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# Health Agency

July 11, 2016

**Los Angeles County Board of Supervisors**

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First District

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Second District

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Third District

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Director, Health Agency

**Robin Kay, Ph.D.**
Interim Director, Department of Mental Health

**Cynthia A Harding, M.P.H.**
Interim Director, Department of Public Health

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

*"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 Hilda L. Solis, Chair
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **MEDI-CAL FUNDED SERVICES FOR PEOPLE EXPERIENCING HOMELESSNESS**

On February 9, 2016, your Board directed the Health Agency, in collaboration with the Chief Executive Officer and the Los Angeles Homeless Services Authority, to report back to the Board of Supervisors on a quarterly basis for one year regarding the following items: 1) Descriptions of health, mental health, substance abuse treatment, housing and/or social service programs targeted to people experiencing homelessness, or who have experienced homelessness in the past, for which the County is drawing down Medi-Cal support; 2) A plan for increasing access to mental health and substance abuse treatment services for people experiencing homelessness; 3) Opportunities to seek Medi-Cal reimbursement for outreach, bridge housing, housing-related activities, and rapid re-housing services included in the Homeless Initiative strategies, as well as opportunities to expand case management and integrated services available to homeless and formerly homeless individuals; and 4) An analysis of successful models in other states for drawing down Medicaid reimbursement to fund services, bridge housing, or other programs for people experiencing homelessness. In addition, your Board directed that the Los Angeles Community Development Commission (LACDC) work with the Health Agency to create an inventory of all planned permanent supportive housing developments.

## Current Programs and Services

The Department of Health Services (DHS), Department of Mental Health (DMH), and Substance Abuse Prevention and Control (SAPC) have a variety of programs that serve people who are homeless. Medi-Cal beneficiaries who are homeless are served at all levels of the health, mental health, and substance use disorder service delivery systems. DHS and SAPC do not have homeless programs that are exclusively funded by Medi-Cal; however, DMH does.

Substance Use Treatment Services

SAPC claims data indicate that 18 percent of SAPC patients were homeless in FY 2014-15. SAPC does not have any programs that specifically focus on the homeless; however, a number of SAPC's contracted agencies primarily serve people who are homeless. These agencies are funded through a variety of funding sources and contracts. They receive Drug Medi-Cal (DMC) funds if they are DMC-certified, and if not, they receive non-DMC funds (i.e., Substance Abuse Prevention and Treatment [SAPT] Block Grant, AB 109, General Relief etc.), depending on the service provider contracts they hold. The particular contract that agencies use to fund services for a specific patient depends on the patient's characteristics. For example, someone who is homeless may meet criteria for AB 109 funding or General Relief. Approximately 2 percent of total DMC services billed to the State by LA County ($786,503 of $42,384,742) in FY 2014-2015 were for services for people who were homeless. This low percentage of services billed to DMC is because (a) the existing DMC benefit package is limited and poorly reimbursed, so many providers are not able to provide the services at the DMC rates; (b) many homeless clients are not currently eligible for residential services through the DMC waiver and therefore cannot access that often needed service and, (c) many of the providers serving the homeless are not currently DMC-certified so even if they provided a service that is DMC billable, they cannot bill Medicaid.

Health Services

DHS provides primary care, specialty care, emergency services, and inpatient services to patients, including homeless patients, for which it draws down Medi-Cal dollars. These services are provided to all Medi-Cal beneficiaries and are not exclusive to homeless clients. In November 2014, DHS opened the Star Clinic which primarily serves homeless and formerly homeless patients. DHS provides supportive housing to individuals with complex health and/or behavioral health conditions, high utilizers of public services, and other vulnerable populations through its Housing for Health (HFH) program. HFH provides clients with interim housing (such as recuperative care), rental subsidies through the Flexible Housing Subsidy Pool through a contract with Brilliant Corners, and intensive case management services through contracts with community-based homeless services providers. HFH is not currently drawing down Medi-Cal funding, but is pursuing opportunities through the Whole Person Care (WPC) Pilot that will allow for additional services to be created through Medicaid revenue via the 1115 waiver. DHS is also looking closely at the opportunities to begin using other currently un-utilized or under-utilized revenue sources of Medi-Cal Targeted Case Management (TCM) and Medi-Cal Administrative Activities (MAA). Although DHS has traditionally not used these funding sources due to cumbersome administrative requirements that have historically outweighed the benefit of the revenue, with the WPC Pilot opportunity, DHS is assessing the needs to build the infrastructure to potentially do more TCM and MAA, in the future. Some additional details on these programs are described in more detail in the next section.

