Date of Hearing: April 25, 2023

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 85 (Weber) – As Amended April 17, 2023

SUBJECT: Social determinants of health: screening and outreach.

SUMMARY: Requires a health plan contract or health insurance policy, as specified, to include coverage for screenings for social determinants of health (SDOH), as defined. Requires a health plan or health insurer to provide primary care providers with adequate access to community health workers (CHW) in counties where the health plan or health insurer has enrollees or insureds, as specified. Makes SDOH a covered benefit for Medi-Cal beneficiaries and requires the Department of Health Care Services (DHCS) to provide reimbursement for those screenings. Requires the Department of Health Care Access and Information (HCAI) to convene a working group, with specified membership, to create a standardized model and procedures for connecting patients with community resources, to assess the need for a centralized list of accredited community providers, and to determine gaps in research and data to inform policies on system changes to address SDOH. Requires the working group, by January 1, 2025, to submit a report to the Legislature with recommendations on the topics addressed by the working group. Specifically, **this bill**:

1) Requires a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, to include coverage and provide reimbursement to health care providers for SDOH regardless of the screening method utilized.

2) Requires health plans and insurers to provide physicians who provide primary care services with adequate access to peer support specialists, lay health workers, social workers, or CHW as defined, including Promotores and community health representatives, in counties where the health plan and insurer has enrollees and insureds. Requires the health plan or insurer to inform physicians who provide primary care services of how to access these CHW, Promotores, community health representatives, peer support specialists, lay health workers, or social workers.

3) Authorizes the Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) to adopt guidance for health plans and insurers to implement this bill.

4) Requires HCAI to convene a working group to create a standardized model and procedures for connecting patients with community resources, to assess the need for a centralized list of accredited community providers, and to determine gaps in research and data to inform policies on system changes to address SDOH. Requires the working group to:

    a) Include representatives from the California Health and Human Services Agency, CDI, and Covered California, representatives of physician specialties who provide primary care services, including, but not limited to, family medicine, obstetrics and gynecology, and pediatrics, and representatives of health plans and health insurers, community-based organizations, social workers, and consumer groups. Allows the working group to consult with other individuals, groups, or organizations for additional insight or expertise on issues under consideration by the working group; and,

b) Submit a report to the Legislature with recommendations on the topics addressed in a) above, as specified.

5) Specifies that SDOH screenings are a Medi-Cal covered benefit. Requires DHCS to provide reimbursement to a Medi-Cal provider who renders this service regardless of the screening method utilized. Requires federally qualified health centers and rural health clinics to be reimbursed for these services at the Medi-Cal fee-for-service rate.

6) Defines SDOH as the conditions under which people are born, grow, live, work, and age, including housing, food, transportation, utilities, and personal safety.

EXISTING LAW:

1) Establishes DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and CDI to regulate health insurers. [Health and Safety Code (HSC) § 1340, *et seq*. and Insurance Code § 106, *et seq*.]

2) Requires DMHC, on or before March 1, 2022, to convene a Health Equity and Quality Committee (HEQC) to make recommendations, by September 30, 2022, to DMHC for consideration in establishing standard health equity and quality measures, including annual benchmark standards for assessing equity and quality in health care delivery, by taking into consideration the interaction of multiple characteristics in determining where disparate outcomes exist, including, but not limited to, race, ethnicity, gender, sexual orientation, language, age, income, and disability. [HSC § 1399.870]

3) Requires a health plan, upon DMHC's establishment or updating of standard measures and annual benchmarks, to annually submit to DMHC a report containing health equity and quality data and information. Requires a health plan to implement the policies, procedures, and systems necessary for compliance, as specified. Requires the DMHC to coordinate with DHCS to support the review of, and any compliance action taken with respect to, Medi-Cal managed care plans to maintain consistency with the applicable federal and state Medicaid requirements governing those plans. [HSC §1399.872]

4) Provides that the standards developed by DMHC pursuant to 3) above apply to health plans that cover hospital, medical, or surgical expenses, including a health plan that contracts with DHCS to provide health care services to Medi-Cal beneficiaries, and specialized health plans that provide behavioral health care. [HSC §1399.873]

5) Establishes the Medi-Cal program, administered by DHCS, under which low-income individuals are eligible for medical coverage. [Welfare and Institutions Code (WIC) § 14000, et seq.]

