California Behavioral Health Planning Council

Legislation Committee Agenda

Thursday, April 15, 2021

Zoom Meeting Link:
https://us02web.zoom.us/j/85667259665?pwd=ajU1V1ZvWmZCRVgwV1R1bkxVbFI5UT09
Meeting ID: 856 6725 9665 **Passcode:** CBHPCLC
Join by Phone: 1 669 900 6833 Passcode **(Phone):** 8398217
1:30 pm to 3:15 pm

1:30 pm	**Welcome and Introductions** *Tony Vartan, Chairperson*	
1:35 pm	**Approve January and March 2021 Meeting Minutes** *Tony Vartan, Chairperson*	**Tab 1**
1:45 pm	**Review Proposed Legislation for 2021** *Tony Vartan, Chairperson, All Members*	**Tab 2**
2:40 pm	**Break**	
3:00	**Public Comment**	
3:10 pm	**Wrap-up/Next step**	
3:15 pm	**Adjourn**	

The scheduled times on the agenda are estimates and subject to change.

Legislation Committee Members

Tony Vartan, Chairperson — Iris Mojica de Tatum, Chair-Elect

Gerald White	Barbara Mitchell	Daphne Shaw	Marina Rangel
Deborah Starkey	Darlene Prettyman	Susan Wilson	Karen Baylor
Monica Caffey	Noel O'Neill	Veronica Kelley	Hector Ramirez
Angelina Woodberry	Joanna Rodriguez	Catherine Moore	

If reasonable accommodations are required, please contact the Council at (916) 701-8211 not less than 5 working days prior to the meeting date.

TAB 1

California Behavioral Health Planning Council
Legislation Committee
Thursday, April 15 2021

Agenda Item: Approve January and March 2021 Meeting Minutes

Enclosures: January 2021 Quarterly Meeting Minutes
March 2021 In-Between Meeting Minutes

Background/Description:

The Committee members are to discuss any necessary edits and vote on the acceptance of the draft minutes presented for the January and March meetings.

Motion: Accept and approve the January and March Legislation Committee Minutes.

CBHPC **January 21, 2021**
Legislation Committee **Meeting Summary**

Members Present:

Gerald White, Chairperson	Tony Vartan, Chair-Elect	Hector Ramirez
Catherine Moore	Iris Mojica de Tatum	Barbara Mitchell
Daphne Shaw	Susan Wilson	Angelina Woodberry
Monica Caffey	Karen Baylor	Darlene Prettyman
Marina Rangel	Deborah Starkey	

CBHPC Staff present:
Jane Adcock, Executive Officer, Laura Leonelli, Jenny Bayardo

Meeting Commenced at 1:30 p.m.
Chairperson Gerald White welcomed everyone in attendance. Introductions were made. The meeting continued under the new Chair, Tony Vartan, who thanked Gerald for his service.

Approve October 2020 Meeting Minutes:
A motion to approve the October 2020 minutes with no amendments or edits was made by Catherine Moore and seconded by Monica Caffey. The motion passed with no abstentions.

California Behavioral Health Directors Association (CBHDA) Legislative Priorities for 2021:
Tyler Rinde, Policy Advocate, CBHDA, and Elia Gallardo, Director, Government Affairs, CBHDA

2021 begins a new 2-year legislative cycle. The deadline to introduce new legislation is February 19, and often the most proposed new bills appear in the week before the deadline. Not many new bills introduced thus far. It is expected that there will be renewed attention on the Lanterman-Petris-Short Act and Assisted Outpatient Treatment (AOT), such as follow-up legislation to AB 1976 (Eggman) which requires counties to opt out rather than opt in to AOT. There are a few school bills so far, especially SB 14 (Portantino) which will require schools to excuse absence for mental health reasons and train students and teachers in Mental Health First Aid. There is expected attention for housing, including AB 71 (Luz Rivas) for which co-sponsors include the Corporation for Supportive Housing, Housing CA and Los Angeles County, which seeks a permanent source of funds for housing and homelessness. It would increase corporate taxes by $2 billion annually. It is expected that there will be more bills related to CalAIM, due to the waiver being delayed by COVID 19. New waivers would start in January 2022.
Currently, CBHDA has four legislative priorities:

1. Elia Gallardo stated that their organization is a co-sponsor of SB-14, which will ensure that children will be identified at the earliest onset of mental health symptoms. CBHDA is also supporting a bill, to be carried by Silva, and co-sponsored by California Behavioral Health

Association, for integrated school-based behavioral health: to expand what is available under Medi-Cal through partnerships with schools. Partners will determine if private insurance will cover these services. If not, then students should receive an initial assessment and brief services at school, then be referred to their in-network health provider. If health plans are unable to provide these services then they have to explain to the Department of Managed Care how the children's needs will be met. A recent study showed that children receive out-of-network mental health services far more often than adults do.

2. Another bill, to be carried by Arambula, will propose a unified system of outcomes and performance measures. There are too many mental health services systems and not all are coordinating, and many populations who are reported separately. The bill will establish a work group to develop measures across all systems, especially mental health and substance abuse services across payer types, and will include measures of disparities and equity issues. The bill builds on AB 470 (2017, Arambula) and the co-sponsor is the California Pan-Ethnic Health Network.
3. Tyler mentioned another priority bill, a follow-up to AB-826 (Reyes), which would establish continuity of mental health care for foster youth transferred outside their county for short-term placements. Care would be better coordinated across placement agencies in counties of residence as well as the county of placement. Co-sponsors are the Alliance for Child and Family Services.
4. Another priority bill is to be carried by Assemblymember Ramos, to improve LPS data collection for 5150 holds. The LPS audit mentioned a lack of demographic data collected at the state level. Existing data is from 2016/17 and is not comprehensive.