Mental Health Services

DMH does operate some programs that receive Medi-Cal funding that focus on serving people who are homeless. These include the Integrated Mobile Health Teams, Multidisciplinary Integrated Teams, SB 82 Mobile Triage Teams, Project 50 replicas and HOME teams. In addition to Medi-Cal, these programs have a variety of funding sources including Projects for Assistance in Transition from Homelessness (PATH), Homeless Prevention Initiative, and Mental Health Services Act (MHSA). Please see Attachment I for a list of DMH programs that serve people who are homeless, amount and percentage of Medi-Cal funding, and number of homeless clients served.

**Increasing Medi-Cal Reimbursement to Expand Programs and Services**

In evaluating the information regarding funding sources, it is important to note that there are local funding requirements associated with the provision of many Medi-Cal services. More specifically, federal funds, known as federal financial participation (FFP) are only available to reimburse expenditures of state or local funds.

- For the traditional Medi-Cal population, which includes a portion of the homeless because they qualify as disabled, the current federal matching percentage is 50%, which means that for every dollar of state or local expenditures, the federal government will reimburse 50 cents.
- For the Medicaid Coverage Expansion population created by the Affordable Care Act, there is presently no state or local funding required, but starting on January 1, 2017, there is a 5% state/local share, which increases incrementally to 10% by January 1, 2020 (i.e. the federal government will reimburse only 90-95% of the expenditures).
- In the case of Medi-Cal services provided by DMH or its contractors, the County must fund the non-federal share of the expenditure, although it is theoretically given realignment funds to do so. Similarly, the County must provide the non-federal share for all inpatient services at County hospitals and all targeted case management services and Medi-Cal administrative activities, and it funds part of the non-federal share for hospital emergency services.
- Accordingly, when services are expanded in these areas, the County must bear a part of the additional expense; federal or other funds will never cover the whole cost.

DMH has two proposed models of funding to expand supportive services to assist those that are transitioning from homelessness to housing and helping them retain their housing. The first is $2.7 million of MHSA on-going funding for supportive services to those in Permanent Supportive Housing. This funding will serve as the local match to draw down federal Medicaid funds, which will increase the available dollars to approximately $4.0 million. The second funding allocation is $7.5 million of one-time MSHA funds (also for supportive services) that will not leverage Medi-Cal. However, the funding will allow DMH to broaden the provider network beyond those with legal entity contracts and allow DMH to serve a broader range of individuals and families that

are homeless with more flexibility. It will be similar to the DHS Intensive Case Management Services (ICMS) program and there may be future opportunities to use similar funding to draw down federal Medicaid dollars through the Whole Person Care project under the State's 1115 Waiver.

The Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver will vastly expand substance use disorder (SUD) services for people who are homeless. In fact, most in this group (with the exception of those who are undocumented) will be eligible for a full continuum of SUD services as an entitlement based on medical necessity. The DMC-ODS will provide much increased access to withdrawal management, residential treatment, case management, and recovery support services. In addition, the DMC-ODS allows providers to deliver field-based/mobile services that can more effectively reach patients out in the community.

Moreover, many people who are homeless are likely newly eligible for Medi-Cal (i.e., adults without minor children). Therefore, DMC-ODS services for this group of beneficiaries would be eligible for 100 percent matching funds in calendar year (CY) 2016 and 95 percent matching funds in CY 2017. The addition of residential and withdrawal management as DMC-ODS benefits - the most costly in the continuum of SUD care - along with other newly covered services, will vastly increase revenue from federal matching funds in SAPC's delivery system.

