Key Findings:

Analysis of California Assembly Bill 166 Violence Preventive Services

Summary to the 2019–2020 California State Legislature, April 21, 2019

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

The version of California Assembly Bill 166 analyzed by CHBRP would require DHCS to "develop and implement services targeted at reducing injury recidivism among violently injured Medi-Cal beneficiaries, and provide direct reimbursement to qualified violence prevention professionals for violence preventive services."

1. CHBRP estimates that, as of July 1, 2020, all 10.5 million Medi-Cal beneficiaries (27% of all Californians) will have insurance subject to AB 166.
2. **Benefit coverage.** Currently, 0% of Medi-Cal beneficiaries have coverage for violence prevention services provided by prevention professionals as defined in AB 166. Coverage would increase to 100% postmandate.
3. **Utilization.** Baseline utilization is estimated at 700 enrollees per year. Due to constraints on the supply of qualified violence prevention professionals (QVPPs) and the time needed to develop reimbursement mechanisms for a new Medi-Cal benefit, no increase in utilization is projected in the first 12 months postmandate.
4. **Expenditures.** The estimated increase in expenditures is $525,000, or about 0.001% of all Medi-Cal expenditures, in Year 1 postmandate.
5. **Medical effectiveness.** There is limited evidence showing that violence prevention services decrease reinjury, prevent retaliation or future perpetration of violence, and may impact other related outcomes.
6. **Public health.** No short-term public health impact is anticipated due to no change in utilization in the first 12 months postmandate.
7. **Long-term impacts.** Utilization of violence prevention services is projected to increase gradually over time as the number of QVPPs increases, but cost impacts cannot be estimated. The long-term public health impact is unknown, but there may be reductions in violent injuries and reinjuries, and impacts on other related outcomes for some Medi-Cal beneficiaries who successfully complete a violence prevention program.

Refer to CHBRP's full report for full citations and references.

CONTEXT

About 115,000 Californians are treated annually for violent injury, with approximately 2,000 cases resulting in death in 2017.[1] Data from 2014 show that Medi-Cal beneficiaries under age 65 years had 48,261 emergency department, trauma center, or hospital visits for these types of injuries. Among the under age 65 cohort, about half of the violent injuries treated were in those aged 10–30 years. About twice as many Medi-Cal beneficiaries aged 10–65 years are treated for violent injury than in the privately insured population.

A substantial portion of individuals who experience a violent injury experience a violent reinjury; 10% to 25% of those with an initial violent injury have one or more violent reinjuries, and up to 20% of reinjuries result in death.

The primary intent of violence prevention programs is to prevent injury, reduce violent reinjury, and improve victim/perpetrator physical and mental health. Under AB 166, a licensed health care provider would be responsible for identifying patients with violent injuries and referring them to a qualified violence prevention professional (QVPP) if the patient is deemed to be at high risk for reinjury and/or retaliation.

Programs that currently provide the type of services identified in the bill are (1) *hospital-based* violence intervention programs (HVIPs), or (2) *hospital-linked* programs led by community-based organizations (CBOs), some of which employ violence prevention specialists.

AB 166 uses the term "*interpersonal* violence." However, for several reasons, CHBRP's analysis focuses on injuries from *community* violence, a subset of interpersonal violence that excludes other types of violence such as self-harm, domestic violence, and elder and child abuse.

BILL SUMMARY

AB 166 requires "violence preventive services" provided by a "qualified violence prevention professional" (QVPP) to be a covered Medi-Cal benefit by July 1, 2020, if:

> "The beneficiary has received medical treatment for a violent injury, including, but not limited to, a gunshot wound, stabbing injury, or any other form of violent injury; and
>
> A licensed health care provider has determined that the beneficiary is at elevated risk of violent reinjury or retaliation and has referred them to participate in a violence preventive services program."

The bill describes these services as "evidence-based, trauma-informed, supportive, and nonpsychotherapeutic services provided by a prevention professional for the purpose of promoting improved health outcomes and positive behavioral change, preventing injury recidivism, and reducing the likelihood that violently injured individuals will commit or promote violence themselves." The bill identifies a variety of services including peer support and counseling, mentorship, conflict mediation, crisis intervention, targeted case management, referrals, patient education, and screening services that are provided to "victims of *interpersonal* violence."

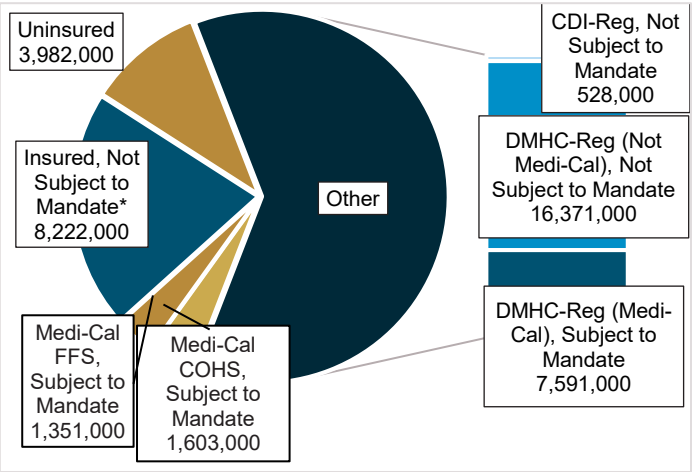
QVPPs are a new category of health care professionals as identified by AB 166. The bill outlines criteria that QVPPs must meet to be eligible for reimbursement, including specified training and certification, continuing education, and experience with providing violence prevention services.