6) Establishes a schedule of benefits under the Medi-Cal program, which includes benefits required under federal law and benefits provided at state option but for which federal financial participation is available. [WIC § 14132]

7) Defines CHW to mean a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural

competence of service delivery. States that CHWs include Promotores, Promotores de Salud, Community Health Representatives, navigators, and other nonlicensed health workers, including violence prevention professionals. Requires a CHW's lived experience to align with and provide a connection to the community being served. [WIC § 18998]

8) Requires DHCS to develop statewide requirements for CHW certificate programs in consultation with stakeholders. [WIC § 18998.1]

9) Authorizes DHCS to collect workforce data on CHWs from individuals who have enrolled in or completed CHW certificate programs. [WIC § 18998.3]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, research shows that an individual's economic and social conditions influences their health status. Identifying these SDOH for individuals and families is a critical step in ensuring health equity and optimal health outcomes for all people in California. Additionally, the author states that a recent study discovered that physicians feel discomfort not being able to address their patient's SDOH needs. This bill will help physicians begin to address patients' needs by referring patients to supportive resources closest to them. The author concludes that this bill will also require the HCAI to, in part, determine gaps in research and data to inform policy improvements to continue to address SDOH for all in California.

2) **BACKGROUND.**

   a) **DMHC Health Equity and Quality Committee**. AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, requires DMHC, on or before March 1, 2022, to convene a HEQC to make recommendations to the DMHC for standard health equity and quality measures, including annual benchmark standards for assessing equity and quality in health care delivery. The DMHC established standards for health plans to comply with starting in 2023 and will produce a Health Equity and Quality Compliance annual report beginning in 2025. The HEQC considered the following in making recommendations for standard health equity and quality measures:

      i) Quality measures, including, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures and the federal Centers for Medicare and Medicaid Services Child and Adult Core Set measures;

      ii) Surveys or other measures to assess consumer experience and satisfaction, including alternative approaches that take into account cultural competence, health literacy, exposure to discrimination, and social and cultural connectedness, such as connection to community, identity, traditions, and spirituality;

      iii) Other child and adult quality or outcome measures that the HEQC determines are appropriate, including establishing new measures for patient reported outcomes;

      iv) Effective ways to measure health outcomes in the absence of quality measures, including both of the following:

(1) Demographic data or other data related to race, ethnicity, or socioeconomic variables that are currently collected by health plans; and,

(2) Other data sources, including the Health Payments Database, the health evidence initiative of Covered California for the individual and small group markets, and other statistically valid and reliable sources of data.

v) Approaches to stratifying reporting of results by factors, including, but not limited to, age, sex, geographic region, race, ethnicity, language, sexual orientation, gender identity, and income to the extent health plans or public programs have data on these factors and that the results are statistically valid and reliable;

vi) Alternative methods to measure health outcomes that permit sufficient stratification to determine impacts on health equity and quality that are not subject to the methodological limitations of current measurement approaches;

vii) Alternative methods to measure physical and behavioral health outcomes, including, but not limited to, measures to assess social and cultural connectedness, such as connection to community, identity, traditions, and spirituality. Requires the DMHC to consult with the Office of Health Equity in identifying these alternative methods; and,

viii) Measures of SDOH, such as housing security, food insecurity, caregiving, and other nonmedical determinants of health.

