Health Services
LOS ANGELES COUNTY

July 6, 2016

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SUBJECT: **MY HEALTH LA (MHLA) PROGRAM**

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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

On May 3, 2016, the Los Angeles County Board of Supervisors (Board) instructed the Director of Health Services (DHS) to report back on the potential impact of Senate Bill (SB) 75 on the MHLA rate methodology, on the rate of disenrollment of children from MHLA as they transition to full-scope Medi-Cal under the new SB 75 program and provide an update on the Board's previous instruction to consider improvements to MHLA, such as increasing the income threshold, adding additional services and easing the re-determination process (Agenda Item No. 14 from the August 11, 2015 Board meeting).

Background

On October 1, 2014, DHS formally launched the MHLA program, to provide health care services to low income, uninsured residents of Los Angeles County for up to 146,000 individuals. Enrollment in MHLA is voluntary. As of May 31, 2016, 145,025 individuals were enrolled in the program (99% of targeted 146,000 enrollees). This makes MHLA the largest program for the residually uninsured in the United States.

The Board allocated $61 million ($56M health and $5M dental) for MHLA in fiscal year 2015-16. The program is currently operating at 54 clinic agencies with 196 clinic sites. Of those sites, 159 (81%) were open to new participants and 37 (19%) were closed as of early June 2016. Community Partner (CP) clinics participating in MHLA receive a Monthly Grant Fund (MGF) amount of $32 per enrolled participant. Of this amount ($28 is for medical and $4 is for pharmacy). In developing the reimbursement level, DHS used an average utilization rate of 3.2 visits per participant which was tied to the former HWLA-Unmatched Program for fiscal year 2012-13. Also included in the rate development was the equivalent of a 1.5% per year Cost of Living Adjustment (COLA) for eight years in recognition that the CPs had not received a cost-of-living increase to their former HWLA-Unmatched contract in the previous eight years before MHLA became operational. Because MHLA involved the migration from a fee-for-service visit rate to a monthly reimbursement per participant (i.e., MGF), if you were to take the $32 MGF and calculate its fee-for-service equivalent, it was 70% of the average CP Federally Qualified Health Center

Prospective Payment System rate of $150 per visit or $105 (an increase of $14 per visit from the HWLA-Unmatched rate of $91 per visit).

Individuals eligible for full-scope Medi-Cal are ineligible for MHLA to ensure that the County uses its financial resources for those with no health insurance options. On May 16, 2016, undocumented children who met the income criteria became eligible for full-scope Medi-Cal via SB 75. Of the 145,025 participants in the MHLA on May 31, 2016, 9,900 (7%) were 6 – 18 years old and therefore eligible for full-scope Medi-Cal. Based on Board action taken May 3, 2016, a child can remain in MHLA until December 31, 2016 unless DHS receives information from the Los Angeles County Department of Public Social Services (DPSS) indicating that the child has been enrolled in full-scope Medi-Cal at which time, DHS will disenroll the child from MHLA.

MHLA Disenrollments Due to SB 75 Implementation

To date, DHS has disenrolled 2,900 children from MHLA who were identified by DPSS as being enrolled in full-scope Medi-Cal. DHS and DPSS have developed a system to conduct a monthly match between files as a way to verify that Medi-Cal enrollment occurs before MHLA disenrollment occurs.

Potential Impact of SB 75 on MHLA Rate Methodology

The Board asked DHS to conduct an analysis to re-evaluate the rate methodology for MHLA, given that the program's percentage of adult members, who require a higher level of service than the program's pediatric population, will increase. In assessing if there was any impact, DHS examined the distribution of children enrolled in the program by medical home and utilization for both children and adults.

During the 2015–16 fiscal year, roughly 10,000 MHLA participants were children 6 to 18 years of age. Across all CP agencies, on average 7.2% of their MHLA population was comprised of children. Half of the CP agencies had fewer than 100 children participants. Specifically:

- for 64% of CP agencies, children were 5% - 9.99% of their MHLA population
- for 22% of CP agencies, children were 2% - 5% of their MHLA population
- for 10% of CP agencies, children were 10% - 13% of their MHLA population
- for 4% of CP agencies, children were less than 2% of their MHLA population

While an important population, children have not been a significant driver in MHLA enrollment across the CP agencies.

This has also been the case when utilization is examined. DHS reviewed utilization data based on the first nine months of the current fiscal year (July 2015 to March 2016) and annualized the data (i.e., projected utilization for a 12-month period based on nine months of actual utilization data). DHS used 2015-16 fiscal year data as opposed any data from 2014-15 fiscal year (which included six months of fee-for-service data) because it is more reflective of current utilization in the program. Consistent with the Board's request, DHS met with and discussed the data with the Community Clinic Association of Los Angeles County (CCALAC) although there is not complete agreement on how best to interpret the existing data.

