SENATE COMMITTEE ON HEALTH
Senator Dr. Susan Talamantes Eggman, Chair

BILL NO: AB 85
AUTHOR: Weber
VERSION: June 19, 2023
HEARING DATE: June 28, 2023
CONSULTANT: Jen Flory

SUBJECT: Social determinants of health: screening and outreach

SUMMARY: Requires health plans and insurers to cover screenings for social determinants of health (SDOH) and provide primary care providers with adequate access to community health workers, social workers, and other specified types of workers. Requires the Department of Health Care Services to provide reimbursement for SDOH screenings as a covered Medi-Cal benefit. Requires the Department of Health Care Access and Information to convene a working group with specified membership to create a standardized model for connecting patients to community resources.

Existing law:
1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and the California Department of Insurance (CDI) to regulate health insurers. [HSC §1340, et seq. and INS §106, et seq.]

2) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which low-income individuals are eligible for medical coverage. [WIC §14000, et seq.]

3) Requires DMHC to establish standard measures and annual benchmarks for equity and quality in health care delivery. Requires a health plan to annually submit to DMHC a report containing health equity and quality data and information. Requires DMHC to coordinate with DHCS to support the review of, and any compliance action taken with respect to, Medi-Cal managed care (MCMC) plans to maintain consistency with the applicable federal and state Medicaid requirements governing those plans. Also applies the requirements on health plans to MCMC plans that contract with DHCS to provide health care services to Medi-Cal beneficiaries. [HSC §1399.871-1399.873]

4) 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. Includes community health worker (CHW) services as a covered Medi-Cal benefit. [WIC §14132, §14132.36]

5) Requires DHCS to require each MCMC plan to develop and maintain a beneficiary-centered population health management (PHP) program that meets specified standards, including identifying and mitigating SDOH and reducing health disparities or inequities. [WIC §14184.204]

6) Establishes the Department of Health Care Access and Information (HCAI) and assigns HCAI various duties in health planning, health policy and research, health professions development, health care demonstrations projects, health data, facilities loan insurance and financing, and facilities design review and construction. [HSC §127000 et seq.]

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. Requires HCAI, on or before July 1, 2023, to develop and approve statewide requirements for CHW certificate programs and to approve the curriculum required for programs to certify CHWs. Authorizes HCAI to collect workforce data on CHWs from individuals who have enrolled in or completed CHW certificate programs. [WIC §18998, §18998.1, §18998.3]

This bill:

1) Defines "SDOH" to mean the conditions under which people are born, grow, live, work, and age, including housing, food, transportation, utilities, and personal safety. Conditions the implementation of this bill on an appropriation by the Legislature.

HCAI Workgroup

2) 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.

3) Requires the working group to 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 care service plans and health insurers, community-based organizations, social workers, and consumer groups. Permits the working group to consult with other individuals, groups, or organizations for additional insight or expertise on issues under consideration by the working group.

4) Requires the working group to submit a report to the Legislature with recommendations on the topics listed in 2) above by July 1, 2024.

Health Plan and Health Insurance Requirements

5) Requires a health plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2025, to include coverage, and provide reimbursement to health care providers, for SDOH screenings regardless of the screening method utilized. Exempts specialized health plans from this requirement.

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

7) Authorizes DMHC and CDI to adopt guidance for health plans and insurers to implement 5) and 6).

Medi-Cal Requirements

8) Establishes screenings for SDOH as a Medi-Cal covered benefit and requires DHCS to provide reimbursement to a Medi-Cal provider who renders this service, regardless of the screening method utilized.

9) Requires DHCS to reimburse federally qualified health centers (FQHCs) and rural health clinics (RHCs) for SDOH screenings at the Medi-Cal fee-for-service rate in addition to any other amounts payable with respect to those services, including payments received pursuant to the prospective payment system (PPS) rate and the alternative payment methodology (APM) rate.