Last, the bill requires the California Department of Health Care Services (DHCS) to "approve at least one governmental or nongovernmental accrediting body with expertise in violence preventive services to review and approve training and certification programs." AB 166 recognizes the National Network of Hospital-Based Violence Intervention Programs (NNHVIP) as an organization certifying violence prevention professionals.

The violence prevention services described in AB 166 would be a covered benefit for all Medi-Cal enrollees through an addition to the Welfare and Institutions Code. AB 166 does not apply to commercial or CalPERS plans.

Figure A shows how many Californians have health insurance that would be subject to AB 166.

Figure A. Health Insurance in CA and AB 166



IMPACTS

Benefit Coverage, Utilization, and Cost

The impacts that CHBRP projects AB 166 to have on Medi-Cal beneficiaries are described below.

Benefit Coverage

Currently, 0% of enrollees with health insurance that would be subject to AB 166 have coverage for violence prevention services provided by a QVPP as described by the bill. Medi-Cal already covers some services listed in AB 166, such as targeted case management or crisis counseling, but does not cover these services when provided by QVPPs, as this is not currently a category of providers that can bill Medi-Cal for services. Coverage would increase to 100% postmandate.

Utilization

Baseline: CHBRP estimates that 700 Medi-Cal enrollees will receive 50 hours of violence prevention services per year from QVPPs.

Year 1 Postmandate: Due to constraints on QVPP supply and the time needed to develop reimbursement mechanisms for the new Medi-Cal violence prevention services benefit, no increase in utilization is projected in the first 12 months postmandate.

Year 2 Postmandate: CHBRP estimates that utilization of violence prevention services would increase by 20%.

Expenditures

Year 1 Postmandate: Although CHBRP projects no increase in utilization from baseline to postmandate, the cost of violence prevention services provided by QVPPs are expected to shift to Medi-Cal under AB 166. Thus, Medi-Cal expenditures for these services are expected to increase by $525,000 (0.001%) in Year 1 postmandate.

Year 2 Postmandate: Due to increased utilization in Year 2, CHBRP projects total Medi-Cal expenditures of $626,000 (0.001%) attributable to expenses for covered benefits, minus offsets for reductions in treatment for reinjuries.

Number of Uninsured in California

No measurable change in the number of uninsured persons is expected due to the enactment of AB 166.

Medical Effectiveness

CHBRP's literature review results show the difficulties that HVIPs face with regard to rigorous evaluation, such as that provided by a randomized controlled trial (RCT). Most RCTs reviewed suffered from issues such as high attrition rates, small sample sizes, and low occurrence of events required to assess outcomes. As a consequence, many studies of existing programs are observational in nature and lack adequate comparison groups and statistical analysis.

CHBRP found *limited* evidence that violence prevention services lead to desired outcomes, including reducing reinjury, preventing retaliation or likelihood of perpetrating violence, and impacting other related outcomes and determinants of violent behavior.

Public Health

Continued exposure to violence is a known contributor to poor health status such as increased rates of cardiovascular disease, cancer, diabetes, sexually transmitted infections, mental health, and substance use disorders.

However, CHBRP concludes that AB 166 would have no short-term public health impact due to no change in utilization. This is based on a constrained supply of QVPPs in the first year postmandate and likely administrative delays associated with DHCS identifying an appropriate QVPP training and certification program.

Long-Term Impacts

CHBRP anticipates that following the establishment of the certification and training requirements by DHCS, existing HVIPs will increase the number of QVPP positions, community and health care organizations will develop new programs, and the overall number of QVPPs will increase in response to demand. CHBRP also anticipates that health care providers will develop increasing knowledge about community violence screening and referrals, as well as familiarity with violence prevention services. CHBRP thus projects that utilization of violence prevention services will increase in the long-term but is unable to quantify the long-term cost attributable to AB 166.

The long-term public health impact of AB 166 is unknown, but if effective violence prevention programs are expanded and replicated throughout California, CHBRP anticipates a reduction in community violence-related injuries, reinjuries, retaliation, and future perpetration of violence among some Medi-Cal beneficiaries who successfully complete a violence prevention program.

CHBRP is unable to estimate any reductions in existing health disparities. However, because violent injury disproportionately impacts young boys and men of color, any reduction in premature deaths and poor secondary health outcomes could help close the overall mortality rate disparity among males aged 10–30 years in California.

Essential Health Benefits and the Affordable Care Act

As AB 166 is relevant only to the benefit coverage of Medi-Cal beneficiaries, it seems unlikely that the bill, which would require a set of violence prevention services provided by QVPPs to be a covered benefit, would exceed the definition of essential health benefits (EHBs) in California.