Further, since SAPC currently relies on federal SAPT Block Grant funds to support many non-DMC services that will be newly covered DMC-ODS services, a portion of SAPT block grant funds may be freed up to support recovery housing (i.e., sober living homes or alcohol and drug free living centers), while individuals are engaged in SUD treatment.

DHS is seeking to expand recuperative care services, intensive case management services in interim and permanent housing, and related services for homeless clients through WPC and also exploring the longer term utilization of TCM and MAA, which are described in more detail below.

**Increasing Access to Services**

Mental Health Services

Historically, clients that are homeless have experienced barriers to accessing mental health services in a clinic-based model in which they had to seek treatment and be assessed for mental health services in clinics. In 1999, DMH implemented the AB 34 program that targeted the homeless population. With this program, the services were field based, included a strong outreach and engagement component, and brought services to individuals that were homeless rather than waiting for them to come to the clinic which many never did. This field based model included intensive services and funding for Client Supportive Services such as food, clothing and shelter. Since then, DMH has developed many other such programs that target the homeless population such as the Full Service Partnership Programs, Integrated Mobile Health Teams, Multidisciplinary Integrated Teams, SB 82 Mobile Triage Teams, Project 50 replicas and

HOME teams, with the purpose of eliminating barriers to accessing mental health services. With these teams, DMH uses evidence based practices such as outreach and engagement, housing first, harm reduction, critical time intervention and motivational interviewing. All of these teams are multidisciplinary and include staff with substance use expertise as many clients that are homeless have co-occurring substance use disorders. Services are not denied for those with co-occurring disorders. In fact, DMH Policy 305.01 which was originally issued in 1995 and was most recently updated in 2005 specifically states that the policy is to "ensure that individuals who qualify for DMH services and substance-related services are not denied access to these services because of concomitant substance abuse problems." DMH has included an integrated substance use assessment in its initial assessments and is accountable for diagnosing substance use disorders through DMH's Strategies for Total Accountability and Total Success (STATS).

With regard to barriers to treatment related to charging clients fees, State law requires a fee to be charged to those with an ability to pay. However, although each client is assessed for the ability to pay fees, it is rare for someone that is homeless to actually be charged a fee, due to the low income status of most homeless individuals. As a result, fees should not be a barrier to accessing mental health care.

Substance Use Treatment Services

As noted, the DMC-ODS Waiver will significantly expand SUD treatment services for all Medi-Cal eligible recipients, including those who are homeless. However, access to these expanded SUD treatment services is dependent upon the current capacity of the contracted provider delivery system to provide the services, especially residential SUD treatment. While it is anticipated that residential treatment facilities will expand their residential SUD bed capacity, the Department of Health Care Services (DHCS) must certify and license those beds before they can be brought online. DHCS' Provider Enrollment Division (PED), which is responsible for the certification and licensing process, is experiencing delays of up to a year and half or more to complete this process due to a staffing shortage. As the DMC-ODS Waiver is rolled out across the State, it is expected that the delay between providers submitting certification and licensing applications and receiving approval will grow considerably.

SAPC has initiated conversations with DHCS about having LA County fund several positions that would focus exclusively on processing certification and licensing applications received from LA County providers. This would significantly reduce the time to bring SUD residential treatment beds into service and increase access to residential SUD treatment through increased bed capacity. Discussions thus far with DHCS have been very encouraging and SAPC and DHCS are working to determine the best mechanism through which to fund the positions.

As we look forward to the implementation of the DMC-ODS, SAPC plans to deploy more community-based navigators to provide outreach and engagement services for people who may need SUD treatment. These new services should help support high-risk and often hard to engage populations, such as the homeless, into services and will work to

identify individual and system barriers to engagement and access. The additional funding for treatment through ODS will allow for SAPC to shift existing funding toward these activities. Similarly, the activities that are being proposed as part of the County's WPC Pilot application targeting homeless individuals will support these engagement and assessment efforts by bringing these efforts to the streets, shelters and encampments. Moreover, the DMC-ODS case management benefit explicitly allows providers to use this level of care to make connections with other needed social services, including job training and housing, among others. As we near the launch of ODS next year, we plan to engage agencies that provide these services to offer trainings for our SUD service providers and their case managers to educate them about making connections to these resources.