Governor Newsom's Proposed FY 2021-22 State Budget Highlights: A summary document of the highlights of the proposed State Budget prepared by Tyler Rinde was sent to members separately. The document outlines the estimated dollar amounts for each behavioral health funding source.

This is the Governor's third budget, released on January 8 for the fiscal year that begins July 1, 2021. There is an unexpected $15 billion surplus, due to underspending last fiscal year and more capital gains taxes received from higher-income Californians not impacted by the pandemic. However, much of these funds will be one-time-only spending. $40 million of these funds are being re-directed to the No Place Like Home program.

Elia stated that overall, the attention to behavioral health in the proposed budget is positive. One-time funds of $750 Million will be allocated to counties for competitive 3-year grants to rehabilitate real estate and expand the County continuum for treatment. The administration wants to see a commitment to more bed capacity – up to 5,000 units, and there will be a county match required. The administration linked this investment to its intention to pursue an opt-in to the Institutes of Mental Disease (IMD) waiver under CalAIM.

California Advancing and Innovating Medi-Cal (CalAIM) waiver – A revised proposal was released on January 8. A significant amount of resources, $1.1 billion over this fiscal year, has been allocated to this initiative to support counties in a transition from one payment structure to another. One change will be in how counties can determine medical necessity, which will

ensure that more people will be served at an earlier stage. The transition from documenting expenses and billing minutes to intergovernmental transfers (IGTs) will reform the documentation burden for providers. As part of CalAIM, the state is looking towards an IMD waiver, as mentioned.
Student mental health - $400 million will be allocated over multiple years, to address unmet needs of children returning to school after COVID restrictions. Funds will be available through Medi-Cal plans but should be in coordination with County behavioral health and schools. Funds include incentives for partnerships with service providers for prevention and early intervention.
Adult residential facilities (ARF) – the budget includes an exciting proposal for board and care: $250 million in one-time funds for ARF and residential care facilities for the elderly (RCFE), to be focused on expanding housing for low-income seniors, in response to advocacy for those at risk of homelessness with mental health needs and substance abuse disorder needs.
MHSA – the budget secures some of the flexibilities in county spending that were negotiated last year. Also included is $25 million one-time funds over 5 years to the Mental Health Services Oversight and Accountability Commission (OAC) for a second round of the Student Services Act Partnership Grant Program. Another $25 million will be allocated through Proposition 98 to local education agencies as a match to funding from county MHSA spending plans, to support the mental health needs of students.
Elia wrapped up by stating that the COVID response will likely last until December, 2021, and Federal Medicaid Assistance Percentage (FMAP) will be continued this year at an enhanced rate, thereby saving some state and local funds.

Tyler continued with the section on criminal justice impacts – of interest to the group is the fact that county jails have not yet used $202 million of jail bonds and this is being considered to re-allocate to community mental health and for purchasing or modifying mental health facilities. This will not show up in the budget until the May revision.
Proposition 47 – General funds continue to be saved through this initiative, an estimated $114.8 million last fiscal year. 65% of this amount should be returned to the communities for recidivism reduction services such as mental health and substance use disorders.
State Hospitals – the Community Care Demonstration Project for Felony Incompetent to Stand Trial (CCDP-IST). There is a growing crisis of over 1400 individuals waiting to get in to State Hospitals for felonies and IST restoration. If the State can't admit them, the department faces the risk of significant fines. The budget includes $233 million to contract with three counties to provide a continuum of services to 1252 ISTs at the county level during the first year. In addition, $46 million is budgeted to expand the IST Diversion program in both current and new counties over 3 years, and includes funds for evaluation, research and administration.
Family Urgent Response System – a collaboration between child welfare and the county behavioral health systems, for foster youth and their caregivers, that is being put in place. It includes a single phone number that will provide access to resources throughout the state. The budget will extend the temporary timeframe of this program until December, 2022, by which time it should be up and running.
Youth Returning from Out of State - $5.2 million in General Funds are to support counties in their COVID response and supportive services for foster youth returning from out of state placements.

COVID response – The proposed State budget includes $820 million to continue emergency response measures, and $350 million for vaccine administration costs and a public information campaign. Another $4.3 billion in General Funds is budgeted for an anticipated increase in Medi-Cal caseloads in this fiscal year, based on an estimated 14 million caseload in the last fiscal year which is expected to increase to 15.6 million.
Re-opening Schools Safely - $2 billion in one-time Proposition 98 funds are allocated starting in February 2021 to incentivize and support schools to re-start in-person instruction.

Break for 5 minutes. Due to the combining of Legislative Priorities and State Budget topics, questions and public comment will follow.

