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CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 2266

Introduced by Assembly Member Mitchell
(Principal coauthor: Assembly Member Atkins)
(Coauthors: Assembly Members Wieckowski and Williams)

February 24, 2012

An act to add Article 3.9 (commencing with Section 14127) to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 2266, as amended, Mitchell. Medi-Cal: Enhanced Health Homes for Frequent Hospital Users with Chronic Conditions.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing federal law authorizes a state, subject to federal approval of a state plan amendment, to offer health home services, as defined, to eligible individuals with chronic conditions.

This bill would require the department, upon approval of a state plan amendment and subject to the availability of specified funding, to

establish a program to provide health home services to frequent hospital users, as prescribed. If federal matching funds are available, this bill would require the department to prepare, or contract for the preparation of, an evaluation of the program, and to complete the evaluation and submit a report to the appropriate policy and fiscal committees of the Legislature within 18 months after designated providers have been selected and have begun to seek payment.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) The Health Homes for Enrollees with Chronic Conditions option (Health Homes option) under Section 2703 of the federal Patient Protection and Affordable Care Act (Affordable Care Act) (42 U.S.C. Sec. 1396w-4) offers an opportunity for California to address complex, co-occurring, chronic, and disabling health conditions, as well as social determinants of poor health outcomes and high costs among Medi-Cal beneficiaries.

(b) Almost half of the people who frequently use the emergency department for reasons that could have been avoided with earlier or primary care are homeless. People who are chronically homeless are vulnerable to frequent hospitalization. Frequent users who are homeless face significant difficulties accessing regular or preventive care and complying with treatment protocols, having no place to store medications, an inability to adhere to a healthy diet or maintain appropriate hygiene, frequent victimization, and a lack of rest to recover from illness. Homeless Medi-Cal enrollees will, in fact, continue to use costly acute care services and actually increase their inpatient days, even if receiving medical home services to reduce their return to the hospital.

(c) Increasingly, health providers are partnering with community behavioral health, social services, and housing providers to offer a person-centered interdisciplinary system of care that includes intensive paraprofessional care coordination or case management, often in supportive housing. Programs that offer intensive and comprehensive care coordination to frequent hospital users integrate primary care, behavioral health care, and social services,

and facilitate coordination of care among health systems, making this model an ideal health home that fosters a "whole person" orientation.

(d) Data show that programs providing intensive case management and care coordination, including connecting to and sustaining people in housing, decrease Medicaid costs within a year by reducing avoidable emergency department visits, hospital admissions, and readmissions. A randomized study of chronically homeless frequent users receiving intensive case management in housing demonstrated decreases in hospital admission rates of 46 percent, hospital days of 46 percent, and emergency department visits of 36 percent after 18 months of intervention, compared to a control group receiving usual care. Medi-Cal beneficiaries participating in foundation-funded frequent user programs experienced reductions in Medi-Cal costs of three thousand eight hundred forty-one dollars ($3,841) per beneficiary after one year and seven thousand five hundred nineteen dollars ($7,519) per beneficiary per year after two years, while drastically improving clinical outcomes.

(e) Additionally, the Massachusetts Office of Medicaid, as another example, reported that its Medicaid Program offering intensive interdisciplinary services and connecting chronically homeless individuals to housing reduced Medicaid costs by 67 percent for a total cost decrease of nine thousand eight hundred ten dollars ($9,810) per resident, even when considering the costs of housing.

(f) Federal guidelines allow the state to access enhanced federal matching rates under the Health Homes option for multiple target populations to achieve more than one policy goal.

SEC. 2. Article 3.9 (commencing with Section 14127) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 3.9. Enhanced Health Homes for Frequent Hospital Users with Chronic Conditions

14127. For the purposes of this article, the following definitions shall apply:

(a) "Department" means the State Department of Health Care Services.

(b) "Eligible individual" means an individual who meets the criteria defined by the department consistent with subdivision (c) of Section 14127.1 for eligibility for enhanced health home services identified in subdivision (d) of Section 14127.2.

(c) "Enhanced health home" means a designated provider, such as a physician, clinical practice or clinical group practice, rural health clinic, community health center, community mental health center, home health agency, or any other entity or ~~provider,operating~~ *provider, operating* or proposing to operate in coordination with a team of health care professionals, such as physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, and paraprofessionals, that satisfies all of the following:

(1) Meets the criteria described in federal guidelines.

