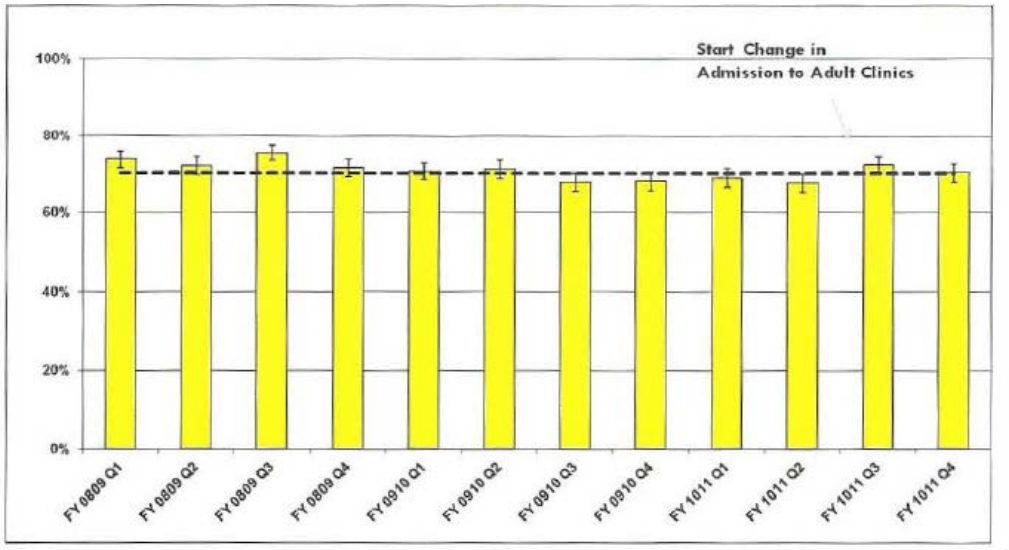
Diabetes Performance Indicator	HEDIS 90th Percentile Goal	Numerator / Denominator	2012 Qtr 1 '12	2012 Qtr 2 '12	2012 Qtr 3 '12	2012 Qtr 4 '12	2012 Year 2012	2013 Qtr 1 '13	2013 Qtr 2 '13	2013 Qtr 3 '13	2013 Qtr 4 '13	2013 Year 2013
3: Percentage of diabetic patients who had an LDL test/screening completed	≥ 84	See definitions below										
		Rate	84%	72%								
		# diabetic patients who had a test for LDL — Numerator (N=)	141	480								
		total # diabetic LIHP patients seen in clinic at least once — Denominator (D=)	168	667								

Conclusions, Actions Follow-up

LDL TESTED

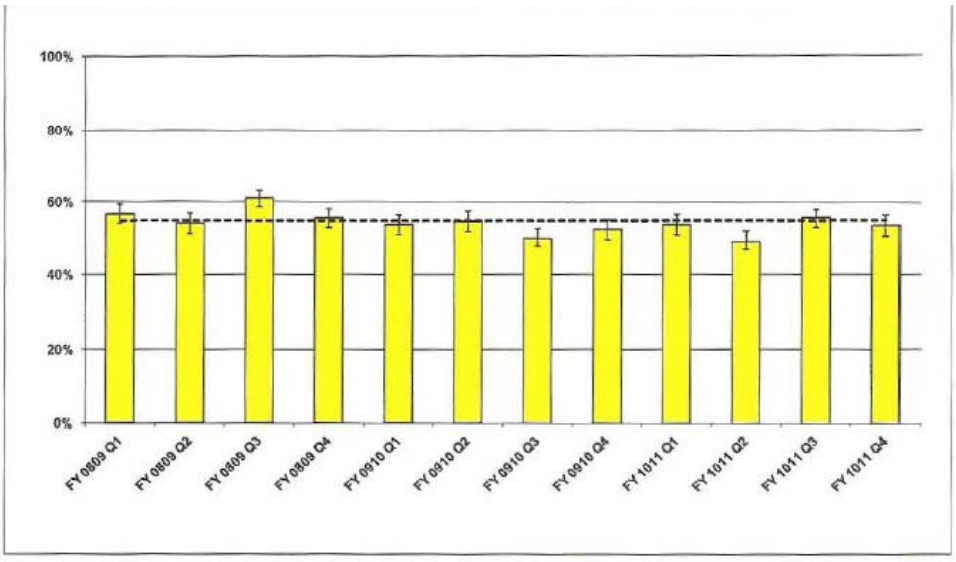
Notes: Riverside County collects data at the clinic level and has similarly styled reports for all health centers participating in LIHP. Indicators for Riverside County Health Care Centers are offered here as an example.
Source: Voluntary LIHP reporting.

