AMENDED IN SENATE SEPTEMBER 1, 2015

AMENDED IN ASSEMBLY MAY 21, 2015

AMENDED IN ASSEMBLY MAY 13, 2015

AMENDED IN ASSEMBLY APRIL 21, 2015

AMENDED IN ASSEMBLY APRIL 6, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

# ASSEMBLY BILL No. 50

**Introduced by Assembly Member Mullin**

December 1, 2014

An act to add Section 14148.25 to the Welfare and Institutions Code, relating to perinatal care.

LEGISLATIVE COUNSEL'S DIGEST

AB 50, as amended, Mullin. Medi-Cal: evidence-based home visiting programs.

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, including perinatal services for pregnant women.

Existing law establishes the Nurse-Family Partnership program, which is administered by the State Department of Public Health, to provide grants for voluntary nurse home visiting programs for expectant first-time mothers, their children, and their families. Under existing law, a county is required to satisfy specified requirements in order to be eligible to receive a grant.

This bill would require the State Department of Health Care Services, in consultation with specified stakeholders, to develop a plan on or before January 1, 2017, to ~~ensure that~~ *determine the feasibility of offering* evidence-based home visiting programs ~~are offered and provided~~ to Medi-Cal eligible pregnant and parenting ~~women, and would require the department, on or before January 1, 2022, and every 5 years thereafter, to report to the Legislature, as specified.~~ *women.* The bill would also require the department, in developing the plan, to consider, among other things, establishing Medi-Cal coverage for evidence-based home visiting program services and incentives for Medi-Cal providers to offer those services, and would require the department, in developing the plan, to prioritize the identification of funding sources, other than General Fund moneys, to fund evidence-based home visiting program services.

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) According to United States Census Bureau, California has a poverty rate of 23.5 percent, the highest rate of any state in the country.

(b) Children born into poverty are at higher risk of health and developmental disparities, including, but not limited to, premature birth, low birth weight, infant mortality, crime, domestic violence, developmental delays, dropping out of high school, substance abuse, unemployment, and child abuse and neglect.

(c) In 2014, the Legislature passed Assembly Concurrent Resolution No. 155 by Assembly Member Raul Bocanegra, recognizing that research over the last two decades in the evolving fields of neuroscience, molecular biology, public health, genomics, and epigenetics reveals that experiences in the first few years of life build changes into the biology of the human body that, in turn, influence the person’s physical and mental health over his or her lifetime.

(d) On May 3, 2012, Governor Edmund G. Brown Jr. issued Executive Order B-19-12, establishing the “Let’s Get Healthy California Task Force” to develop a 10-year plan for improving

the health of Californians, controlling health care costs, promoting personal responsibility for individual health, and advancing health equity.

(e) The task force identified several priorities, including a subset for "Healthy Beginnings," which include reducing infant deaths, increasing vaccination rates, reducing childhood trauma, and reducing adolescent tobacco use.

(f) The final report of the task force ~~states~~ *states*, "the challenge going forward is to identify evidence-based interventions and quicken the pace of uptake across the ~~state,"~~ *state"* in order to meet the ambitious goals in the Governor's directive.

(g) Voluntary evidence-based home visiting programs, such as Nurse-Family Partnership, Healthy Families America, Early Head Start (Home-Based Program Option), Parents as Teachers, and Home Instruction for Parents of Preschool Youngsters, strengthen the critical parent-child relationship and connect families with information and resources during the pivotal time from pregnancy to five years of age. Extensive research has shown that evidence-based home visiting programs serving pregnant and parenting mothers, prenatal to the child turning five years of age, increase family self-sufficiency, positive parenting practices, child literacy and school readiness, and maternal and child health.

(h) Voluntary evidence-based home visiting program models the prenatal to five years of age range from low to high intensity, reflecting the broad spectrum of family needs that home visiting can impact. Many experts hail home visiting program diversity as essential to providing parents with choices and ensuring that programs are well matched with local needs and strengths, as well as responsive to the diverse needs of California's children and families.

(i) In 2013, more than 248,000 Medi-Cal beneficiaries gave birth to a child. Because Medi-Cal covers half of all births in the state, this has increased costs for taxpayers. Medi-Cal expansion has resulted in an 18 percent increase in Medi-Cal enrollment to a total of 11.3 million, and enrollment is expected to exceed 12 million in 2015.

(j) The California Health and Human Services Agency recently submitted its State Health Care Innovation Plan, including the Maternity Care initiative, which addresses issues of high costs in maternity care, to the federal Center for Medicare and Medicaid

Innovation. Child deliveries and related expenses, including high-risk births, rank among the top 10 high-cost episodes of health care, and in the last 15 years, California has seen a continual rise in maternal mortality.

(k) The cost of health care specifically related to high-risk pregnancies, neonatal intensive-care unit (NICU) services, toxic stress, and emergency room visits has increased and is projected to continue to rise. Average health care costs for women were 25 percent more than men primarily due to higher costs of health care during childbearing years.