(2) Offers a whole person approach.

(3) Coordinates or proposes to coordinate services for all of the needs of eligible individuals.

(4) Elects to participate in the program pursuant to this article.

(5) Offers services in a range of settings, including the eligible individual's home.

(d) "Federal guidelines" means all federal statutory guidance, and all regulatory and policy guidelines issued by the federal Centers for Medicare and Medicaid Services regarding the Health Homes for Enrollees with Chronic Conditions option under Section 2703 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 1396w-4), including the State Medicaid Director Letter issued on November 16, 2010.

(e) "Homeless" has the same meaning as that term is defined in Section 91.5 of Title 24 of the Code of Federal Regulations. "Chronic homelessness" means the state of an adult whose conditions limit his or her activities of daily living and who has experienced homelessness for longer than a year or for four or more episodes over three years.

14127.1. (a) No later than January 1, 2014, the department shall do all of the following:

(1) Design, with opportunity for public comment, a program to provide enhanced health home services to persons at high risk of avoidable and frequent use of hospital services due to complex co-occurring health and behavioral health conditions.

(2) Upon a request for proposals process, select providers in accordance with subdivision (e) of Section 14127.2, as designated providers working in coordination with health care providers under the Health Homes option state plan amendment.

(3) Submit any necessary applications to the federal Centers for Medicare and Medicaid Services for a state plan amendment under the Health Homes option to provide enhanced health home services to Medi-Cal beneficiaries, to newly eligible Medi-Cal beneficiaries upon Medicaid expansion under the Affordable Care Act, and to Low Income Health Program (LIHP) enrollees, if applicable, in counties with LIHPs willing to match federal funds.

(b) The program established pursuant to this article shall provide services to Medi-Cal beneficiaries, to newly enrolled Medi-Cal beneficiaries upon implementation of Medicaid expansion under the Affordable Care Act, and, if applicable, in counties with a LIHP established under California's Bridge to Reform Section 1115(a) Medicaid Demonstration implemented on November 1, 2010, willing to match federal funds, to enrollees of the LIHP. The program established pursuant to this article shall be designed to reduce a participating individual's avoidable use of hospitals when more effective care, including primary and specialty care, and social services, can be provided in less costly settings.

(c) The department shall seek, to the extent permitted by federal law and to the extent federal approval is obtained, to define the population of eligible individuals experiencing both of the following:

(1) Two or more of the following current diagnoses:

(A) Mental health disorders identified by the department as prevalent among frequent hospital users.

(B) Substance abuse or substance dependence disorders.

(C) Chronic or life-threatening medical conditions identified by the department as prevalent among frequent hospital users.

(D) Significant cognitive impairments associated with traumatic brain injury, dementia, or other causes.

(2) Two or more of the following indicators of severity:

(A) Frequent inpatient hospital admissions, including long-term hospitalization for medical, psychiatric, or substance abuse related conditions.

(B) Excessive use of crisis or emergency services or inpatient hospital care with failed linkages to primary care or behavioral health care.

(C) Chronic homelessness.

(D) History of inadequate followthrough, related to risk factors, with elements of a treatment plan, including lack of followthrough in taking medications, following a crisis plan, or achieving stable housing.

(E) Two or more episodes of use of detoxification services.

(F) Medication resistance due to intolerable side effects, or illness interfering with consistent self-management of medications.

(G) Self-harm or threats of harm to others.

(H) Evidence of significant complications in health conditions.

14127.2. (a) In accordance with federal guidelines, the state may limit the availability of services geographically, provided that providers meet criteria identified in subdivision (e) in each county designated.

(b) The department may designate providers working under a managed care organization contract or as a fee-for-service provider.

(c) The department may develop a payment methodology other than a fee-for-service payment, including a per member, per month payment to designated providers.

(d) (1) Subject to federal approval for receipt of the enhanced federal match, services provided under the program established pursuant to this article shall include all of the following:

(A) Comprehensive and individualized case management.

(B) Care coordination and health promotion, including connection to medical, mental health, and substance abuse care.