FISCAL EFFECT: According to the Assembly Appropriations Committee:

1) Coverage of SDOH Screenings.
   a) Cost pressure to DHCS to include SDOH screening. The California Health Benefits Review Program (CHBRP) indicates Medi-Cal already covers SDOH screening and CHWs; however, this bill removes DHCS' ability to stop covering these services. According to CHBRP, Medi-Cal coverage for SDOH screening costs more than $17 million per year (General Fund, federal funds).
   b) Costs to DMHC will be minor and absorbable.
   c) Costs to CDI of approximately $125,000 in fiscal year (FY) 2023-24 and $114,000 in FY 2024-25 for additional workload (Insurance Fund).
   d) CHBRP estimates premiums for CalPERS health plan enrollees would increase by $415,000 overall, a substantial portion of which would be paid by state and other government agencies (various funds).
2) Working Group. HCAI estimates General Fund costs of $5 million In FY 2024-25 to convene meetings and develop recommendations to create a standardized model 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 in the six months allowed by the bill.
3) Budget Request. Additional General Fund cost pressure in the tens of millions of dollars, as evidenced by a budget request for $41 million submitted by the author and another Assemblymember to fund this bill.

PRIOR VOTES:

Assembly Floor:	61 - 0
Assembly Appropriations Committee:	11 - 1
Assembly Health Committee:	12 - 0

COMMENTS:

1) *Author's statement.* 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, a recent study discovered that physicians feel discomfort not being able to address their patient's social determinants of health needs. This bill will help physicians begin to address patients' needs by referring patients to supportive resources closest to them. Lastly, 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) *Current state efforts to address SDOH in healthcare settings.* SDOH, also referred to as "social drivers of health" refers to the nonmedical factors that influence health outcomes, sometimes more significantly than particular medical diagnoses. For example, if someone has food insecurity, the lack of food and poor nutrition can have a significant short and long term impact on that person's health and can also interfere with other attempts to treat a condition such as diabetes through traditional medical interventions. Several efforts have been made recently in California to screen for and address SDOH through the health care system.

   a) *ACEs Screenings.* In partnership with the California Office of the Surgeon General, DHCS created a statewide effort to screen patients for Adverse Childhood Experiences (ACEs) that lead to trauma and the increased likelihood of ACEs-associated health conditions due to toxic stress with the goal of reducing ACEs and toxic stress by half in one generation. All providers are encouraged to receive training to screen patients for ACEs. According to DHCS, 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. As of January 1, 2020, DHCS has been paying Medi-Cal providers $29 per screening for children and adults with Medi-Cal coverage. SB 428 (Hurtado, Chapter 641, Statutes of 2021) now requires commercial health plans and health insurers that provide coverage for pediatric services and preventive care to also include coverage for ACEs screenings.

   b) *Medi-Cal's CalAIM initiative.* CalAIM is a collection of Medi-Cal initiatives aimed at addressing SDOH, reducing program complexity and increasing flexibility, and modernizing payment structures to promote better outcomes. The CalAIM initiative started on January 1, 2022, after passage of AB 133 (Committee on Budget, Chapter 143, Statutes of 2021) and after the approval of a federal Section 1115 demonstration waiver and a Section 1915(b) waiver. These waivers, named for the section of the Social Security Act authorizing each, allow DHCS to waive certain federal Medicaid and Children's Health Insurance Program requirements to test innovating program improvements or change how services are delivered. DHCS received approval on December 29, 2021 for both waivers, effective through December 31, 2026.

      Population Health Management (PHM) is a specific initiative within CalAIM that identifies and manages member risk and need through whole person care approaches while focusing on and addressing SDOH. DHCS issued guidance to Medi-Cal managed care plans on collecting SDOH data, stating that SDOH data is vital to the success of the PHM initiative. The guidance included 25 DHCS Priority SDOH Codes, based on the International Classification of Diseases, Tenth Revision, Clinical Modification for managed care plans and providers to use when coding for SDOH to ensure correct coding and capture of reliable data. The PHM initiative collects SDOH data not just based on information obtained while screening plan enrollees, but also by coding and documenting SDOH among network providers and subcontractors, including providers of enhanced care management and community support services providers, which include social services providers in addition to traditional medical providers. The PHM policy guide details efforts to streamline several initial screening processes by eliminating some questionnaires that duplicate information and relying on data otherwise available to reduce screening fatigue among Medi-Cal enrollees while still meeting the goals of the

program and federal and the National Committee for Quality Assurance (NCQA) requirements. 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.