b) Covered California Contract Requirements. Covered California's contracts with its Qualified Health Plans include elements to address health equity and disparities. A 2021 Covered California document describes the following elements:

i) Networks designed to meet diverse populations needs: All health plans are required to have as part of their networks a mix of essential community providers, which ensures that traditional safety net providers that serve vulnerable communities are included in network design. Covered California's ongoing monitoring includes assessment of health plan approaches to assessing member cultural and linguistic needs and preferences, as well as efforts to build and maintain culturally responsive networks;

ii) Demographic data collection: The ability to analyze data for disparities is the foundation of our health equity work and requires complete and accurate demographic data. Covered California has an approximately 80% voluntary response rate to race/ethnicity questions during the enrollment process. In addition, Covered California requires health plans to achieve an 80% self-reported response rate for race/ethnicity, tied to a performance guarantee. For 2023, health plans will also be expected to collect self-reported spoken and written language;

iii) Ongoing work to stratified performance measures by race/ethnicity: Covered California has consistently sought to stratify key clinical measures by race and ethnicity but has found these efforts challenging. Initially Covered California identified 14 measures for stratification but encountered significant methodologic issues. In 2021, Covered California transitioned to four HEDIS measures using issuer-submitted patient level data; these are being used to inform disparities

reduction interventions. In the future, the Quality Transformation Initiative, which is under consideration and would use a small number of critical clinical measures to hold health plans accountable, will be stratified by race/ethnicity, language, and income;

iv) Disparities reduction interventions are required of all health plans and are tied to performance guarantees. Health plans are being supported with mandatory learning and technical assistance sessions, and each plan is required to submit a disparity intervention plan for approval with a target disparity reduction. Most plans are working on diabetes control in Latino or Black enrollees; and,

v) The National Committee for Quality Assurance Multicultural Health Care Distinction or Health Equity Accreditation must be obtained by 2023, with a performance guarantee credit for early attainment in December 2022.

c) California Advancing and Innovating Medi-Cal (**CalAIM).** DHCS began implementing provisions of CalAIM in 2022, which is a multi-year program to improve health outcomes and quality of life for Medi-Cal beneficiaries through broad delivery system, program, and payment reform. One of the components of CalAIM is Population Health Management, in which plans identify and manage social risks and needs of Medi-Cal beneficiaries using whole person care approaches to mitigate negative SDOH. Additionally in early 2022, DHCS released an All Plan Letter (APL) to provide guidance for the collection of SDOH data. The letter states that DHCS expects Medi-Cal managed care plans to develop processes to work closely with providers to promote screening and regularly report SDOH data. The APL also emphasizes that clinicians other than a beneficiary's primary care clinician can document and code SDOH. New Medi-Cal managed care contracts require plans to identify and track SDOH and develop partnerships with local agencies to support community needs, including supports like housing and other non-health–related programs. Also as part of CalAIM, in July 2022, Medi-Cal released an updated provider manual that included CHW as a covered benefit. CHWs may include people known by a variety of job titles, including promotores, community health representatives, navigators, and other nonlicensed public health workers. CHWs must obtain a certificate (or can work without a certificate for up to 18 months) and must work under a supervising provider (this includes licensed clinicians, hospitals, outpatient clinics, local health jurisdictions, or community-based organization). Covered services include health education, health navigation, screenings and assessments that do not require a license, and support or advocacy. Medi-Cal covers CHW services as preventive services and on the written recommendation of a physician or other licensed practitioner for a subset of beneficiaries (those with one or more chronic conditions, exposure to violence and trauma, at risk for a chronic health condition or environmental health exposure, who face barriers to meeting their health or health-related social needs, and/or who would benefit from preventive services). HCAI is working with stakeholders to develop standards for certifying CHWs and training programs. HCAI is also developing plans for the certification process and training new CHWs.

d) SDOH. This bill requires coverage for SDOH screenings. According to the California Health Benefits Review Program (CHBRP), SDOH are nonmedical underlying structural factors that influence health status and health outcomes. There are multiple definitions of SDOH, but it is commonly defined as "the conditions in which people are born, grow,

work, live, and age" in which a "wider set of forces and systems shape the conditions of daily life" and "affect health, functioning, and quality-of-life outcomes and risks." The Centers for Disease Control and Prevention (CDC) defines these forces and systems as economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems. The determinants themselves are neutral concepts (housing, education, food access) that can positively or negatively influence every person's health status, longevity, and quality of life depending on their access to and the quality of these determinants (e.g., good or bad education; un/reliable transportation; un/safe, un/affordable housing).