(C) Comprehensive transitional care from inpatient to other settings, including appropriate followup.

(D) Individual and family support, including authorized representatives.

(E) If relevant, referral to other community and social services supports, including transportation to appointments needed to manage health needs, connection to housing for participants who are homeless or unstably housed, and peer and recovery support.

(F) Health information technology to identify eligible individuals and link services, if feasible and appropriate.

(2) Beneficiaries may require less intensive services or graduate completely from the program upon stabilization.

(e) The department shall select designated providers operating with a team of health care professionals that have all of the following:

(1) A designated lead provider that is a community clinic, a provider of mental health services pursuant to the Adult and Older Adult Mental Health System of Care Act (Part 3 (commencing with Section 5800) of Division 5), or a hospital.

(2) Demonstrated experience working with frequent hospital users, with documentation of experience reducing emergency department visits and hospital inpatient days among the population served.

(3) Demonstrated experience working with people experiencing chronic homelessness.

(4) The capacity and administrative infrastructure to participate in the program, including the ability to meet requirements of federal guidelines.

(5) Documented ability to provide or to link clients with appropriate community-based services, including intensive individualized face-to-face care coordination, primary care, specialty care, mental health treatment, substance abuse treatment, peer and recovery support, permanent or transitional housing, and transportation.

(6) Experience working with supportive or other permanent housing providers.

(7) Current partnership with essential community hospitals, particularly the hospital or hospitals serving a high proportion of Medi-Cal patients, such as disproportionate share hospitals.

(8) A viable plan, with roles identified among providers of the enhanced health home, to do all of the following:

(A) Reach out to and engage frequent hospital users and chronically homeless eligible individuals.

(B) Connect eligible individuals who are homeless or experiencing housing instability to permanent housing, including supportive housing.

(C) Ensure eligible individuals receive whatever integrated services are needed to access and maintain health stability, including medical, mental health, and substance abuse care and social services to address social determinants of health.

(D) Track, maintain, and provide outcome data to the evaluator described in Section 14127.4.

(E) Identify appropriate funding sources for the nonfederal share of costs of services for the first eight quarters of implementation of the program.

(F) Identify appropriate funding sources for the nonfederal share of costs of services to sustain program funding beyond the first eight quarters of implementation of the program. Identifying sources may include a plan to partner with managed care organizations, counties, hospitals, private funders, or others.

14127.3. (a) This ~~section~~ *article* shall not be construed to preclude local ~~entities~~ *governments*, health plans, or foundations from contributing the nonfederal share of costs for services provided under this program.

(b) This article shall not be construed to limit the department in targeting additional populations or creating additional programs under the Health Homes option.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this article through provider bulletins or similar instructions, without taking regulatory action.

14127.4. (a) If federal matching funds are available, the department shall prepare, or contract for the preparation of, an evaluation of the program identified in this article. The department shall seek out and utilize only nonstate public funds or private funds to fund the nonfederal share of costs of the evaluation. The department, within 18 months after designated providers have been selected and have begun to seek payment, shall complete the evaluation and submit a report to the appropriate policy and fiscal committees of the Legislature.

(b) The requirement for submitting the report imposed under subdivision (a) is inoperative four years after the date the report is due, pursuant to Section 10231.5 of the Government Code.

14127.5. (a) This article shall be implemented only if federal financial participation is available and the federal Centers for Medicare and Medicaid Services approves the state plan amendment sought pursuant to subdivision (a) of Section 14127.1.

(b) Except as provided in subdivision (c), this article shall be implemented only if nonstate public funds or private funds are available to fully fund the creation, implementation, administration, and service costs during the first eight quarters of implementation, and thereafter.

(c) Notwithstanding subdivision (b), if the department finds, after the first eight quarters of implementation, that Medi-Cal costs avoided by the participants of the program are adequate to fully fund the program costs, the department may use state funds to fund the program costs.

(d) The department may revise or terminate the enhanced health home program any time after the first eight quarters of implementation if the department finds that the program fails to result in improved health outcomes or fails to decrease total Medi-Cal costs, including managed care organization costs, if applicable, for the population it is serving. The department may also designate additional providers, with federal approval, or may remove providers operating under the program if those providers are unable to provide the nonfederal matching funds or do not meet the department's guidelines.

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