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Assembly Speaker John Perez
State Capitol
Sacramento, CA 95814

Dear Speaker Perez:

On behalf of the Corporation for Supportive Housing, I am writing in opposition to AB 342 unless amended to ensure the state's 1115 Demonstration waiver meets the needs of highly vulnerable people with disabilities.

The Corporation for Supportive Housing is a national non-profit organization with a mission of preventing and ending homelessness. We are a member of the 1115 Waiver Stakeholder Advisory Committee and have participated in multiple meetings with the Department of Health Care Services (the Department), legislative staff, and other stakeholders involved in the waiver process.

CSH housed the Frequent User of Health Services Initiative, overseeing funding for six projects across the state that provided community-based multidisciplinary services to "frequent users," people who make frequent avoidable visits to the emergency room and experience psychosocial complexities, like behavioral health conditions, homelessness, extreme poverty, and social isolation.

Data from the Department of Health Care Services (DHCS) indicates that over 28,000 Medi-Cal beneficiaries with disabilities were frequent users in 2007, with costs to Medi-Cal of almost $40 million. By receiving "health care home" services, the Frequent User Initiative participants who were Medi-Cal beneficiaries experienced a 60% decrease in emergency room visits and a 69% decrease in inpatient days, translating into hospital costs avoided of $3,841 per beneficiary after one year and $7,519 per beneficiary per year after two years. California's 1115 waiver is the best vehicle to support the interventions frequent user programs provide.

Concerns Over Existing Language:

Under AB 4 6, the Legislature intended the 1115 waiver renewal to, "restructure the organization and delivery of services to be more responsive to the health care needs of Medi-Cal enrollees for the purpose of providing the most vulnerable Medi-Cal beneficiaries with access to better coordinated and integrated care that will improve their health outcomes, [and] slow the long-term growth of the Medi-Cal program . . ." AB 342 fails to include provisions that would improve health outcomes for the most vulnerable Medi-Cal beneficiaries. As a result, these beneficiaries will continue to incur high costs to the state. Even though most beneficiaries will become the

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financial responsibility of managed care plans, the state will base capitated rates partly on the high costs of these individuals.

Care Coordination and Medical Homes

A Lewin Group evaluation of the Frequent Users of Health Services Initiative demonstrated that very intensive face-to-face care coordination was a cornerstone of success in improving health outcomes and decreasing costs among this population. Care coordination included forming a trusting relationship with the participant at low coordinator-to-patient ratios (1:25), advocating for treatment with mental health and substance abuse treatment professionals, engaging patients to participate in their care, facilitating regular communication among clinicians working with the patient, and creating partnerships with social services programs, including those offering permanent housing. Programs that failed to address participants' non-medical barriers to care were unable to improve outcomes. For example, homeless people who were not linked to permanent housing actually increased their inpatient stays by 26%, despite receiving intensive medical care coordination.

AB 342 does not address the needs of this population for the following reasons:

- While we support the bill's requirement for the Department of Health Care Services (the Department) to use an algorithm to identify beneficiaries with complex conditions, and health plans to use aide codes to stratify beneficiaries by risk (Sections 14183(b)(6) and (c)(11)), the bill does not require health plans to deliver higher levels of services to individuals considered "high risk," other than updated assessments of the beneficiaries' needs (Section 14183(c)(12)(B)). It also does not define who would be considered a "high risk" beneficiary.

- The bill requires health plans to administer a risk assessment survey tool telephonically to determine "risk level of enrollees" (Section 14183(c)(12)). However, many beneficiaries who will be newly enrolled do not have telephones. Many more do not respond to letters or telephonic surveys. Further, particularly for the subset of the highest cost and most vulnerable beneficiaries, answering a long series of questions that address, with few exceptions, medical background, will not provide health plans with a true assessment of beneficiary need. The bill requires managed care plans to identify beneficiary need and refer beneficiaries to community resources (Section 14183(c)(13)(C)), but it is unclear how a health plan will identify beneficiary need for community resources, particularly since the bill's provisions do not include an assessment of such need.

- We support the bill's requirement that plans refer beneficiaries to community services (Section 14183(c)(12)(B), (13)(C), and (14)(C)); however, the bill's language indicates that a plan could simply hand beneficiaries a list of community resources. People who are homeless or frequent users typically cannot navigate the complex health care or social services systems to access behavioral health care services, to obtain housing, or to maintain benefits consistently. Without working face-to-face with high-need beneficiaries, providing a list of community services will not improve their health outcomes. We therefore recommend linking high risk beneficiaries with these services.