Health Disparities. SDOH are primary drivers of health disparities, a number of which are noticeable and preventable differences between groups of people. Disparities in SDOH such as education, housing, safety, and community development have been shown to contribute to up to 20 years difference in longevity, even among people who live within a few miles of each other. Moreover, research also demonstrates that discrimination (e.g., racism, ageism, sexism, ableism) prevents equal access to social and economic resources (e.g., housing, education, transportation, wealth, and employment with living wage or better) thereby creating social and health disparities. For example, poverty is highly correlated with poorer health outcomes and higher risk of premature death; safe and stable housing is correlated with lower rates of preventable health care use; healthy, affordable, and convenient food choices are correlated with reductions in obesity and problematic cholesterol or blood glucose levels and improved maternal child health outcomes; and affordable and accessible transportation is also correlated with better chronic disease management leading to reductions in preventable acute care. SDOH are thought to account for up to 80% of health outcomes while health care accounts for about 20% (though estimates do vary; for example, some research attributes up to 10% of health outcomes to genetics).

Health Disparities in California. According to CHBRP, there are persistent and pervasive heath disparities experienced by subpopulations in California. For example, Black Californians have the shortest life expectancy as compared with Asian and Latinx Californians who have the longest life expectancy. Black Californians have the highest mortality rates from breast, cervical, colorectal, lung, and prostate cancers among all racial and ethnic groups. This population also experiences the highest maternal mortality rate and infant mortality rate in California (exceeding that of some developing nations). Asthma emergency department visits are three times greater for Black children than Latinx children, and seven times greater than that of children in other racial/ethnic groups. Opioid overdose deaths are greatest among American Indian and Alaska Native populations followed by white and Black populations. More Latinx Californians report delaying care due to cost than other racial/ethnic groups. These health disparities are preventable or modifiable through the reduction of social risks and improved SDOH.

e) SDOH screening. According to CHBRP, the multidomain SDOH screening tools vary in length (seven to 130 items), format (verbal, electronic, or paper), content (three to six categories), setting in which they are administered (primary care, pediatrics, specialty care, inpatient), and who conducts the screening (provider or self-administered). Many tools are designed for adults or all-ages populations, while some are designed specifically to assess pediatric populations. The screening tools are generally free of charge to use, although there appears to be a growing commercial field including tools embedded in

large electronic health record systems. Scoring or interpreting the screener results also varies by tool. Some tools do not instruct clinicians about the number of answers warranting a referral offer to social needs care. A handful of tools have more complicated scoring methods that take longer to calculate. In these cases, a lower total score (but greater than zero) may not trigger an offer of referral. One study cited by CHBRP found that despite tools being easy to administer, clinician ability to interpret the screening results is limited, which may suggest poor directions in how to score a test, unclear score ranges or cut-off scores, or lack of instructions for handling missing data. According to CHBRP, few SDOH screening tools have been tested for their validity (accurately captures the true social risk), reliability (consistently captures the right information), or pragmatic properties (cost, length, readability, etc.). The limited testing among these social screening tools leaves major gaps in evidence to guide screening tool selection.