In addition to the PHM initiative, as part of CalAIM, CHW services were added as a Medi-Cal benefit starting July 1, 2022. CHW services are intended to prevent disease, disability, and other health conditions or their progression; to prolong life; and, promote physical and mental health. Community health workers may include individuals known by a variety of job titles, including promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals. Covered CHW services include health education, screening and assessment that does not require a license, individual support or advocacy, and health navigation. Health navigation services are intended to help a beneficiary access health care, understand the health system, or connect to community resources necessary to promote a beneficiary's health including enrolling or maintaining enrollment in government programs or other assistance if those programs would improve their health. Given concerns about the lack of CHW workforce, in 2022, HCAI was tasked with developing a statewide requirements to certify CHWs and to approve curriculum requirements for programs to certify CHWs in consultation with specified stakeholders through the health trailer bill SB 184 (Committee on Budget and Fiscal Review, Chapter 47, Statutes of 2022) by July 1, 2023. HCAI is also tasked with collecting workforce data on CHWs.

c) *DMHC Health Equity and Quality Committee*. DMHC convened a Health Equity and Quality Committee in 2022 to make recommendations for standard health equity and quality measures, including annual benchmark standards for assessing equity and quality in health care delivery as required by AB 133. The Committee included consumer representatives, health plan representatives, providers, and quality measurement and health equity experts, along with non-voting members representing various state agencies. The Committee met nine times in 2022 and voted on a final list of 13 recommended measures. The Committee did consider including a new measure being proposed by health plan accreditor NCQA for social needs screening and intervention, but ultimately determined due to the stage of development of this proposed measure, it was too early to propose for inclusion in its final recommended measure set. Among the issues to be determined at the time for whether this tool would be adopted by NCQA was what screening tools should be used and expected intervention performance rates.

d) *Covered California*. Covered California contracts with its qualified health plans contain several provisions designed to reduce health disparities and increase health equity. With regards to SDOH screenings in particular, Covered California contracts require plans to screen all Covered California enrollees for food insecurity using the Accountable Health Communities Health-Related Social Needs tool developed by the Centers for Medicare and Medicaid Services that has been tested on Medicare and Medicaid populations. The contract highly encourages screening for additional health-related social needs. Health plans must report on their process for screening for SDOH, which questions are used, and actions the plan takes to coordinate screening and linkage to services within its provider network and to resources to address the social need.

3) *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, and reviewed this bill. Key findings include:

   a) *Coverage impacts and enrollees covered*. Currently, 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. This bill would expand coverage to 5,640,000 enrollees (25% of the enrollees with state-regulated health insurance), 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.
   b) *Medical effectiveness.* CHBRP reviewed 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. Studies on screening for SDOH in a clinical setting were limited in number and quality; there were few randomized controlled trials and the observational studies lacked control arms. 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.
   c) *Utilization*. Currently, 325,700 enrollees in the large group, small group, CalPERS, and individual insurance market with existing coverage received SDOH screening. Approximately 1,763,400 Medi-Cal enrollees received SDOH screening. Postmandate, based on 25% of the state-regulated enrollee population gaining coverage for SDOH screening, CHBRP estimates that use of SDOH screening would increase by 210,949 among enrollees with commercial or CalPERS insurance (a 64.77% increase).
   d) *Medi-Cal.* Because all MCMC plans reported providing and paying for SDOH screening at baseline, no increase is estimated. Due to the combination of Medi-Cal contracting requirements, 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 MCMC plans.
   e) *Impact on expenditures*. See the fiscal impact discussion above.
   f) *Public health.* The public health impact 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 at least one social need; and of those, ~7,300 might connect with a CHW, it is unknown:
      - If the supply of CHWs in California is sufficient;
      - If CHWs can successfully connect patients to at least one needed social resource;
      - If social services/community-based organizations have adequate resources to meet increased needs;
      - If these commercially insured enrollees would qualify for social services or community-based resources, most of which are income tested;

- 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);
- Whether health outcomes would improve within 12 months and to what extent; and,
- If and to what extent new social needs would develop and be addressed.

