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**Los Angeles County
Board of Supervisors**

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"The mission of the Los Angeles County Health Agency is to improve health and wellness across Los Angeles County through effective, integrated, comprehensive, culturally appropriate services, programs, and policies that promote healthy people living in healthy communities."

TO: Supervisor Janice Hahn, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Katherine Barger

FROM: Fred Leaf
Interim Director, Health Agency

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SUBJECT: **ENHANCING THE MY HEALTH LA PROGRAM**

On November 20, 2018, the Los Angeles County Board of Supervisors (Board) approved a motion instructing the Directors of Public Health (DPH) and Mental Health (DMH) to report back to the Board with 1) an assessment of the current utilization of Substance Use Disorder (SUD) treatment services by My Health LA (MHLA) participants and recommendations for how to improve utilization rates, and 2) recommendations for funding options to support and expand on-site mental health services being provided to the mild-to-moderate MHLA population in the primary care setting.

Background

On October 1, 2014, DHS formally launched the MHLA program with the goal of increasing access to primary health care services for low income, uninsured residents of Los Angeles County. As of the date of this report, approximately 145,000 individuals are enrolled in the program.

On November 20, 2018, the Board approved numerous changes to the MHLA agreement with Community Partner (CP) clinics, including a new requirement that CP clinics, as a condition of receiving Monthly Grant Funding (MGF) payment, provide at least one visit to a MHLA



participant within a prior twenty-four (24) month period. During contract negotiations, CPs expressed their desire to be reimbursed for the mental health services that they provide to MHLA patients with mild-to-moderate mental health issues, and for these services to be considered a visit for the purposes of MGF payment.

MHLA Behavioral Health Workgroup

In January 2018, in response to better understand obstacles to behavioral health access for MHLA participants, MHLA created and chaired a behavioral health workgroup. This workgroup included representatives of key stakeholders including DMH, DPH's Substance Abuse Prevention and Control (SAPC) Division, the Community Clinic Association of Los Angeles County (CCALAC), Community Health Councils (CHC), California Pan-Ethnic Health Network (CPEHN), California Immigrant Policy Center (CIPC), Maternal and Child Health Access (MCHA), Special Services for Groups (SSG) and Asian Americans Advancing Justice – LA (AAAJ – LA).

The workgroup met monthly through July 2018 with the goal of understanding behavioral health care access gaps and opportunities, and to better understand and create access points for mental health and SUD treatment services for the uninsured. The workgroup developed communication materials to increase both clinic and patient awareness of the availability of SUD treatment and mental health services for MHLA participants. The MHLA program also made changes to its website and the MHLA participant handbook to highlight the availability of mental health and SUD treatment services under the MHLA program, including how to access those services.

One of the highest priority issues identified by the behavioral health workgroup related to SUD treatment access was the need to better educate CP clinics and MHLA participants about the availability of no cost, no fee SUD treatment services through DPH's network of contracted providers. To this end, the workgroup collaboratively developed communication materials for patients, advocacy groups and enrollers to help spread the word about the availability of these services and how to access them.

Similarly, one key issue identified by the workgroup related to mental health access was the need to better support MHLA CPs who provide mental health care services for the mild-to-moderate mental health population in the primary care setting. It was recognized that DMH will generally prioritize Severe Mental Illness (SMI) populations to receive mental health services at their directly operated and contracted clinics. Mild-to-moderate mental health patients without health insurance are more likely to obtain treatment at the CP clinic, if at all. Currently, there is no data collected to determine the volume or type of mental health services provided to MHLA patients at either DMH or the CPs.

Sunset for the behavioral health workgroup was July 2018.

DMH Recommendations: Expanding Access to Mental Health for MHLA and DHS Patients in a Primary Care Setting

Although DMH is statutorily required to provide mental health treatment to those with SMI, it is also committed to providing quality mental health services to Los Angeles County's most vulnerable residents. In line with this commitment, DMH employs a variety of strategies to develop new as well as expand existing platforms for those who need care. To this end, and in accordance with the Board's efforts to ensure access to care for MHLA uninsured patients in the primary care setting, DMH proposes to fund and support services focused on prolonged engagement to manage risk factors associated with the onset of serious mental illness of low income, MHLA uninsured patients initially at CP clinics using a mental health prevention services approach. Nonetheless, the most sustainable solution to this unmet need is legislation that provides full scope Medi-Cal benefits to individuals regardless of immigration status. Such legislation (Assembly Bill 4) is under consideration as part of the 2019-2020 legislative session.