Member questions:

Question: Barbara Mitchell asked whether it wouldn't be better to require private insurance to pay for school-based services, rather than offering the services first and expecting the insurance to pay?
Answer: yes, that is what the proposed bill would require, the private insurance plans will pay for children's services that they can't provide themselves within the state-mandated time frames.
Question: Is the FMAP now at 50%? Or did it increase?
Answer: Yes, the enhanced Federal Medicaid Assistance Percentage is now at 56.2%, I believe.
Question: Karen Baylor asked about the savings from jail operations being re-allocated to purchase or modify community mental health facilities and how will this funding be distributed?
Answer: Tyler responded that they don't have more information on the jail bonds right now. The administration says they will submit a proposal in May.
Question: Barbara Mitchell asked when will the state start the process to develop more beds? Will these be treatment or housing or locked beds? Also, there was some discussion about the counties trying to work on the bill modifying involuntary outpatient commitment.
Answer: Elia - The Governor's proposal is to address the entire crisis continuum, including prevention and early intervention as well as facilities and treatment beds to support those at the highest acuity levels. They are going to be doing a gap analysis and looking to see where funds should go but the intention is to support the entire and behavioral health continuum.
Answer: Tyler - regarding Assisted Outpatient Treatment (AOT), the CBHDA is not proposing any changes to AOT. We know that Senator Eggman is interested in a follow-up bill that would require counties to opt out rather than opt in. The (LPS) audit had some recommendations about changing the criteria to allow those exiting conservatorship to access AOT. We know that this will be a topic that will be addressed in legislation later this year.
Question: Catherine Moore asked, in relation to improving the continuum of beds from residential to higher levels, is there recognition that the reason so many beds are closing is that the rate of reimbursement is so low?
Answer: Yes, this is a concern and yet the administration is not actually dealing with this, since these are one-time-only funds. That is usually restricted to bricks and mortar type projects, and counties are going to have to think carefully about making sure each new bed is for billable services because that's the only way they can ensure sustainability.

Question: Daphne Shaw asked if there would be legislation related to the LPS Act, and whether they will be revisiting physical health related to LPS.
Answer: The bill to consider medical condition during a 5150 hearing might be re-introduced later this year.
Elia commented that in reference to the question about housing beds, they are waiting for trailer bill language or a potential budget change proposal that will provide more details.
Tony mentioned that the proposed budget and proposed legislation seem to have similar themes or emphasis.
Karen Baylor asked if there is a new mental health champion in the legislature, now that Senator Beall has retired? Have the noontime caucus meetings been continued?
Answer: We are definitely looking for someone who can fill that role and there are several people who are interested in these issues. Senators Ramos and Weiner and Assemblymember Dr. Arambula consistently introduce bills on these issues. Even Senator Eggman, who we don't always agree with, does bring forth bills on these topics. No, the Senate mental health caucus does not seem to be active.
Question: Steve Leoni asked about the IMD waiver, they were put in place to incentivize the use of lower levels of care because it was regarded that the long-term use of IMDs were often unnecessary and the federal government tried to encourage people to use more voluntary and community-based services, which California supported. Is the waiver for the short term IMD beds or the acute care beds, or is it a blanket waiver for all IMD services? And a second question has to do with the Arambula bill on outcomes measures – will there be enough input from clients and family members on that bill, and isn't this a statutory requirement for the Planning Council to review performance outcome measures?
Answer: to the second question, yes, the bill mandates stakeholder participation including clients and family members, and it names the Planning Council as one of the participants in the process. Daphne re-iterated that it is mandated in the WI code for the Planning Council to review and approve performance outcome measures.
On the IMD waiver, the reason the State mentions it in the context of the $750 million investment is they want to make sure it conforms to the CMS guidelines not to build up IMDs but build alternatives, step down facilities. The IMD waiver has a 30-day or less average length of stay requirement, so the intent is for the state and counties to get reimbursement for short-term stays and the transition to community facilities is to reduce reliance on IMDs.

Public Comment:

Question: Steve McNally thanked the presenters and asked how advocates at the local level can support statewide legislative efforts. Second question, it's difficult to know what's happening at the State level – for example, the Orange County Board of Supervisors wanted to use $100 million MHSA funds as the match for housing, then No Place Like Home got implemented and we lost that $100 million MHSA.
Answer: Theresa Comstock replied that Steve is a member of the Orange County Mental Health Board, and the CA Local Mental Health Boards and Commissions association has notified local boards of the bills that the Association supports and that they will continue to do that.
Regarding the MHSA match, Elia added that they don't know what the match requirement will be and if there will be flexibility. The value of the building being rehabbed should count as in-

kind. MHSA does have some portion of Community Services and Supports funds to support that, so counties could choose to use them but they need to go through a community planning process. That is another avenue for local community participation.
After no further comments, Tony thanked Elia and Tyler for their presentation and partnership.

Review Proposed Legislation - Tony Vartan, Chairperson and Members
The first bill to consider is SB 14 (Portantino) for youth mental health, which Tyler mentioned. The bill will ensure that youth absences from school for mental health issues or appointments will be excused the same as physical health absences. The bill also adds some education for 10 – 12th graders with the opportunity to train and recognize the signs and symptoms of mental health issues with their peers. We can comment and take a position to support or oppose. Any discussion or comments on this bill?
Question: Angelina Woodberry commented that often trainings are voluntary, especially for teachers. Will this training be mandatory?
Answer: in looking at the bill, there are requirements imposed on the local education agencies to provide mandated training.
Question: Barbara Mitchell asked aren't schools already required to recognize absences, the same way? It seems strange to combine that requirement with training of staff.
Answer: (someone) replied that she used to have to email schools for individuals who had counseling appointments. Maybe not all schools do this so the bill is building some consistency of practice? Elia stated that yes, this bill combines elements of two different bills last year. The author felt that they were related enough to be in one bill.
Question: Catherine Moore asked if the second part of the bill related to the mental health first aid that was proposed last year?
Answer: Elia replied that actually the MH first aid was part of a budget item that didn't move forward last year, due to COVID-19 and too many other things going on. This bill includes some additional requirements and timelines.
Question: Darlene asked about the training for 10, 11 and 12th graders, who will provide this training? Many teens already recognize behavioral health issues in their peers, but who would frame this and what would the teens do with it?
Answer: Just like schools do other types of training, this will become a requirement. There will be some requirements of who the trainers will be and what they would do with the information.
Angelina stated that in Sacramento the students receive youth mental health first aid, and youth are taught officially how to be mental health first leaders. Also, teachers at the district level learn to use mental health first aid. It is similar to other teen prevention programs where a group of students receives training and it will teach them how to elevate the concerns within their school. Darlene stated that she has an issue with that.