CHBRP does acknowledge to the extent that some screened enrollees would be linked to and use social resources, real changes in individual health status and outcomes could occur during the first year postmandate. CHBRP also found that the impact on health disparities is unknown, primarily because the number of social resources available to the commercially insured population is less than those available to Medi-Cal beneficiaries (who already have coverage for SDOH screening). Because eligibility for social services (housing vouchers, CalFresh, etc.) 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.

g) *Essential health benefits*. CHBRP found that this bill does not exceed the definition of essential health benefits in California because screenings are a preventive services and are therefore included in the definition of essential health benefits.

4) *Background on clinic PPS and APM rates.* FQHCs and RHCs are federally designated clinics that provide primary care services to serve medically underserved populations. FQHCs and RHCs are reimbursed by Medi-Cal on a per-visit rate which is known as the prospective payment system (PPS) rate. Each FQHC and RHC has a specific Medi-Cal PPS rate for each face-to-face encounter, irrespective of the reason for the visit or the number of providers seen. For Medi-Cal managed care patients, DHCS reimburses FQHCs and RHCs for the difference between its per-visit PPS rate and the payment made by the plan through a wrap-around payment. SB 147 (Hernandez, Chapter 760, Statutes of 2015) authorized a three-year APM pilot program for county and community-based FQHCs. As proposed under the FQHC APM pilot, the PPS payment and wrap-around would be replaced by an upfront, clinic-specific capitation rate. The purpose was to move the clinics away from volume-based, PPS to a more flexible payment methodology that would enable "non-traditional" services like integrated primary and behavioral health visits on the same day, group visits, email visits, phone visits, community health worker contacts, case management, and case coordination across systems. In 2016, DHCS submitted a concept paper for the APM pilot program to CMS, but CMS indicated the proposal did not comply with federal APM requirements, thus the pilot was not implemented. DHCS held a series of stakeholder meetings in 2021 and updated SB 147 via trailer bill language in SB 184 for submission of a State Plan Amendment for federal approval of the APM with the intent of implementing the APM no sooner than January 1, 2024. This bill would require payments to FQHCs and RHCs to be made through the fee-for-service system on top of payments made through either the PPS system or the APM system. This aligns with how clinic providers are currently paid for ACEs screenings.

5) *Prior legislation.* SB 184 (Committee on Budget and Fiscal Review, Chapter 47, Statutes of 2022) is the health trailer bill that, among other things, defines CHWs and their required core competencies and requires HCAI to develop statewide CHW certificate programs and approve training curriculum.

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. SB

1033 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. SB 1033 would have also required 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. *SB 1033 was held on the Assembly Appropriations Committee suspense file.*

AB 2697 (Aguiar-Curry, Chapter 488, Statutes of 2022) codifies CHW services as a covered Medi-Cal benefit. Requires MCMC plans to engage in outreach and education efforts to enrollees, that includes specified information to enrollees on what the CHW services are and how to find a CHW.

SB 428 (Hurtado, Chapter 641, Statutes of 2021) requires a health plan contract or health insurance policy that provides coverage for pediatric services and preventive care to additionally include coverage for ACEs screenings.

AB 133 (Committee on Budget, Chapter 143, Statutes of 2021) is the health trailer bill that among other things, establishes the CalAIM initiative, including the PHM program to identify and mitigate SDOH and reduce health disparities or inequities.

6) *Support.* Sponsors the California Academy of Family Physicians write that screening for SDOH can help physicians better contextualize the care they are providing patients. The challenge is the lack of resources to operationalize a large task with many factors into a busy practice environment in a manner that is actionable and practical. Moreover, physicians don't know how to address the needs of patients outside the clinic walls. This bill would require health plans and insurers to pay for the SDOH screening. It will also increase efforts to bridge patients to community resources or government social services to address their SDOH needs by requiring health plans and insurers to provide access to CHWs or social workers. Access to CHWs or social workers will provide the linkage between the healthcare team and community resources, which will close the gap in follow-ups after screening. Lastly, the bill will establish a workgroup to create a standardized model and procedures for connecting patients with community resources, assess the need for a centralized list of accredited community providers, and determine gaps in research and data to inform policies on system changes to address SDOH.