**Opportunities to Seek Medi-Cal Reimbursement for Homeless Initiative Strategies**

Whole Person Care Pilot

Funding through the WPC Pilot initiative, a new portion of the recently agreed upon 1115 Medicaid Waiver, will help us build a more integrated health delivery system that meets the complex needs of high-risk LA County residents that often fall through gaps in our current system. WPC will deliver an array of services to help our sickest and most vulnerable individuals, that are homeless or at risk for homelessness, move from streets and shelters to permanent housing with the services and supports to help these individuals develop the hope, supportive relationships, coping skills and self-efficacy they need to thrive.

The WPC Pilot is a 5-year program with a total budget of $3 billion that is administered by the State. In order to draw down the federal funding component of the $3 billion, the local entity, LA County, must provide the non-federal share. Money under the WPC Pilot is being distributed based on applications. Counties, like Los Angeles, are eligible to respond as the lead entity to a recently released application to be a pilot site. DHS plans to focus on several high risk populations for its WPC application. These populations will include the homeless, the reentry and diversion populations, as well as those with serious medical, mental health or SUD problems that have led to high use of acute care services and persistent poor health. DHS and the many partners who will be involved in the application will be discussing the proposal for the WPC Pilot in the weeks to come. We anticipate that the final WPC application will be due to DHCS by early July 2016.

Through the WPC Pilot, we hope to strengthen collaboration and care coordination between our physical health, mental health and SUD service providers to help ensure that all high-risk individuals enrolled in the WPC Pilot are assessed comprehensively for needs and connected to appropriate services. The WPC Pilot will also provide LA County an opportunity to build its spectrum of recuperative and interim housing options as these services seem to be allowable under the terms and conditions of this Pilot program. Permanent housing is not an allowable expense under WPC. Among the largest opportunities in the WPC Pilot is the opportunity to increase the County's Flexible Housing Subsidy Pool. The exact mechanics of how to increase the pool via

WPC is not entirely clear at this time, but it will likely be through savings earned through the efforts of the pilot and contributions provided by any WPC partner who is able to make such a contribution. The final WPC application should clarify how each applicant can create or grow its County housing pool.

Health Homes

Another opportunity within the Affordable Care Act which will provide additional support toward the care of homeless individuals is the Health Homes demonstration project. It is also known as the 90/10 Health Homes program. Unlike the WPC Pilot, the Health Homes initiative is created through the State's submission to the Centers for Medicare and Medicaid Services (CMS) of a State Plan Amendment (SPA). After years of preparing for this SPA submission, California recently submitted the SPA to CMS. We are now awaiting final approval. We know that LA County will be in the final cohort of counties to roll out Health Homes – proposed to be January 2018. We also know that, unlike WPC where the County is the lead entity, Health Homes is led by the health plans. DHS has been in conversations with L.A. Care Health Plan and Health Net regarding the roll-out for Health Homes in LA County. No definitive plans have emerged. We look forward to future conversations on how County departments and service providers can participate in the Health Homes effort. As soon as we have a better sense, we will communicate with you.

Targeted Case Management and Medi-Cal Administrative Activities

DHS has determined that there is an opportunity to bring in additional Medi-Cal revenue by billing for certain intensive case management services it currently provides as targeted case management ("TCM"). TCM is a benefit which is only available to certain specific segments of the Medi-Cal population, but it does cover persons who are in jeopardy of negative health or psycho-social outcomes as a result of experiencing substandard housing. TCM, except where provided as an adjunct to specialty mental health, is provided and paid for outside of managed care and therefore can be offered to all qualified Medi-Cal beneficiaries in a "no wrong door" approach. Covered TCM services can be provided where homeless individuals are located; they do not have to come to a clinic or office to receive the services. TCM is reimbursed on a cost basis and the County has to provide the non-federal share of the final payment amount. Depending on whether the recipient is part of traditional Medi-Cal or the Medi-Cal Expansion population, the matching percentages will be 50% or 95% starting in January 2017.