One of the primary goals of screening for SDOH is to identify unmet social needs to link patients to appropriate nonmedical resources to ultimately improve or maintain their health. Other goals include data collection to calculate prevalence of social needs to inform risk adjustment or plan social service programs. Such information can also inform clinician treatment choices such as using the information about financial security to choose less expensive medications, avoid refrigerated medications, provide point of care ultrasound, or change target blood sugar goals.

f) CHW workforce. This bill also requires health insurers to provide primary care clinicians with adequate access to CHWs in counties where the plan/policy has enrollees and provide information about how to access those CHWs. Starting July 2022, DHCS added CHW services as a covered Medi-Cal benefit in California. According to CHBRP, CHW is a general term that can be used to define several types of frontline public health workers. CHWs are trusted members of communities and/or have deep understandings of the communities they serve, which allows them to serve as intermediaries for patients between health care and social service providers and the community. There is evidence of CHW effectiveness in improving chronic disease management and addressing unmet social needs among primary care patients. The 2019 California Future Health Workforce Commission (Commission) noted that CHWs provide an effective and efficient bridge for patients between health care, home, and community, especially when integrated with a care team. The Commission recommended that California modify reimbursement mechanisms to grow the CHW workforce to meet increasing demand for these frontline workers. CHBRP notes that approximately 6,740 CHWs were employed in California in May 2021, according to the Bureau of Labor Statistics. A 2021 survey of CHWs and promotores in California found nearly 60% reported employment with a community-based organization, while close to 20% were employed by a federally qualified health center (FQHC). The remaining 20% were employed by faith-based organizations, managed care organizations, and agencies offering mental health or social services. As for work setting, more than half of the respondents reported working in a community-based organization and many worked in a community clinic or a community health center. Other work settings included managed care plans, housing agencies, and long-term care/rehabilitation facilities. Average patient caseloads for CHWs may vary widely in the context of the team composition, experience of staff, and needs of the patient population. Literature suggests that optimal client caseloads for CHWs range between 10 and 30 clients; however, average caseloads may be around 60 clients. California stakeholders involved in the production of a resource guide for how managed care plans

can integrate CHWs into their programs have reported caseload sizes ranging from 10 to 35 patients assigned to community-based CHWs. California does not require certification or licensure of CHWs although employers or payers may require CHW training and certification as a condition of employment. Notably, DHCS, which administers Medi-Cal, does require CHW certification to qualify for Medi-Cal reimbursement. CHW training programs vary in length, scope, content, and cost. As noted previously, HCAI is working of CHW certification and eligibility.

g) **Adverse Childhood Experiences Screening (ACES).** DHCS, in partnership with the California Office of the Surgeon General, created a first-in-the-nation statewide effort to screen patients for ACES that lead to trauma and the increased likelihood of ACES-Associated-Health Conditions due to toxic stress. The bold goal of this initiative is to reduce ACES and toxic stress by half in one generation. DHCS encourages all providers to receive training to screen patients for ACES. By screening for ACES, providers can better determine the likelihood a patient is at increased health risk due to a toxic stress response, which can inform patient treatment and encourage the use of trauma-informed care. Detecting ACES early and connecting patients to interventions, resources, and other supports can improve the health and well-being of individuals and families. ACES screening was subsequently expanded to include commercial coverage.

h) **CHBRP analysis.** AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on essential health benefits (EHBs), and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. CHBRP analysis of this bill includes the following:

   i) **Enrollees covered.** This bill allows insurance carriers to determine criteria for coverage of SDOH screening and allows clinicians to be reimbursed for medically necessary screening. CHBRP assumes the voluntary nature of screening for both patients and clinicians would not result in universal screening. Instead, the use of screening by clinicians would vary across patient populations. CHBRP estimates that 3.2% of employer-sponsored and CalPERS commercial enrollees would obtain an annual SDOH screening, while 6.4% of individual insurance market enrollees, and 20% of Medi-Cal enrollees would use the service. Despite other state policy efforts to link SDOH screening with care management and coordination activities to address high-cost, high-need populations, this bill does not require enrollment or reimbursement for those activities by a plan or clinician. Therefore, the impact of this bill is limited to the new utilization of SDOH screening itself and the resulting reimbursement for screenings due to new benefit coverage and use of SDOH screening. At baseline, 75% (or 17,202,000) of the 22,842,000 enrollees with health insurance regulated by DMHC or CDI already have coverage for SDOH screening. As a result of this bill, 5,640,000 enrollees (25% of the enrollees with state-regulated health insurance) would gain coverage for SDOH screening, representing a 32.79% increase in benefit coverage postmandate. All of the enrollees who would gain SDOH screening coverage have commercial insurance or insurance through CalPERS; this group represents 40% of the commercial and CalPERS population.