7) *Opposition.* The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans write in opposition to this along with 22 other health insurance mandate bills. These bills include mandates for health plans and insurers to cover specific services, as well as bills that eliminate cost sharing and limit utilization management, which have similar cost impacts as coverage mandates. Moreover, they will increase costs, reduce choice and competition, and further incent some employers and individuals to avoid state regulation by seeking alternative coverage options. 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. Benefit mandates that do not promote evidence-based medicine can lead to lower quality care, over- or misutilization of services, and higher costs for treatments that may be ineffective, less

safe, or higher cost than other, new or trusted services. California is rightly focused on achieving both universal coverage and cost containment at a time when the national conversation has shifted toward lower costs through less comprehensive options.

8) *Policy Comment.* A literature review published in July 2022 by the Social Interventions Research & Evaluation Network at UC San Francisco that reviewed social screening practices found that there is no consensus as to what topics should be included in such screening tools and that the tools had rarely been tested using gold standard tools for assessing psychometric validity screening practices in health care. The current language in this bill allows for any screening tool to be used, which could diminish the effectiveness of the screening. While it is understandable that providers would not want to use different screening tools based on the payer, there should be some evaluation of what tools are acceptable. The author should consider language that permits providers to use tools that have been approved by an outside body such as one of the state departments or the NCQA.

   Additionally, through the CalAIM initiative and plan contracts, MCMC plans and providers are already required track individual SDOH data. DHCS has made efforts to expand and streamline these efforts through the PHM program, and should maintain the authority to determine the appropriate SDOH tools and avoid duplicate screenings. However, while the majority of Medi-Cal beneficiaries are enrolled in managed care plans, not all are, particularly in the first months of enrollment. In some cases, such as for pregnant individuals enrolled by a provider through the presumptive eligibility program or uninsured individuals enrolled through hospital presumptive eligibility during a medical emergency, SDOH screening outside of the managed care plan requirements may be beneficial. The bill language should be modified to give DHCS authority to determine what tools may be used and when.

9) *Amendments.* In addition to the issues identified above, additional technical amendments should be made. The HCAI working group to create a standardized model and procedures for connecting patients with community resources should also have a representative from DMHC as most of the people who will now have access to SDOH screenings are in DMHC-regulated plans, as well as a representative from a CHW organization. The appropriation language as applied to the sections regulating health plans and health insurers should specify that such an appropriation is intended for the departments affected, not to cover the SDOH screenings or CHW or social worker services.

SUPPORT AND OPPOSITION:

Support: California Academy of Family Physicians (sponsor)
Aguilas
Alliance of Catholic Health Care
American College of Obstetricians and Gynecologists District IX
Black Leadership Council
California Association of Social Rehabilitation Agencies
California Black Health Network
California Chronic Care Coalition
California Dialysis Council
California Health+ Advocates
California Life Sciences
California Long-term Care Ombudsman Association
California Medical Association

California Pan - Ethnic Health Network
California State Association of Psychiatrists
California Telehealth Network
Children's Choice Dental Care
Children's Specialty Care Coalition
Community Clinic Association of Los Angeles County
Crohns and Colitis Foundation
Having Our Say Coalition
Health Access California
Health Officers Association of California
Mom's Meals
National Association of Social Workers, California Chapter
National Health Law Program
Nomi Health
Ochin, INC.
Planned Parenthood Affiliates of California
Rady Children's Hospital
Steinberg Institute
Sutter Health
The Children's Hospital
The Los Angeles Trust for Children's Health
UCLA Chapter of Universities Allied for Essential Medicines
Venice Family Clinic
Welbe Health
Western Center on Law & Poverty

Oppose: America's Health Insurance Plans
Association of California Life & Health Insurance Companies
California Association of Health Plans

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