Tony asked if there were any more comments or questions, and if not then we can make a motion to take a position. This is not a vote, but opening a motion for discussion and public comment.
Tony made a motion to support the bill, Iris seconded the motion.

Barbara doesn't want to take a position until we know what the source of funding is. She doesn't want this bill to be funded with MHSA dollars. She recommends taking a wait-and-see position and only take a support or oppose position on the first (school absences) provision because there is no cost associated with it.
Elia said that CBHDA is a co-sponsor of the bill and this issue comes up often, they would not want the bill funded through MHSA. The California Behavioral Health Association (CBHA) is in support. The authors know that neither organization would support a bill that mandated that MHSA funds be used like this. The one piece we do look at is MHSA Administrative funds, not the MHSA County funds that are distributed at the local level through a community planning process. Tyler added that the bill is conditional upon appropriation in the actual budget act, so that would not be known until the budget bill is signed and the source of funds would probably be general funds for this purpose.
Jane suggested that the Committee could take a position on a dated version of the bill, and then if anything changes, such as it becomes MHSA funded, then we can take a different position and that we can oppose the latest amendment. That is an option.
Catherine suggested that we could modify the motion to say the position is contingent on the funding remaining not MHSA funds. The Committee members agreed to the modified motion.

Public Comment:
Steve Leoni expressed objection to the mental health training for high school students, noting that youth can use this information against each other in bullying or discrimination. Providing teens with a little bit of knowledge could instead lead to others being victimized.

Chairperson Tony Vartan called for votes in favor of the modified motion, to take the Support position on the bill pending the funding source. A roll call vote was taken: Of the 14 members present, 6 voted Yes and 8 voted No. The motion to Support did not pass.

There is support for re-visiting this bill for further discussion. Therefore, the Committee did not take an Oppose position. Since Tyler and Elia were there and CBHDA is a sponsor, they can take back the comments and concerns raised today and have a conversation with the other sponsors and get back to the Committee.

Next bill: AB 32 (Aguiar-Curry), Telehealth. The State DHCS would indefinitely continue the telehealth flexibilities that were put in place during the COVID-19 pandemic emergency. The bill requires and advisory group to provide input to a revised Medi-Cal health policy that promotes telehealth. The DHCS would also have to complete an evaluation of benefits by 2024 including an analysis of improved access. Some feedback that came through the (Planning Council's) Data Notebook was that using telehealth enabled access to clients that had been unable to access otherwise.
Marina Rangel proposed a motion that the Committee vote to Support this bill.
Angelina Woodberry seconded the motion.

Discussion: Darlene suggested that telehealth consumers be part of the advisory group. Daphne reported that there was a discussion of telehealth in the Patient's Rights Committee, and the Patient's Rights advocates were not always happy with how they were able to do their job as they would prefer to do and are hoping to be able to return to in-person services soon. She is concerned about the indefinite extension of telehealth services in terms of patients' rights. Tony replied that the bill does keep those options as additional tools for providers to use as appropriate, it is not intending to mandate that services have to be provided through telehealth. Daphne's concern is that telehealth could become the fallback position.
Karen asked whether the DHCS has the authority to grant such flexibilities, shouldn't this approach be in the state plan or in the waiver, and that seems like it would be a lot of work for the Department. The bill extends telehealth until 2025, by then it might be a moot subject if telehealth is built into the CalAIM waiver. She assumed that the Department had to submit requests for this kind of flexibility to CMS as part of billing Medicaid. Catherine agreed that telehealth would have to be approved by CMS in order to be paid, and that possibly CMS would approve for the entire country rather than as an individual state waiver. Tony stated that existing law provides for the licensure and regulation of the healthcare service plans by the Department of Managed Health Care. If private insurers are providing telehealth it might push CMS in that direction.
Jane clarified that DHCS definitely does want to apply to CMS for a waiver for telehealth and continue services under the Medicaid plan.
Karen responded that she would rather see a bill to support DHCS implementing or adding this to a waiver, since it is a lot of work to assemble an advisory group, and getting all the information for evaluation when there has already been research on the benefits of telehealth.
Tony asked for public comments:
Barbara Wilson stated that she has heard from both mental health providers and the Social Security Administration that they are planning to continue to use telehealth and eliminate much in-person care, since telehealth is less expensive and provides services to rural and remote areas.
Steve Leoni said he wanted to support and reinforce Darlene's concern that the advisory committee include people who have used or had experience with telehealth.

There followed a roll call vote: of the 14 members present, 10 voted Yes and 4 voted No. the motion to Support passed.

The next two bills, SB 21 (Glazer) which concerns mental health funding through specialty license plates, and AB 77 (Petrie-Norris), a placeholder bill which will address substance abuse disorder treatment, are considered not urgent and can be brought back to the next meeting.

Public Comment:

Barbara Wilson commented that she was glad she attended because it helped her understand why the Governor's proposed budget is only addressing deferred maintenance and acquisitions when there is such a critical need for bailout funds for Adult Residential Facilities. She asked if anyone knows of a legislator to advance a request for bailout funds so the ARF's can stay in business until May or June (when the new budget passes).