(*l*) With more than three decades of evidence from randomized, controlled trials and rigorous followup evaluation studies, evidence-based home visiting programs have demonstrated sustained improvements in maternal health, child health, positive parenting practices, child development and school readiness, reductions in child maltreatment, family economic self-sufficiency, linkages and referrals, and reductions in family violence.

(m) Evidence-based home visiting programs have specifically demonstrated reductions in preterm births, preventable maternal mortality, smoking during pregnancy, complications of pregnancy, closely spaced subsequent births, childhood injuries resulting in costly emergency department use and hospitalizations, improved childhood immunization rates, compliance with well child visit schedules, lower body mass index rates, higher birth weights, and improved family well-being, including increased family health literacy, and parent self-help development. As a result of families benefiting from evidence-based home visiting, there have been cost savings to federal, state, and local governments with respect to programs and services, including Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and the Temporary Assistance for Needy Families (TANF) program.

(n) The strong evidence of effectiveness and predictable return on investment demonstrate that evidence-based home visiting programs should be brought to scale in California to improve maternal and child health outcomes and help reduce health care costs for generations to come.

(o) By supporting families from the start, voluntary evidence-based home visiting programs serving families from prenatal to five years of age provide a foundation for subsequent early childhood programs and family support efforts to build upon,

and can help ensure that families are well-equipped to raise California's next generation of productive, healthy, and successful adults.

(p) Therefore, it is the intent of the Legislature to develop a means to leverage public and private dollars to substantially expand the scale of evidence-based home visiting programs throughout California, beginning with communities and populations with the greatest need.

SEC. 2. Section 14148.25 is added to the Health and Safety Code, to read:

14148.25. (a) The department shall, in consultation with stakeholders, including, but not limited to, representatives from Medi-Cal managed care plans, public and private hospitals, evidence-based home visiting programs, and local governments, develop a plan on or before January 1, 2017, to ~~ensure that~~ *determine the feasibility of offering* evidence-based home visiting programs ~~are offered and provided~~ to Medi-Cal eligible pregnant and parenting women. The department shall consult with stakeholders from diverse geographical regions of the state. The department shall consider all of the following in developing the plan:

(1) Establishing Medi-Cal coverage for evidence-based home visiting program services.

(2) Incentives for Medi-Cal providers to offer evidence-based home visiting program services.

(3) Other mechanisms to fund evidence-based home visiting program services for Medi-Cal eligible pregnant and parenting women.

(4) Identifying among evidence-based home visiting programs those with established evidence to improve health outcomes, the experience of care, and cost savings to the health care system.

(b) In developing the plan, the department shall prioritize the identification of funding sources, other than General Fund moneys, to fund evidence-based home visiting program services, including local, federal, or private funds, or any other funds made available for these program services.

~~(c) (1) Notwithstanding Section 10231.5 of the Government Code, the department shall, on or before January 1, 2022, and every five years thereafter, report to the Legislature on implementation progress and the effectiveness of evidence-based~~

~~home visiting services in improving maternal and child health outcomes, the experience of care, and cost savings to the Medi-Cal program and the state.~~

~~(2) A report to be submitted pursuant to paragraph (1) shall be submitted in compliance with Section 9795 of the Government Code.~~

~~(d)~~

*(c)* For the purposes of this section, the following definitions shall apply:

(1) "Evidence-based program" means a program that is based on scientific evidence demonstrating that the program model is effective. An evidence-based program shall be reviewed on site and compared to program model standards by the model developer or the developer's designee at least every five years to ensure that the program continues to maintain fidelity with the program model. The program model shall have had demonstrated and replicated significant and sustained positive outcomes that have been in one or more well-designed and rigorous randomized controlled research designs, and the evaluation results shall have been published in a peer-reviewed journal.

(2) "Evidence-based home visiting program" means a program or initiative that does all of the following:

(A) Meets, on or before April 1, 2015, the United States Department of Health and Human Services Maternal, Infant, and Early Childhood Home Visiting (MIECHV) criteria, as described in Section 511(d)(3)(A)(i)(*I*) of Title V of the Social Security Act (42 U.S.C. Sec. 711).

(B) Contains home visiting as a primary service delivery strategy by providers satisfying home visiting program requirements to provide services to families with a pregnant or parenting woman who is eligible for medical assistance.

(C) Offers services on a voluntary basis to pregnant women, expectant fathers, and parents and caregivers of children from prenatal to five years of age.

(D) Targets participant outcomes that include all of the following:

(i) Improved maternal and child health.

(ii) Prevention of child injuries, child abuse or maltreatment, and reduction of emergency department visits.

(iii) Improvements in school readiness and achievement.

(iv) Reduction in crime or domestic violence.

(v) Improvements in family economic self-sufficiency.

(vi) Improvements in coordination of, and referrals to, other community resources and support.

(vii) Improvements in parenting skills related to child development.

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