ii) Impact on expenditures. This bill would increase total net annual expenditures by $9,926,000 or 0.01% for enrollees in state-regulated insurance. For most commercial market segments, this would translate to increasing premiums by 0.01%. However, enrollees with insurance purchased outside of Covered California would experience the largest proportional increase in enrollee premiums (0.03%) due to lower levels of benefit coverage at baseline. Premiums for enrollees in individual plans purchased through Covered California would increase by $0.05 per member per month (0.01%).

(1) Medi-Cal. Since all Medi-Cal plans reported providing and paying for SDOH screening at baseline, no increase is estimated due to this bill. Due to the combination of Medi-Cal contracting requirements, the National Committee for Quality Assurance (NCQA) accreditation requirement changes, and the upcoming CalAIM Medicaid Waiver, CHBRP estimates that this bill would not result in new benefit coverage or increased use of SDOH screening in Medi-Cal managed care plans.

(2) CalPERS. For enrollees associated with CalPERS in DMHC-regulated plans, premiums would increase by 0.01% ($0.04 per member per month, $415,000 total increase in expenditures).

(3) Number of Uninsured in California. Since the change in average premiums does not exceed 1% for any market segment, CHBRP estimates this bill would have no measurable impact on the number of uninsured persons.

iii) EHBs. This bill does not exceed the definition of EHBs in California because screenings are a preventive service and covered under the federal Patient Protection and Affordable Care Act (ACA).

iv) Medical effectiveness. According to CHBRP, the medical effectiveness review summarizes findings from 2019 to present on the evidence that multi-domain clinical screening for SDOH leads to referrals to CHWs or other social service navigators, to use of social services, and to changes in social outcomes, health care utilization, or health outcomes. CHBRP also reviewed evidence of harms of SDOH screening in a clinical setting. Studies on screening for SDOH in a clinical setting were limited in number and quality. It is hard to generalize the findings of this research across studies because of the variety of populations included in studies, the various social needs, the variety of SDOH screening tools, and the variety of referral interventions used in the studies. Therefore, taken together, the evidence on the effectiveness of screening for SDOH in a clinical setting, referral to navigators/social services, and downstream outcomes after screening is a mixture of limited, inconclusive, and insufficient. The lack of evidence due to limited research literature is not evidence of lack of effect.

v) Public health. The public health impact of this bill on improved health (or socioeconomic) status and outcomes is unknown. Although CHBRP estimates that an additional ~211,000 commercially insured enrollees would receive SDOH screening in a clinical setting; and of those, ~25,000 are likely to screen positive for ≥ 1 social need; and of those, ~7,300 might connect with a CHW. CHBRP notes the following as unknown:

(1) If the supply of CHWs in California is sufficient;

(2) Insufficient evidence indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective;

(3) If CHWs can successfully connect patients to ≥1 needed social resources;

(4) If social services/community-based organizations have adequate resources to meet increased needs;
(5) If these commercially insured enrollees would qualify for social services or community-based resources, most of which are income tested;
(6) If these commercially insured enrollees, if eligible for social services, would be able to use them (e.g., geographic, time, transportation or other barriers to their use);
(7) Whether health outcomes would improve within 12 months and to what extent; and,
(8) If and to what extent new social needs would develop and be addressed.