Tony replied that there may be a patch available to counties, some of them took their concerns to their Boards of Supervisors last year for assistance to providers during COVID-19. If some of those providers are contracted through the county mental health systems then that kind of assistance would be extended to the providers. There was also the option for providers to apply for CARES Act funds. These are many small patches that don't add up to a complete blanket for providers, but hopefully we will continue to receive information as the proposed budget moves forward.

Wrap Up/Next Steps:

Tony thanked everyone and asked for any changes or things the Committee would like to see included in the objectives or topics to be considered? The consensus was the meeting went well and no suggestions were offered. The Committee will review new legislation at the next meeting.

Meeting was adjourned at 3:30 pm.

CBHPC **March 30, 2021**
Legislation Committee **Meeting Summary**

Members Present:

Tony Vartan, Chairperson	Iris Mojica de Tatum, Chair-Elect	
Catherine Moore	Noel O'Neill	Hector Ramirez
Barbara Mitchell	Marina Rangel	Angelina Woodberry
Daphne Shaw	Susan Wilson	Ronnie Kelley
Deborah Starkey	Darlene Prettyman	

CBHPC Staff present:

Jane Adcock, Executive Officer, Laura Leonelli, Jenny Bayardo

Meeting Commenced at 3:00 p.m.

Chairperson Tony Vartan welcomed everyone in attendance. Introductions were made.

Legislation Committee Consent Agenda: Oppose

A motion was made by Catherine Moore, seconded by Marina Rangel, to strike the following bills from the consent agenda: AB 574, SB 106, SB 507, SB 516, SB 782. AB 940 remained on the consent agenda. Susan Wilson moved to approve the consent agenda as amended, and Iris seconded the motion. The votes were 12 in favor, one opposed, and the motion carried. The Committee position on AB 940 is Oppose.

Question: Hector Ramirez and Steve Leoni had questions about the consent process: why were some bills added, why were others removed? Other organizations have different lists of bills to oppose.

Answer: Tony replied that the Planning Council focus is on its mission, and the Committee will select items that will maximize its advocacy efforts in alignment with our mission. All entities choose to support/oppose bills according to their mission.

AB 574 was considered. Marina moved to neither support nor oppose but to take a watch position. The motion was seconded by Catherine.

Discussion: Catherine is not familiar with conservatorship as defined, and asked for any additional information to clarify. Daphne asked who would be affected by this bill? An individual could be committed by another person without their consent? Ronnie remarked that under this bill, the LPS definition of 'gravely disabled' can be extended to the unhoused. There are no funding/resources/facilities currently available for conservatees. Housing is a completely separate need. 'Ad Litem' guardians are usually provided to children, not adults.

Hector asked about the process of voting on these bills? The Lanterman/Petris/Short Act (LPS) topic has been covered by the media lately, and he is confused about what is being asked. Tony replied that the committee process has been shared with members in the meeting materials.

The staff has not changed the process, they recommend bills for consent agenda but the bills can be pulled.
Barbara Mitchell had a comment about the process: can the committee allow anyone to move to oppose or support a bill, and if there is no decision then we just do nothing?

Darlene stated she would like to vote to oppose the bill, she has concerns about who would be affected.
Marina stated that the intent of the bill is to give more immediate help outside the conservator process, which is lengthy. Jails have become a revolving door for the mentally ill; it is frustrating that persons with mental illness don't have options for treatment outside of the prison system. This bill would appoint someone to provide help and support.

Public comment: Steve said this is all the more reason to have a robust system of services outside the jails, rather than invest in expensive conservatorship services.

Members voted on the motion to take a watch position: 9 No votes, 3 Yes votes, the motion failed.
Barbara made a motion to oppose AB 574, seconded by Hector. No discussion.
No public comment.
The motion received 11 Yes votes and two No votes, so the motion passed. The Committee position is to Oppose.

SB 516 was considered. The bill would consider an individual's medical status in the decision to certify for intensive outpatient treatment. Catherine stated that some psychiatrists support and others oppose this measure. Catherine made a motion to Watch, seconded by Angelina Woodberry.
Barbara commented on the length of time to consider the bill: it is being heard in committee in two days, it is too late for a Watch position. The motion was amended to Take no Action.
No public comment. The motion received 4 Yes votes and 9 No votes, so the motion failed.

Daphne Shaw made a motion to Oppose SB 516, and Iris seconded the motion.
Discussion: The concern is that someone could be certified for 5150 based on their inability to deal with their medical condition, but will be released based on their mental health condition. Upon release from the hospital there is no follow up medical care provided. Catherine stated that most hospitals treat both physical and mental conditions of each patient. If patients don't follow up then their condition deteriorates. Barbara agreed that there are many individuals who do not have mental illness and who refuse medical treatment, it can't be forced. Marina said that the bill didn't seem coercive, that medical information would be considered in order to provide more whole-person care. Tony responded that this information would be used to uphold a 5250 hold and extend the stay based on the medical condition. Angelina agreed that whether an individual has a medical problem it has no bearing on their mental health. Keeping someone in the hospital longer seems punitive, eliminates a person's choice in their health care. Catherine responded that medical conditions such as diabetes certainly do impact a

person's thinking and judgement. Some individuals need multiple hospitalizations for their condition and this bill tries to address that larger problem.
No public comment.
Members voted on the motion to Oppose SB 516: the motion received 11 Yes votes and 2 No votes, the motion passed. The Committee position is to Oppose.