- Even though the Department's concept paper indicated the waiver would require the plans to improve Medi-Cal's health care delivery system, the bill's definition of "medical homes" is not consistent with recognized definitions of medical homes, such as the Joint Principles of Patient-Centered Medical Homes (Section 14183(c)(13). We believe the bill could provide a more specific definition of a medical home, consistent, at minimum, with the Joint Principles.

- We appreciate that the bill includes a definition of care coordination/management. Though we believe care management functions performed telephonically will not work to address the needs of most beneficiaries, as evidence suggests, this level of care management, if provided face-to-face, would address the needs of many beneficiaries. Yet, it will not address the needs of high-cost vulnerable beneficiaries and the bill includes no provisions for the provision of more intensive or different services to these populations. We recommend "high risk" individuals receive more intensive care coordination services.

Integration of Behavioral Care

Half of all beneficiaries who will be mandated to enroll in managed care face serious mental illness, and many more experience less serious or other behavioral health conditions. The Centers for Medicare and Medicaid Services, in a Dear State Medicaid Director letter, identified integrated care as a way for a state to comply with obligations under the *Olmstead* case, so we believe the state should take advantage of federal interest in this area to integrate care.

The bill does not include any provisions that would integrate behavioral health care with medical care. Within the care coordination requirements, the bill includes a requirement to facilitate communication among a beneficiaries' health care providers, including behavioral health care providers "when appropriate" (Section 14183(c)(14)(D)). However, the bill includes no provision for facilitating access to behavioral care, and assumes that beneficiaries enrolled in managed care will have ready access to behavioral care, an inaccurate assumption. Additionally, the language does not clarify when a managed care coordinator will facilitate communication among behavioral health providers. We recommend strengthening these provisions.

Counties Without Health Plans

The bill does not affect beneficiaries residing in non-managed care counties. We recommend the Department promote the creation of medical or health care homes in these counties as well. Federal health reform includes means of doing so at little to no cost to the state.

Transportation

The lack of transportation is a considerable barrier to access to care for many in extreme poverty. The bill requires health plans to, "Inform seniors and persons with disabilities of procedures for obtaining transportation to service sites that are offered by the plan or are available through the Medi-Cal program," (Section 14183(c)(8)), but does not require the plans to offer transportation services. We recommend requiring the provision of transportation services, at least for covered services.

Coverage Expansion and Enrollment Demonstration

The Coverage Expansion and Enrollment Demonstration sections of the bill do not include any standards counties must meet in serving people with significant difficulties accessing appropriate health care. Specifically, while the bill requires participating counties to provide medical homes and enhanced medical homes, it does not include definitions of these terms. It does not require provision of care coordination. Without addressing the barriers frequent users face, many of these individuals will remain frequent users once enrolled in Medi-Cal in 2014 under health reform, and will continue to incur high costs to the state.

Recommendations for Amendments:

To achieve the purposes of improving health outcomes and controlling costs, CSH recommends the following amendments:

- Section 14183(c)(8): Delete paragraph and replace with, "(8) Provide transportation services to seniors and persons with disabilities for all covered services, and inform beneficiaries about transportation services in the community for all non-covered services."

- Section 14183(c)(12): Add after paragraph (A), "(B) If the beneficiary does not respond to a request to complete an assessment, is homeless, does not have access to a telephone, suffers from a cognitive impairment, or has been diagnosed with a behavioral health condition, the health plan shall complete a face-to-face risk assessment that will include an assessment of the beneficiary's behavioral health care needs and other non-medical barriers to care, including homelessness."

- Section 14183(c)(12): Delete "(B)" and add "(C)" after amended paragraph (B), and delete "telephonic" before "health risk assessment."

- Section 14183(c)(12): After current subparagraph (B)(v), add the following:

  "vi. (I) For beneficiaries with high levels of need, the health plans will contract with community-based organizations to provide the following care coordination services:

  (a) Identifying and assessing a beneficiary's health needs and working with the beneficiary, face-to-face when necessary, to arrive at a plan to meet those needs;
  (b) Arranging timely access to primary, specialty, mental health, substance abuse, and/or social services care;
  (c) Connecting the beneficiary to relevant health-impacted social service resources, including permanent housing providers if the beneficiary is homeless or unstably housed, veterans services organizations if the beneficiary is a veteran, and any relevant county agencies, to address significant barriers to receipt of appropriate care;
  (d) Ensuring continuity of care;
  (e) Facilitating communication among the beneficiary's providers;
  (f) Educating a beneficiary regarding self-care, including medication management;
  (g) Helping the beneficiary fulfill the requirements of maintaining Medi-Cal eligibility;
  (h) Conducting outreach to locate and engage beneficiaries in their health treatment, when the beneficiary is difficult to engage and does not respond to other forms of contact;
  (i) Collaborating with hospitals to plan for a beneficiary's discharge from inpatient stays; and
  (j) Working with health professionals and the beneficiary to change treatment plans when a beneficiary's health does not improve or worsens.