For the time period of July 2015 to March 2016, 3% of the visits were for children and 97% of visits were for adults. The annualized visit rate for children was 1.07 meaning that there were 1.07 visits

per 12-month period. The data further shows that during this 9-month period almost 70% of children had no visits. This data is consistent with the overall healthcare industry data that shows children to be relatively healthy and low utilizers of health services. The annualized visit rate for adults was 2.99 meaning that there were 2.99 visits per 12-month period. The data further shows that during this time period, 40% of adults had no visits.

Table 1 below provides summary utilization information. It indicates a combined annualized utilization rate of 2.85 visits per 12-month period for fiscal year 2015-16. Note that this is below the 3.2 visit rate assumed in the initial rate methodology. The decrease in visit rate is a positive development and reflects the success of the program and the providers. By giving participants a medical home, it reduces duplication of effort (patients seen at multiple clinics for the same issue). By eliminating the need for having a clinic visit in order to receive payment, providers can see patients when the patient needs to be seen and can care for them via other methods. Lastly, because it is a program with defined services, there will be people who will want to enroll even though they do not currently have any medical needs.

Table 1
Fiscal Year 2015-16 (Annualized Based on July 2015 – March 2016 Data)

	Visits	% of Total Visits	Annualized Visit Rate	% w/ No Visits	% w/ 1 Visit	% w/ 2-3 Visits	% w/ 4+ Visits	Avg. Visit Rate
Adults	281,694	97.0%	2.99	40.2%	15%	26.0%	18.8%	$128.29
Children	7,818	3.0%	1.07	68.0%	16.4%	12.0%	3.6%	$359.17
Combined	289,512	100.0%	2.85	42.3%	15.1%	24.9%	17.7%	$134.52

In a MGF reimbursement model, funding is provided to the CPs irrespective of whether or not an individual utilizes services in any given month or year. This structure is similar to reimbursement that DHS might receive from health plans for capitated managed care members. While CPs are not reimbursed on a per visit rate, an estimate can be computed by dividing total MGF funding received for all participants irrespective of whether they had a visit or not by total number of visits provided by CPs (289,512). The estimated average visit rate for both adults and children is $134.52. Note that this calculation may change based on complete data for the fiscal year.

With the disenrollment and ineligibility of children in MHLA and based on current enrollment, 10,000 children could be replaced by 10,000 adults (assuming continued CP capacity to accept new participants). The question posed is whether the addition of 10,000 adults would significantly alter the current utilization pattern of adults in the program. Assuming the new adults have the same pattern of utilization as the adults currently in the program, the annualized visit rate for the program will increase from 2.85 to 2.99 and the average visit rate will decrease from $134.52 to $128.29, which is still above the target rate ($105.00) at program initiation.

Based on its review of the data, it is not anticipated that the replacement of adults with children as a result of SB 75 will have a significant change on utilization and therefore warrant a change in MHLA rate methodology. At the same time, DHS recognizes that any change in MHLA rate methodology and budget allocation to MHLA is a policy decision of the Board. If the Board wishes to increase the rate to make up for the difference between children and adults, then it could increase the 2015-16 MGF per participant per month amount from $32.00 to $33.52 ($134.52 multiplied by 2.99 divided by 12). Assuming an average monthly enrollment of 146,000 participants, the increase in costs would be an estimated $2,663,004 annually.

Funding Trade-Offs

As mentioned above, the Board has allocated a set amount of funding for MHLA, $61 million annually ($56M health and $5M dental) for a targeted enrollment of 146,000 MHLA participants per month. From a policy perspective, any adjustment in the program's rate methodology that increases the MGF to CPs must be juxtaposed to other potential uses for those funds with in the program.

In reviewing this, DHS would like to provide the Board with additional information on fiscal year 2015-16 enrollment and expenditures. DHS currently estimates fiscal year end expenditures for MHLA will be $57M (93.4% of allocation) with a potential unexpended amount of an estimated $4M. Of the $57M:

- $52.85M is MGF (potential unexpended amount of $3.15M)
- $4.28M is Dental (potential unexpended amount of $720K)

While this projection is subject to change with updated expenditure data that reflects MGF payments for June 2016 participants and adjudicated dental claims, DHS has worked closely with CCALAC in implementing Board supported and approved program amendments that have helped ensure that the $61 million allocated in fiscal year 2015-16 is expended to the fullest extent possible.