Using Mental Health Services Act (MHSA) funding, DMH proposes to support the provision of prevention and prolonged engagement services in a phased approach first to MHLA, and by July 1, 2020, to DHS-uninsured patients. DMH will accomplish this through the creation of a supplemental behavioral health capitated rate for uninsured clients served at DHS and CP sites. DMH remains committed to assisting DHS to care for the residually uninsured through this long-term plan.

The DMH supplemental rate will be developed based on the approximate percentage of MHLA (or DHS) patients that are likely to utilize mental health services through MHLA. Upon receiving this supplemental rate for services provided to this population, MHLA and/or DHS clinics will be expected to collect patient encounter data that will identify client demographics and behavioral health Common Procedural Technology (CPT) codes for mental health services. Behavioral health services that meet MHSA requirements must utilize outcome measures selected by DMH. These services can include (but are not limited to):

- Initial Engagement and Mental Health Screening
- Linkage to non-specialty and specialty mental health services as needed
- Psychoeducation
- Wellbeing workshops and individual support services including but not limited to the following topics:
 - Resiliency development
 - Social and emotional skill development
 - Healthy coping skills
 - Stress reduction
 - Mitigating the impacts of trauma
 - Prevention skills for depression and anxiety

- Emotional wellbeing for underserved or special populations (disability, LGBTQ2SI, caretakers of young children, disabled, and older adults)
- Mental health first aid
- Group-based education and skill building

Upon the development of a payment rate, DMH intends to work collaboratively with DHS to develop and execute a Memorandum of Understanding (MOU) outlining the specific roles and responsibilities for both Departments and the MHLA CPs towards the goal of ensuring greater access to mental health care for the uninsured. DMH will either directly train or provide funding for training for the services listed above. DMH intends to transfer funding to DHS in accordance with the determined supplemental rate for the reimbursement of services provided, as outlined in the executed MOU.

DMH intends to suspend additional strategies for serving this population to allow enough time to implement and assess the outcomes of this plan. DMH recently closed a pending open and competitive solicitation process to select Federally Qualified Health Centers (FQHCs) in favor of this new approach. This new strategy will assist DMH in gathering needed information to continuously improve access to care and to further define the services needed from DHS clinics and CPs to serve specific client populations in primary care settings. This expanded vision will allow DMH to more effectively leverage resources, form stronger collaborative relationships with other County departments and engage diverse community stakeholders in public private partnerships.

The proposed timeline for these actions is as follows:

1. DMH and DHS to create a workgroup to develop the supplemental mental health MGF rate based on data provided by the community clinics.
 - First meeting of the workgroup to convene as soon as possible in May
2. DMH in conjunction with other stakeholders to develop a list of procedure codes to be used by CPs to submit data to MHLA on mental health utilization.
 - Codes will be determined by the last week of June (This means mental health procedure codes to be submitted to the MHLA program have been determined by all applicable parties).
3. Inter-departmental Agency MOU.
 - DMH and DHS aims to complete an MOU related to transfer of funds and including all other required provisions and the development of an established budget for both CP and DHS uninsured patients by July.
4. DMH will use the first six months as a guide to create a successful fiscal and programmatic approach to serving the MHLA population that will serve as the basis for the platform to initiate services to DHS patients by July 1, 2020.

DPH SAPC Recommendations: Improving Substance Use Disorder (SUD) Treatment Utilization by MHLA patients

SUD treatment services have been covered by the MHLA program since July 1, 2016. In the first year that SUD treatment services were made available to MHLA participants, 59 patients accessed these services. However, since its inception, the program experienced a general increase in admissions, with 353 MHLA patients admitted to treatment in FY 17-18 and 283 patients for the 5-month period in FY 18-19 from July 1, 2018 through November 2018. This increase is largely due to ongoing outreach efforts by the MHLA program, SAPC and CP clinics; improved ability to capture MHLA patients through SAPC's electronic records system (known as Sage); and, the establishment of payment incentives that encourage SAPC-contracted providers to identify and facilitate enrollment for MHLA eligible patients accessing SUD treatment.