vi) **Long-term impacts**. CHBRP predicts that this bill would not contribute to long-term changes in health care utilization partly due to the unknown mechanism for establishing a reliable clinician CHW network system for patient referral. Additionally, multiple policy changes mitigate the potential effect of this bill including recent changes in Medi-Cal (new Medi-Cal managed care contracts and CalAIM activities), state-mandated NCQA accreditation of health insurance plans, and other clinician-led initiatives to address social needs through SDOH screening. These factors are likely to increase SDOH screening without passage of this bill. In addition, HCAI is convening a workgroup on licensure and reimbursement for CHWs that could change the use of and payment for CHW services in the long-term. However, that workgroup is focused on Medi-Cal coverage to create a mechanism for billing for CHW services and will not directly affect the commercial insurance market unless separate legislation or decisions to require coverage for CHW-related services are adopted in the commercial market. For reasons similar to CHBRP's unknown short-term public health impact finding, there is also an unknown long-term public health impact finding. Although screening is projected to increase among a concentrated group of commercially insured enrollees (Medi-Cal beneficiaries have baseline benefit coverage), outstanding questions remain about clinician decisions to screen and refer patients, the type and quality of CHW referrals and networks established (including the definition of "adequate" and "access" to CHWs by clinician), and whether there are adequate social resources available for the new influx of commercially insured enrollees with unmet social needs. However, this bill does require a workgroup to issue a report to the legislature by January 1, 2025, that creates a standardized model to connect patients with community resources. Depending on the outcome of that report and subsequent legislative and regulatory changes, this bill could have a larger impact on mitigating social needs among the newly covered commercially insured with unmet social needs. CHBRP acknowledges that, even without Workgroup recommendations or CHW or community resource involvement, SDOH screening could improve patient health status by increasing the information available to clinical teams about patients' social risk, which might then be used to influence treatment plans for patients experiencing social needs. For example, a clinician learns about housing insecurity, which leads to a different medication. Over time, broadening the clinical care approach to routinely incorporate social data could become standard. However, CHBRP states the magnitude of this type of change is unknown.

3) **SUPPORT.** The California Academy of Family Physicians, the cosponsor of this bill, writes that this bill is critical to improving health outcomes and health equity for vulnerable communities and aids in California's efforts to achieve a whole person care health care

system. The CaliforniaHealth+ Advocates state that unaddressed, SDOH adversely impact health equity due to worsening health outcomes, widening disparities, and increased health care costs for vulnerable communities. Health disparities by race, ethnicity, sexual orientation, gender identity, and disability, as well as by economic and community level factors such as geographic location, poverty status, and employment, are only partly explained by disparities in health care. Social and structural factors play a critical role in driving disparate health outcomes.

4) **SUPPORT IF AMENDED.** The California Chapter of the American College of Emergency Physicians writes that this bill would provide greater tools and more incentives to emergency physicians to screen the vulnerable patients that they serve if provisions were amended to clarify that the reimbursement and access to CHW apply in the emergency department.

5) **OPPOSITION.** The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans write that state mandates increase costs of coverage, especially for families who buy coverage without subsidies, small business owners who cannot or do not wish to self-insure, and California taxpayers who foot the bill for the state's share of those mandates. Health plans compete for business based on innovative benefit designs that increase access to care, improve quality, and contain costs. All ACA-compliant plans provide a robust package of EHBs in the large group, small business, and individual markets (both on and off the Exchange). In the individual market, the ACA sought to preserve the balance between comprehensive coverage and affordability by requiring states to bear the cost for new mandates that exceed the EHB package. The Centers for Medicaid and Medicare Services recently affirmed that states are still responsible for defraying the cost of new mandates. The opposition states all of these bills will increase costs and limit flexibility for employers. Faced with higher costs, employers must make difficult decisions about whether to absorb premium increases or seek alternative coverage options.

6) **RELATED LEGISLATION.** AB 1331 (Wood) establishes a Data Exchange Framework governing Board with specified membership, to develop recommendations and to approve any modifications to the Data Exchange Framework data sharing agreement. AB 1331 is pending in Assembly Health Committee.