SB 106 was considered. A motion to Oppose was made by Susan, seconded by Hector. Hector commented that there is a stakeholder process to allocate Mental Health Services Act (MHSA) funds so that they are spent in the right way for that county's communities. If this bill passes it would affect sub-populations including racial and ethnic minorities, TAY, disabled, LGBTQ and would not be fiscally responsible. Marina commented that it sounded like there was a complicated process to get people into the right programs and that bureaucracy and red tape prevent new programs from getting started. She would like to understand why people have objections to removing some of these barriers. Ronnie responded that this bill would shift Innovation dollars and if it passes then it would open up many more demands on and changes to MHSA funds. Tony added that the MHSA requires a 2/3 vote of the Legislature to amend, and this bill would open the door to other ways to bypass this requirement.
No public comment.
Members voted on the motion to Oppose SB 106: the motion received 11 Yes votes and 2 No votes, so the motion passed. The Committee position is to Oppose.

SB 782 was considered. Barbara made a motion to Oppose, Darlene seconded the motion. There was no discussion.
No public comment. Members voted on the motion, which received 11 Yes votes and 2 No votes. The motion passed. The Committee position on SB 782 is Oppose.

SB 507 was considered. Catherine made a motion to Watch, Marina seconded. The motion received 4 Yes votes and 9 No votes, so the motion failed.
Tony commented that the bill would simplify criteria for Assisted Outpatient Treatment, and would extend to anyone leaving conservatorship.
Noel made a motion to Oppose, it was seconded by Susan. They have concerns that this would be an overreach. There was no public comment. The motion received 10 Yes votes, 2 No votes, and 1 abstention. The motion passed; the Committee position on SB 507 is Oppose.

Legislation Committee Consent Agenda: Support
Daphne made a motion to Approve the Consent Agenda to Support. Iris seconded the motion. There was no discussion. No public comment.
The motion received 12 Yes votes, 0 No votes. The motion passed. The Committee position on AB 383, AB 552, AB 942, AB 1051, SB 316, and SB 508 is Support.

Legislation Committee Position List Review: SB 14 and New Bills
At the January Quarterly Meeting, the Legislative Committee discussed SB 14 and some members had reservations about several components of the bill. The motion to Support received an even number of Yes and No votes so no position was taken. The bill's sponsors, the

CA Behavioral Health Directors Association (CBHDA), and many advocacy partners, have requested that the Committee reconsider their position. Additional bill language and a fact sheet were provided for review.
Barbara stated that there is still no information on the funding source, it is contingent upon appropriations. Jane responded that sponsors say there will be a separate bill for funding. Catherine commented that often if there is no appropriation the measure dies. Angelina suggested that SB 21, the bill that raises funds for mental health education through a specialty license plate, might be a funding source? Catherine remarked that the funds raised will go to the Department of Education, Iris stated that presently the funds are not specific for this measure. Jane asked Ronnie and/or Tony, who are members of CBHDA, for their input. Ronnie replied that the bill would be contingent on General Funds and not MHSA funding, and Mental Health First Aid is one of several evidence-based training programs being considered. Tony added that there is no funding attached, and that counties were looking at expanding existing school services with Prevention and Early Intervention dollars.
A motion to Support was made by Catherine and seconded by Ronnie Kelley. Support for the bill is contingent on funding other than MHSA. No public comment. The bill received 10 yes votes, 1 no vote, and 1 abstention. The motion passed. The Committee position on SB 14 is Support.

AB 77 was considered. This bill was presented at the January Quarterly Meeting as a placeholder, and bill language was added by amendment on March 25. Laura read the new bill language pertaining to licensing of Substance Use Disorder (SUD) facilities by the Department of Health Care services. Catherine asked if this means programs for medication assisted treatment, not community programs like AA? Ronnie explained that DHCS licenses all SUD facilities providing services within the public system, and this bill lists requirements for licensing of commercial SUD treatment facilities that don't have the same oversight. The bill's author is focused on treatment, that this bill is not about curtailing sober living environments. Marina asked if this will affect persons providing treatment? Ronnie answered that the bill does not affect SUD staff who are certified rather than licensed.
A motion to Support was made by Iris, and seconded by Catherine. There was no public comment. The motion passed unanimously. The Committee position on AB 77 is Support.

AB 573 was considered. The bill would establish a Youth Mental Health Board to advise the Department of Health and Human Services, and each county would have to establish a local Youth Mental Health Board. Question: how many members would the local MH Boards need? Answer: Susan replied that the number would be proportional to the county population, similar to the existing Mental Health Boards.
Catherine made a motion that the Committee take no position on this bill. Susan seconded the motion. No discussion. No public comment.The motion passed unanimously.

AB 686 was considered. Jane stated that many advocacy partners are asking the Council to take a position. The bill would establish a Community-Based Behavioral Health Outcomes and Accountability Review to facilitate a local accountability system for continuous quality improvement. Catherine asked how this would be different than the Mental Health Services

Oversight and Accountability Commission (OAC). Tony replied that the OAC has oversight only over the MHSA funded programs, and this would consolidate all core outcome measures in one location regardless of funding source. The bill is one result of work on the CBHDA strategic plan, and would establish quality measures and outcomes across all counties.
A motion to support was made by Catherine and seconded by Daphne. No public comment. The motion passed unanimously. The Committee position on AB 686 is Support.

Wrap Up/Next Steps
The remaining bills will be considered at the April Quarterly meeting.
Daphne asked about SB 565, regarding adding beds at State Hospitals, whether the CBHDA supported an effort to build/acquire a privately run hospital to expand available beds? Tony replied that there were discussions on that subject that were later dropped. Re-focusing on regional needs revealed a lack of step-down facilities in counties. The new focus is on a regional model of care instead of a larger facility. Daphne thanked him for the information, that this will affect her evaluation of SB 565.