The MGF expenditure estimate is directly related to enrollment. As of May 31, 2016, there were 145,025 MHLA participants (99% of target). DHS anticipates that MHLA enrollment will exceed 146,000 on June 30, 2016. Based on fiscal year 2015-16 trends, net enrollment increases on average by 1,940 participants each month. While we anticipate ending the fiscal year above 146,000, average monthly enrollment has been 136,591 because the program started the fiscal year with just under 126,000 participants. As a result, even though we estimate enrollment will be above 146,000, there is sufficient funding to cover this enrollment in June 2016.

If the Board were to contemplate any change in MHLA rate methodology (which would provide CPs with a higher MGF rate), DHS would like to make the Board aware of current funding needs that should be accounted for:

1. Ongoing program operations require carry-over into upcoming fiscal year
2. CP rate increase due to COLA

1. *Carry Over Unexpended FY 2015-16 into FY 2016-17*
   Carrying over funds into 2016-17 are needed to address the fact that enrollment is likely to exceed 146,000 based on: (a) May 2016 enrollment was over 145,000, (b) children in the program can remain in the program until December 31, 2016 unless their Medi-Cal full scope enrollment has been determined by DPSS before then at which time they will be disenrolled and (c) enrollment trends which indicate growth of on average 1,940 participants per month. Carrying over the funds into the next fiscal year would provide one-time additional funding above the current $61M base funding allocated by the Board. This option maintains the funds in the program and provides additional cushion for any potential over enrollment (i.e., enrollment in excess of 146,000 target per month) in fiscal year 2016-17. Without a carry-over, new program enrollment may have to cease in the early part of this fiscal year depending on whether or not and the pace at which adults replace children who leave the program upon receiving Medi-Cal.

2. *CP Rate Increase due to COLA*
   On September 23, 2014 when the Board approved creating MHLA, it also approved a provision indicating that CPs would be eligible for an annual COLA for the health component of the MGF, at the County's discretion. The COLA is based on the Consumer Price Index (CPI) for the 12-month period before July 1, however, it may not exceed the general salary increase for County employees. The Chief Executive Office determined that the COLA available for all County contractors effective July 1, 2016 was 2% based on the CPI. As a result, the MGF for MHLA increased from $32 to $32.56 ($28.56 for health and $4 for pharmacy) on July 1, 2016 for enrollment after that date. This represents an additional annual expenditure of $981,000 with maximum enrollment ($0.56 * 146,000 participants * 12 months).

The following chart provides estimates of what the maximum program enrollment might be under different MGF rates for CPs with $56 million for health reimbursement. Note that the maximum enrollment is, as noted above, dependent upon pace at which new adults replace children who have gained health insurance through Medi-Cal.

Table 2
Relationship Between MGF Level and Maximum Monthly Enrollment

	$32.00 MGF (FY 2015-16)	$32.56 MGF (effective FY 2016-17)	$33.52 MGF (Based on $134.52 Visit Rate)
Add'l Annual Cost	N/A	$981,000	$2,663,004
Est'd Maximum Monthly Enrollment	146,000	143,325	139,220

Update on Board Request for MHLA Improvements

In addition, the Board must consider any inherent tradeoffs to using any unexpended funds to expand the program versus increasing the MHLA rate via a change in the MHLA rate methodology.

On August 11, 2015 the Board approved a motion on options to improve MHLA including:

- increasing the eligibility income threshold (to 150% or higher);
- expanding the dental benefits;
- adding substance abuse benefits and
- relaxing redetermination requirements so that they are no more stringent and burdensome than federal Medicaid requirements, but program fiscal integrity is maintained.

Increase in MHLA Income Threshold
The MHLA income eligibility threshold is 138% of the Federal Poverty Level (FPL). As DHS reported back to the Board in December 2015, there are an estimated 9,700 uninsured residents between 139% FPL and 150% FPL. Assuming different take up rates for this voluntary program, the additional costs to expand the income threshold range from approximately $950,000 to $3.8M annually with 12 months enrollment. Based on the program's current enrollment, enrollment trends, continued coverage of children and provision of a COLA to CPs beginning July 1, 2016, there is currently insufficient funding in the MHLA program to expand eligibility to 150% FPL. DHS notes that enrollment of this population would require additional funding. In addition, DHS might need to explore establishing a participant cost structure for those individuals with income above 138% FPL to ensure that:

- there is some level of parity with individuals who are at the same income level and are required to pay some portion of the cost of their healthcare when receiving publicly-financed health care and
- the income eligibility increase does not create a disincentive for eligible individuals to enroll in other publicly funded health insurance with member share of cost fees.

Expanding Dental Benefits

Dental services have been expanded. In July 2015, at the request of the community clinics, DHS expanded the number of dental codes (i.e., dental services provided) that can be billed under the MHLA program. DHS added 23 new dental codes/services that were identified as being most needed by uninsured patients, but which were not previously covered. The Board's November 17, 2015 approval of amendments to the MHLA Agreement removed the maximum dental allocation for CPs with dental contracts. This simplifies the process for clinics to obtain dental funding and eliminates maximum dental allocations by clinics, such that dental funding caps are no longer a barrier for a MHLA dental clinic who wishes to expand the type of dental services provided to MHLA enrolled or eligible patients.