In an effort to further increase SUD service utilization among MHLA patients who need treatment, DPH SAPC recommends the following additional strategies:

1. Build upon CCALAC's SPA-based summits that offer a variety of trainings throughout the year, by providing opportunities to focus on available SUD treatment services, Medications for Addiction Treatment (MAT) on the MHLA drug formulary, and the availability of patient and enroller outreach materials related to behavioral health access through the MHLA program.
2. Increase training and support for CPs to prescribe MAT to MHLA participants. MAT such as Naloxone, Naltrexone and Disulfiram are included on the MHLA drug formulary, but are rarely prescribed by CPs. They provided only 13 MAT prescriptions between July 1, 2016 and December 31, 2018.
3. Increase access to MAT for those with opioid use disorder by creating incentives for CP prescribers to attend trainings for X-Waiver certification to dispense Buprenorphine and Buprenorphine-Naloxone medications to MHLA participants.
4. Implement a pilot program through which SAPC-contracted treatment providers are either partnered with a CP or CPs and given the ability to enroll eligible uninsured patients directly into MHLA through the One-E-App enrollment system (rather than referring patients to the CP for enrollment) or given the ability to work with DHS to empanel the patient to a DHS facility (depending on patient choice). This creates both the opportunity to more directly connect eligible patients to health care services with a CP or DHS and ensures identification of uninsured patients accessing SUD treatment services.
5. Create a page on the MHLA website in Spanish and English that includes information about the availability of behavioral health services and how to access them, including information on the Substance Abuse Services Helpline (SASH), and a link to DPH-SAPCs online provider directory—Service and Bed Availability

Tool (SBAT)—that assists seekers in locating SAPC-contracted SUD treatment providers based on various preferences (e.g. geographical, language accessibility, population, etc.) as well as information about how patients can seek help with their mental health or SUD treatment needs.

6. Explore the feasibility of providing SUD treatment services at identified MHLA clinic locations through SAPC's Field Based Services (FBS) benefit. FBS is a mobile service delivery method for outpatient services, case management, and recovery support services for patients with established medical necessity. FBS is intended to serve populations that have historically been difficult to serve by providing opportunities for patients experiencing challenges with traditional treatment settings, such as physical disabilities, geographic limitations, employment conflicts and transportation limitations, to access treatment in a more flexible and patient-centered way. Utilization of FBS is based on demonstrated patient need for services outside of a DMC-certified site. MHLA patients have historically been difficult to engage in SUD services, therefore, the availability of these services at the primary care sites may increase the utilization of SUD treatment services.
7. Explore the feasibility of including MHLA contracted mobile units at designated SAPC-contracted residential provider locations. Currently, SAPC has seen success in providing co-located services through its Community Engagement and Navigation Services (CENS) contractors. This model would be a "reverse co-location". MHLA clinics would provide primary care services through their approved mobile units. Providing this service could improve connection and care coordination between the SUD provider and the MHLA primary care provider, increasing lengths of stay in SUD treatment and improving health outcomes of MHLA eligible/enrolled patients.

Currently, SUD residential providers are restricted from providing primary care services to patients while they reside in the facility. While an Incidental Medical Service waiver allows these facilities to provide medical services, these services must be related directly to SUD treatment, as is the case with MAT.

Next Steps

In conclusion, DHS, DPH SAPC, DMH and CP clinics are looking forward to working collaboratively in the coming months to expand access to behavioral health services for MHLA and DHS uninsured populations. Some of the work related to these recommendations have already begun. For example, MHLA and DPH SAPC are developing a training schedule to begin within the next six (6) months that will offer MHLA CP providers X-Waiver certification to dispense Buprenorphine and Buprenorphine-Naloxone medications to MHLA participants. The recommended changes to the MHLA website and MHLA communication materials have largely already been implemented.

DHS, DPH SAPC, DMH and the CP clinics have already met to discuss the recommendations outlined in this report, and will soon establish a series of workgroups to further operationalize these proposals. DPH SAPC and the CP clinics had a fruitful brainstorming session on how to improve connections and referral relationships between SAPC contracted and MHLA clinic providers. The MHLA team have begun coordinating with DMH on how to most efficiently use MHSA dollars to support engagement, mental health screening, linkage to mental health services, wellbeing workshops and psychoeducation for uninsured patients at MHLA and DHS clinics. A series of additional workgroups will soon be convened with the community clinics to tackle the complex issues related to implementing a behavioral health capitated rate for uninsured clients. DMH intends to work collaboratively with DHS to develop and execute a MOU that will outline the specific roles and responsibilities for DHS, DMH and the CP clinics towards our shared goal of increasing access to behavioral health care for this high need population.

If you have any questions or need additional information, please let us know.

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c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
Health Services
Mental Health
Public Health