7) **PREVIOUS LEGISLATION.**

   a) SB 1033 (Pan) of 2022 would have required the DMHC and CDI to develop and adopt regulations establishing demographic data collection standards, no later than July 1, 2024. Would have required health plans and health insurers to assess the individual cultural, linguistic, and health-related social needs of enrollees and insureds for the purpose of identifying and addressing health disparities, improving health care quality and outcomes, and addressing population health. Would have also required the DMHC and CDI to require plans and insurers to obtain accreditation, as described, establish standardized categories for the collection and reporting of self-reported demographic and health-related social needs, as outlined, and would have established a program to provide technical assistance and other support to plans and providers. AB 1033 was held in the Assembly Appropriations Committee.

b) SB 428 (Hurtado), Chapter 641, Statutes of 2021, requires a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2022, that provides coverage for pediatric services and preventive care to additionally include coverage for ACES.

c) AB 2697 (Aguiar-Curry), Chapter 488, Statutes of 2022, codifies the requirement that CHW services be a covered Medi-Cal benefit. Requires a Medi-Cal managed care plan to engage in outreach and education efforts to enrollees, as determined by DHCS, but that includes, at a minimum, specified information to enrollees, including, among other things, a description of the CHW services benefit and a list of providers that are authorized to refer an enrollee to CHW services. Requires DHCS, through existing and regular stakeholder processes, to inform stakeholders about, and accept input from stakeholders on, implementation of the CHW services benefit. Specifies implementation only to the extent that federal financial participation is available and not otherwise jeopardized. Authorizes DHCS to implement, interpret, or make specific AB 2697 by means of policy letters, provider bulletins, or other similar instructions, without taking any further regulatory action.

8) POLICY COMMENTS.

a) Eligibility. CHBRP notes that since eligibility for social services is often limited to lower-income people, many commercially insured people might not qualify. This may pose challenges to linking them with services that can sustainably address their social needs. This bill does not mandate reimbursement for or coverage of social services that patients with social needs would be linked to through CHWs.

b) Workforce issues. The Commission cited in this bill noted that CHWs provide an effective and efficient bridge for patients. CHW services are a new benefit under Medi-Cal and available for a subset of beneficiaries. CHBRP also notes that HCAI is currently developing standards for certifying and training for CHWs. This bill authorizes HCAI to convene a work group to create a standardize model and procedures for connecting patients with community resources. Given that the report to the Legislature is due January 2025, is this bill premature as it applies to commercial coverage?

c) Screening criteria. This bill is silent on SDOH screening criteria. The author should consider to the extent possible, aligning requirements with Medi-Cal managed care plans, to avoid potential duplication between health plans, CHWs, and screening providers.

d) Health information exchange. To avoid duplication and ensure that screening services link patients to appropriate social services, it is important that provider and health plans share medical information through the Data Exchange Framework.

REGISTERED SUPPORT / OPPOSITION:

Support

California Academy of Family Physicians (sponsor)
Aguilas
American College of Obstetricians and Gynecologists District IX
California Academy of Family Physicians
California Black Health Network

California Chronic Care Coalition
California Health+Advocates
California Life Sciences
California Medical Association
California Pan - Ethnic Health Network
California State Association of Psychiatrists
California-Hawaii State Conference of the NAACP
Children's Choice Dental Care
Children's Partnership, the
Children's Specialty Care Coalition
California Tele-Health Network
Community Clinic Association of Los Angeles County (CCALAC)
Crohns and Colitis Foundation
Having Our Say Coalition
Health Access California
Leo Baeck Temple
National Association of Social Workers, California Chapter
National Health Law Program
OCHIN, INC.
Planned Parenthood Affiliates of California
PurFoods, Mom's Meals
Sutter Health
The Los Angeles Trust for Children's Health
UCLA Chapter of Universities Allied for Essential Medicines
Western Center on Law & Poverty, INC.

Opposition

America's Health Insurance Plans (AHIP)
Association of California Life & Health Insurance Companies
California Association of Health Plans

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