Appendix B, Exhibit 32: San Mateo County Behavioral Health Outpatient Initiation Quality Performance Relative to County-Established Benchmark, Fiscal Years 2008/09-2010/11



Notes: Initiation refers to a client receiving a second follow-up visit within 14 days of an initial treatment visit. The dotted black line refers to the county-established 70 percent benchmark. All county beneficiaries are included because San Mateo does not collect quality data for individual programs.
Source: Voluntary LIHP reporting.

Appendix B, Exhibit 33: San Mateo County Behavioral Health Outpatient Engagement Quality Performance Relative to County-Established Benchmark, Fiscal Years 2008/09-2010/11



Notes: Engagement refers to a client's receiving third and fourth follow-up visits within 30 days of a second treatment visit. The dotted black line refers to the county-established 55 percent benchmark. All county beneficiaries are included because San Mateo does not collect quality data for individual programs.
Source: Voluntary LIHP reporting.

Appendix B, Exhibit 34: San Diego County LIHP Quality-of-Care Benchmark Goals, Quarter 4, Fiscal Year 2011-12

ALLHEART Age 50+ Focus on CV Risk	Right Care Initiative	National Medicaid Benchmark (90th percentile goal)	National Threshold (50th percentile) NCQA Medicaid	HEDIS/UDS Measure	LIHP Benchmark Goals Q4 F11-12
20% or less	19%	**29% or** less	43%	**Comprehensive Diabetes Care: HbA1cPoor Control (>9%)** ***(a lower rate indicates better performance)***	**29% or less**
65%	52%		**34.6% (For DM 2010 Medicaid HMO)**	**Comprehensive Diabetes Care: Cholesterol Management**	**35%**
65%	N/A		**60.4% (For DM 2010 Medicaid HMO)**	**Comprehensive Diabetes Care: Controlling High Blood Pressure**	**60%**
65%	70%	**64%**	54%	**Controlling High Blood Pressure**	**64%**
	70%	87%	86%	**Cholesterol Management for Patients with Cardiovascular Conditions**	**70%**
50% Meaningful Use Goal	N/A	76%	**68%**	**Medical Assistance with Smoking Cessation: Advising Smokers to Quit**	**68%**
N/A	N/A	N/A (Medicare)	**78%**	**Persistence of Beta-Blocker Treatment After a Heart Attack**	**78%**
N/A	N/A	91%	**85% (Medicaid 2010 for >11y/o)**	**Use of Appropriate Medication for People with Asthma**	**85%**
N/A	N/A	64%	**43% (44.6%2010 Medicaid HMO)**	**Follow-Up After Hospitalization for Mental Illness — 7-Day Rate**	**43%**

Source: Voluntary LIHP reporting.

Appendix B, Exhibit 35: San Mateo County Diabetes Care Quality Metrics, Quarters 1-2, Fiscal Year 2011-12

	Quarter 1	Quarter 2
Total Patients with Diabetes, Ages 18-75	4,244	4,301
Total Patients with Diabetes, Ages 41+	3,840	3,886
A1c<8	1,990	2,039
% with A1c<8	47%	47%
LDL<100	2,179	2,253
% with LDL< 100	51%	52%
BP<140/90	3,187	3,063
% With BP<140/90	75%	71%
BP<130/80	2,246	2,112
% with BP<130/80	53%	49%
No Tobacco	3,699	3,794
% with No Tobacco	87%	88%
ASA for Age Above 41	2,873	2,989
% Above Age 41 on ASA	75%	77%
DSRIP Perfect	782	754
% DSRIP Perfect	18%	18%
Internal Perfect	574	538
% Internal Perfect	14%	13%

Source: Voluntary LIHP reporting.

Appendix B, Exhibit 36: San Mateo County Preventive Care Quality Metrics, Fiscal Year 2011-12

Female Patients 50-74	Patients with Mammogram in Last 24 Months	Percent with Mammogram	Patients over Age 50	Patients over Age 50 with Flu Shot	Percent with Flu Shot
5,433	3,393	62%	10,166	4,130	41%

Source: Voluntary LIHP reporting.

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The views expressed in this report are those of the authors and do not necessarily represent the UCLA Center for Health Policy Research, the Regents of the University of California, or collaborating organizations or funders.

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