Adding Substance Abuse Benefits

Substance Use Disorder (SUD) services became available on July 1, 2016. The Department of Public Health's (DPH) Substance Abuse Prevention and Control Division (SAPC) and its contracted service providers will be responsible for providing SUD care needed for any MHLA participant either self-referred or referred by their MHLA Medical Home, based on an SUD assessment and clinical standards. DPH has indicated that it will be able to use State Realignment funds to provide SUD services to MHLA participants and that current estimates indicate that no additional Net County Costs will be needed.

SUD services are now available to all MHLA participants. There are two ways that a MHLA participant can obtain SUD services through the DPH SAPC network of providers that are participating in MHLA:

1. MHLA participants can self-refer to any MHLA-participating SUD site by contacting a Community Assessment Services Center (CASC) or the DPH line at 888-742-7900.

2. MHLA CPs can refer a MHLA participant to those SAPC providers that provided covered SUD services using existing/current referral channels.

Below is the list of SUD services that MHLA participants can obtain free of charge as of July 1, 2016. Other SUD services, such as Opioid (Narcotic) Treatment services (specifically, methadone maintenance for opioid addiction), will be offered at a later date.

LEVEL OF CARE (The services listed below are for clinically appropriate treatment for all SUDs irrespective of the particular substance being used).	ADULT SUD BENEFIT JULY 1, 2016	ADOLESCENT SUD BENEFIT JULY 1, 2016
Early Intervention (Screening, Brief Intervention, and Referral to Treatment) in Primary Care Settings*	Yes	Yes
Outpatient (maximum of 9 hours per week for adults, and 6 hours per week for adolescents)	Yes	Yes
Intensive Outpatient (9-19 hours per week for adults, and 6-19 hours per week for adolescents)	Yes	Yes
Residential	Yes	Yes
Ambulatory Withdrawal Management	Yes	Yes
Residential Withdrawal Management	Yes	No*
Additional Medication Assisted Treatment	Yes	No
Case Management for SUD Treatment and Care Coordination with other Health, Mental Health, and Social Services	Yes	Yes

*Levels of care and SUD services that are not provided within the SAPC network of providers, but are available via other systems of care (e.g., DHS) and providers within Los Angeles County.

SAPC will be modifying their Los Angeles County Participant Reporting System (LACPRS) forms to include information about a patient's MHLA enrollment status and Participant Identification number. If a MHLA participant self-identifies as MHLA but does not have their ID card, SAPC and its contracted providers have been instructed to call MHLA member services so that the MHLA ID number can be inputted into LACPRS.

The MHLA Handbook, ID card and website have been updated to reflect the addition of SUD services to the MHLA program. This information was included in the July 2016 MHLA participant newsletter. In addition, a new English/Spanish fact sheet is available to explain the new SUD services to participants which can be provided to participants in each clinic.

Relaxing Redetermination Requirements While Maintaining Program Fiscal Integrity

DHS is committed to working with CP clinics to maintain high levels of participant renewals in the program. DHS, in collaboration with CPs and CCALAC, have implemented several important strategies to increase renewal rates and streamline the renewal process, including:

- Developed a MHLA Renewal Committee made up of DHS, CCALAC and community clinics representatives. The Committee is tasked with developing and monitoring target renewal rates, recommending strategies and tactics to remove renewal barriers for MHLA participants and CP enrollers, recommending best practices to improve the accuracy and completeness of MHLA applications and identifying training and education opportunities to improve clinic renewal rates and MHLA enroller performance.
- The MHLA Agreement was amended on November 17, 2015, to relax the renewal process for MHLA participants by allowing one member of a household to renew on behalf of everyone in the household. This means that one adult can bring in the renewal documentation on behalf of every other member of the family.
- The renewal process was shortened by eliminating the requirement that renewing participants re-sign the MHLA Rights and Declaration page and removing the requirement that clinic enrollers re-upload this document.

- The MHLA Eligibility and Enrollment Unit created eligibility "Subject Matter Experts" who provide ongoing assistance to clinic enrollers in real-time on enrollment and renewal questions and issues.
- DHS distributes renewal and re-enrollment reports to clinics and has worked with CCALAC to develop tools and resources for clinics that need a refresher in the renewal process.

DHS is proud of the success of the MHLA and looks forward to working with the Board and our CPs on this vital program.

If you have any questions, please do not hesitate to contact me at (213) 240-8101 or Tangerine Brigham at (213) 240-7953.

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