  (II) Beneficiaries with a 'high level of need' include, but are not limited to the following:

  (a) Individuals who have two or more chronic conditions (including serious mental illness and/or substance abuse disorders),

(b) Individuals who have five or more visits to the emergency department for avoidable reasons over the past 12 months,

(c) Individuals who have been admitted to the hospital two or more times for avoidable reasons over the past 12 months, and

(d) Individuals who have or are at a high risk of developing significant barriers to appropriate care (e.g. homelessness and cognitive impairments).

(III) The Department may work with Medi-Cal managed health care plans and county alternative care plans to design and implement methods for identifying beneficiaries with a 'high level of need' and may identify additional populations with 'high level of need.'

(IV) Care coordinators may provide services outside of a provider's physical facility(ies), including where the beneficiary lives."

- Section 14183(c)(14): Insert ", with occasional face-to-face interactions" after "activities."
  - (A) After "telephonic," insert "and in-person."
  - (B) Delete "referrals for any physical or cognitive barriers to access" after "including" and replace with "linkage to community behavioral health care professionals or agencies when the beneficiary has been diagnosed with or appears to suffer from a behavioral health condition, and to social services, such as housing agencies or organizations, when the beneficiary experiences non-medical conditions, such as homelessness, that impede access to appropriate care."
  - (D) Delete "when appropriate" and replace with, "if the beneficiary is receiving behavioral health care."

- Section 14183.1: Add subsection (f) to read,
  "(f) The Department shall promote the creation of medical homes for beneficiaries residing in counties or regions where a Medi-Cal managed health care plan and a county alternative care plan are not available.

  (i) The Department shall offer administrative fees to medical home providers or groups of providers if the home seeks administrative fees and ensures that beneficiaries with 'high levels of need' receive the services described in Section 14183(c)(12).

  (ii) Medical homes may include or solely consist of primary care providers, specialists, licensed behavioral health providers, or nurse practitioners.

  (iii) The Department shall stratify administrative fees provided in this Section according to beneficiary need."

- Section 15910(b): Before "Counties," insert, "Counties shall prioritize enrollment of people experiencing homelessness and people who frequently use emergency departments for avoidable reasons."

- Section 15910(e)(2)(A): At the end of the paragraph, add the following:
  "Medical homes should have the capacity to provide the following services, according to beneficiary need:
  (I) Community-based coordination of care;
  (II) After hours, weekend care, and open scheduling, with same-day access to clinical services, when needed to avoid worsening health conditions and/or the need for acute care services; and
  (III) Resources that ensure the beneficiary is linked to any necessary behavioral health care services, dental care, and social services existing in the community, including programs

offering permanent housing to people experiencing homelessness or significant housing instability."

- Section 15910(e)(2)(B):
  - Add "to enrollees with high levels of need, as defined in Section 14183(c)(12) of the Welfare & Institutions Code."
  - Substitute "may" after "The enhanced medical home," with "shall."
  - Substitute "case management" after "include" with "the following care coordination services:"
  - Add the following after (B):
    "(I) Identifying and assessing a beneficiary's health needs and working with the beneficiary, face-to-face when necessary, to arrive at a plan to meet those needs, with occasional review and modification of the plan;
    (II) Arranging timely access to primary, specialty, mental health, substance abuse, and/or social services care;
    (III) Connecting the beneficiary to relevant health-impacted social services, including permanent housing providers if the beneficiary is homeless or unstably housed, veterans services organizations if the beneficiary is a veteran, and any relevant county agencies, to address significant barriers to receipt of appropriate care;
    (IV) Ensuring continuity of care;
    (V) Facilitating communication among the beneficiary's providers;
    (VI) Educating a beneficiary regarding self-care, including medication management;
    (VII) Conducting outreach to locate and engage beneficiaries in their health treatment, when the beneficiary is difficult to engage and does not respond to other forms of contact; and
    (VIII) Collaborating with hospitals to plan for a beneficiary's discharge from inpatient stays."

We believe these amendments are necessary to ensure the needs of high-cost, highly vulnerable beneficiaries are met. The state is in the unique position of advancing care integration and attracting federal investment. In fact, several sections of the federal health reform bill advance similar measures, as does the federal Department of Health and Human Services-endorsed Plan to End Homelessness.

We greatly appreciate your commitment to these populations, and hope that you will consider amending AB 342.

Sincerely,

Jonathan C. Hunter
Managing Director, Western Region