Catherine made a motion to adjourn, and complimented Tony on always including public comment in discussions. Tony congratulated members and staff for a heavy lift on the many bills on the agenda. He appreciates having multiple lenses to analyze and evaluate bills.

The meeting was adjourned at 5:00 pm.

TAB 2

California Behavioral Health Planning Council
Legislation Committee
Thursday, April 15, 2021

Agenda Item: Review Proposed Legislation

Enclosures: Legislative Position Matrix (updated 3/30/21)
Listing of currently proposed legislation: AB 1178, AB 1331, SB 221, SB 293, SB 565, SB 578, SB 749
Fact Sheets for AB 1178, AB 1131, SB 221, SB 293, SB 565, SB 578, SB 749
Amended bill language for SB 516

How This Agenda Item Relates to Council Mission
To review, evaluate and advocate for an accessible and effective behavioral health system.

The Council's 2021 Legislation Position Matrix documents the Council's effort to advocate for an effective behavioral health system and assist in educating the public, behavioral health constituency, and legislators on issues that impact individuals with Serious Mental Illness (SMI) and Serious Emotional Disturbances (SED).

Background: As of the deadline on February 19, 22 bills were already introduced by the Legislature that either impact or involve mental/behavioral health. The Legislation Committee members met on March 30 and took positions on some proposed bills. The Committee will discuss the remaining bills on the list and take a position. SB 516 has been recently amended and the Committee can re-evaluate its Oppose position.

For a copy of fact sheet SB 516 contact Laura Leonelli at Laura.Leonelli@cbhpc.dhcs.ca.gov.

Requested Action: Evaluate proposed bills to support or oppose.

California Behavioral Health Planning Council
2021 Legislative Positions

Bill	Author	Summary	Position
AB 32	Aguiar-Curry	**Continue telehealth appointments for behavioral health** Requires the State Department of Health Care Services to indefinitely continue the telehealth flexibilities in place during the COVID-19 pandemic state of emergency. The bill would require DHCS, by January 2022, to convene an advisory group with specified membership to provide input to the department on the development of a revised Medi-Cal telehealth policy that promotes specified principles. . **As amended Feb. 12, 2021**	**Support***
AB 77	Petrie-Norris	**Substance use disorder treatment services** Would require any substance use disorder treatment program to be licensed by the Department of Health Care Services, except as specified. The bill would require DHCS, in administering these provisions, to issue licenses for a period of 2 years for substance use disorder treatment programs that meet the requirements in these provisions, and to issue a license to a substance use disorder program once various requirements have been met, including an onsite review. DHCS may renew a license, as provided. The bill would prohibit providing substance use disorder treatment services to individuals without a license. **As amended March 25, 2021**	**Support**
SB 14	Portantino	**Youth mental and behavioral health** This bill will ensure that youth absences from school for a mental health issue or appointment will be considered an excused absence in the same fashion absences for physical health ailments or appointments are treated. The bill would require the California Department of Education to identify an evidence-based training program for a local educational	**Support**

*Indicates positions that were determined by the Legislation Committee's Policy Platform.

California Behavioral Health Planning Council
2021 Legislative Positions

Bill	Author	Summary	Position
		agency to use to train classified and certificated school employees having direct contact with pupils in youth mental and behavioral health. The bill would also provide 10th, 11th and 12th graders the opportunity to be trained to recognize the signs and symptoms of a behavioral health issue in their peers.	
AB 383	Salas	**Mental health: older adults** Would establish within the State Department of Health Care Services an Older Adult Mental Health Services Administrator to oversee mental health services for older adults. The bill would require that position to be funded with administrative funds from the Mental Health Services Fund. The bill would prescribe the functions of the administrator and its responsibilities, including, but not limited to, developing outcome and related indicators for older adults for the purpose of assessing the status of mental health services for older adults, monitoring the quality of programs for those adults, and guiding decision making on how to improve those services.	**Support**
AB 552	Quirk-Silva	**Integrated School-Based Behavioral Health Partnership Program.** Would establish the Integrated School-Based Behavioral Health Partnership Program to provide prevention and early intervention for, and access to, behavioral health services for pupils. The bill would authorize a county behavioral health agency and the governing board or governing body of a local educational agency to agree to collaborate on and implement an integrated school-based behavioral health partnership program, to develop a memorandum of understanding outlining the requirements for the partnership program, and to enter into a contract for mental health or substance use disorder services.	**Support**

*Indicates positions that were determined by the Legislation Committee's Policy Platform.

California Behavioral Health Planning Council
2021 Legislative Positions

Bill	Author	Summary	Position
AB 573	Carrillo	**Youth Mental Health Boards.** Would establish the California Youth Mental Health Board (state board) within the California Health and Human Services Agency to advise the Governor and Legislature on the challenges facing youth with mental health needs and determine opportunities for improvement. The state board would be comprised of 15 members who are between 15 and 23 years of age, appointed as specified, at least half of whom are youth mental health consumers who are receiving, or have received, mental health services, or siblings or immediate family members of mental health consumers. The bill would specify the powers and duties of the state board, including reviewing program performance in the delivery of mental health and substance use disorder services for youth.	**No Position**
AB 574	Chen	**Guardians ad litem: mental illnesses.** The Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled. Current law also provides for a conservator of the person or estate to be appointed for a person who is gravely disabled. Current law, for the purposes of involuntary commitment and conservatorship, defines "gravely disabled," among other things, as a condition in which a person, as a result of a mental health disorder, is unable to provide for the person's basic personal needs for food, clothing, or shelter. This bill would establish an additional procedure for the appointment of a guardian ad litem for a person who lacks the capacity to make rational informed decisions regarding medical care, mental health care, safety, hygiene, shelter, food, or clothing with a rational thought process due to a mental illness, defect, or deficiency.	**Oppose**

*Indicates positions that were determined by the Legislation Committee's Policy Platform.