Medi-Cal covered TCM includes a comprehensive assessment by a trained professional of the beneficiary's medical, social, educational or other service needs, creation of a plan to address those needs, and providing linkage and referral to the providers which can meet those needs. Periodic reassessment and monitoring of the TCM plan are also covered services. The actual provision of the medical, social or other service needs are not covered as TCM, although they may be covered under other parts of Medi-Cal. TCM should provide reimbursement for many, but not all, of the services presently being rendered under DHS' intensive case management services program.

LA County already has a contract with the State to provide TCM, and therefore has a demonstrated ability to meet the requirements for participating in the program. It appears possible for DHS to seek reimbursement under the existing contract for a least a portion of the expenses under its contracts with case management providers. DHS must establish appropriate claiming and cost reporting systems for TCM, including assuring that DHS' contracted entities meet Medi-Cal's participation requirements and are able to prepare and maintain the documentation necessary to support claiming for the services. DHS will also have to develop charges for the TCM services and a system for billing.

Outreach services and enrollment assistance provided to Medi-Cal beneficiaries may be reimbursed as Medi-Cal Administrative Activities (MAA). MAA services are those that DHCS would otherwise perform for the administration of the Medi-Cal program, but which have been contracted out to counties or other entities. Presently, DMH is actively participating in MAA for a variety of services, including outreach, eligibility assistance and case management for non-open cases, and intake; but DHS is not. To participate in MAA for outreach and eligibility assistance or other services, DHS will have to prepare a MAA Plan, which outlines the services it will provide who will provide the services, and establish a system for tracking time spent on MAA at a detailed level. The MAA Plan then needs to be approved by the State and federal government. MAA is a cost reimbursement system, with the County providing the non-federal share/local match.

In the next quarterly report, DHS will report on our progress toward bringing more Medicaid revenue to LA County via TCM and MAA. We will also report on the progress of the WPC application; by then we will know what specifically went into the LA County WPC application.

**Next Steps**

As directed by the Board, we will provide an update on what other jurisdictions have done to draw down Medicaid revenue for services to homeless beneficiaries and report on the progress made to create a permanent supportive housing inventory with the LACDC in the next report. Future quarterly reports will also track changes in actual use of Medicaid funding for programs and services to homeless individuals.

If you have any questions please contact me or Dr. Mark Ghaly, Deputy Director of Community Health, at (213) 240-8107.

MHK: mg

Attachments

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

**County of Los Angeles -- Department of Mental Health**
**Homeless Projects**
**Medi-Cal Percentage & Number Served**
**FY 2014-15**

| Program Name | | Portion of Budget Serving Homeless | % Budget for Homeless Services | Total Medi-Cal Funding | % Budget Funded by Medi-Cal | Outreach and Linkage Only | Number Homeless Served |
|---|---|---|---|---|---|---|---|
| Project 50 + Replicas | $ 4,289,765 | $ 4,289,765 | 100% | $ 953,526 | 22.23% | No | 658 |
| Homeless Outreach Mobile Engagement | 1,403,553 | 1,403,553 | 100% | 359,797 | 25.63% | Yes | 299 |
| Multidisciplinary Integrated Teams (MIT)* | 3,857,082 | 3,857,082 | 100% | 2,052,587 | 53.22% | No | 746 |
| Integrated Mobile Health Team (IMHT) | 11,413,070 | 11,413,070 | 100% | 2,869,747 | 25.14% | No | 570 |
| SB 82 Mobile Triage Teams** | 2,601,000 | 2,601,000 | 100% | 455,000 | 17.49% | Yes | 172 |
| **TOTAL** | **$ 23,564,470** | **$ 23,564,470** | **100%** | **$ 6,690,657** | **28.39%** | | **2,445** |

**The MIT Program was approved by the Board in May 2015. This budget reflects an entire Fiscal Year and includes the MIT expansion in SAs 2, 4 (C-3), 6 and 8. The Number Homeless Served data is FY 15-16 through March 31, 2016.*

***Represents partial year data; programs began service in July 2015 and continued building their staff through early 2016.*

*CHEERD/CHEERD1/Homeless Initiative 2016/MediCal Motion/DMH Medi-Cal Funding*