California Behavioral Health Planning Council
2021 Legislative Positions

Bill	Author	Summary	Position
AB 686	Arambula	**California Community-Based Behavioral Health Outcomes and Accountability Review.** Would require the California Health and Human Services Agency to establish, by July 1, 2022, the California Community-Based Behavioral Health Outcomes and Accountability Review (CBBH-OAR) to facilitate a local accountability system that fosters continuous quality improvement in county behavioral health programs and in the collection and dissemination by the agency of best practices in service delivery. The bill would require the agency to convene a workgroup to establish a workplan by which the CBBH-OAR shall be conducted and to consult on various other components of the CBBH-OAR process.	**Support**
AB 940	McCarty	**College Mental Health Services Program.** Would amend Proposition 63 by appropriating an unspecified amount annually from the administrative account of the Mental Health Services Fund to the Board of Regents of the University of California, the Board of Trustees of the California State University, and the Board of Governors of the California Community Colleges, as specified, to implement the College Mental Health Services Program. The bill would require those funds to be used for the purpose of increasing campus student mental health services and mental health-related education and training. The bill would require campuses that participate in the program to report annually on the use of those grant funds and to post that information on their internet websites.	**Oppose**
AB 942	Wood	**Specialty mental health services and substance use disorder treatment.** Under current law, for individuals 21 years of age and older, a service is “medically necessary” if it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Current law provides that for individuals under 21 years	**Support**

*Indicates positions that were determined by the Legislation Committee’s Policy Platform.

Bill	Author	Summary	Position
		of age, "medically necessary" or "medical necessity" standards are governed by the definition in federal law. This bill would provide that the above-specified medical necessity standards do not preclude coverage for, and reimbursement of, a clinically appropriate and covered mental health or substance use disorder assessment, screening, or treatment service before a provider renders a diagnosis.	
AB 1051	Bennett	**Medi-Cal: specialty mental health services: foster youth.** Current law requires the State Department of Health Care Services to issue policy guidance concerning the conditions for, and exceptions to, presumptive transfer of responsibility for providing or arranging for specialty mental health services to a foster youth from the county of original jurisdiction to the county in which the foster youth resides, as prescribed. This bill would make those provisions for presumptive transfer inapplicable to a foster youth or probation-involved youth placed in a group home or a short-term residential therapeutic program (STRTP) outside of their county of original jurisdiction, as specified.	**Support**
SB 106	Umberg	**Mental Health Services Act: innovative programs.** **Last Amend:** 3/10/2021 Current law authorizes the MHSA to be amended by a 2/3 vote of the Legislature if the amendments are consistent with, and further the purposes of, the MHSA. This bill would amend the MHSA by authorizing counties to expend funds for their innovative programs without approval by the commission if the program is establishing or expanding a program implementing the full-service partnership model, as defined. **Pulled by Author 3/30/21**	**Oppose**

*Indicates positions that were determined by the Legislation Committee's Policy Platform.

California Behavioral Health Planning Council
2021 Legislative Positions

Bill	Author	Summary	Position
SB 316	Eggman	**Medi-Cal: federally qualified health centers and rural health clinics.** Current law provides that FQHC and RHC services are to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals, including a physician and marriage and family therapist. Under existing law, "physician," for these purposes, includes, but is not limited to, a physician and surgeon, an osteopath, and a podiatrist. This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined. The bill would authorize an FQHC or RHC that currently includes the cost of a medical visit and a mental health visit that take place on the same day at a single location as a single visit for purposes of establishing the FQHC's or RHC's rate to apply for an adjustment to its per-visit rate, and after the department has approved that rate adjustment, to bill a medical visit and a mental health visit that take place on the same day at a single location as separate visits, in accordance with the bill.	**Support**
SB 507	Eggman	**Mental health services: assisted outpatient treatment.** **Last Amend:** 3/11/2021 **Summary:** The Assisted Outpatient Treatment Demonstration Project Act of 2002, known as Laura's Law, authorizes a court in a participating county to order a person who is suffering from mental illness and is the subject of a petition to obtain assisted outpatient treatment if the court makes various findings including, among others,	**Oppose**

*Indicates positions that were determined by the Legislation Committee's Policy Platform.

Bill	Author	Summary	Position
		there has been a clinical determination that the person is unlikely to survive safely in the community without supervision, the person's condition is substantially deteriorating, and, in view of the person's treatment history and current behavior, the person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or to others. Existing law requires the petition to be accompanied by an affidavit of a licensed mental health treatment provider. This bill would, among other things, instead require that the above-described findings include either that the person is unlikely to survive safely in the community without supervision and that the person's condition is substantially deteriorating, or that assisted outpatient treatment is needed to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or to others	
SB 508	Stern	**Mental health coverage: school-based services.** Current law provides that specified services, including targeted case management services for children with an individual education plan or an individualized family service plan, provided by local educational agencies (LEAs), are covered Medi-Cal benefits, and authorizes an LEA to bill for those services. Existing law requires the department to perform various activities with respect to the billing option for services provided by LEAs. Current law authorizes a school district to require the parent or legal guardian of a pupil to keep current at the pupil's school of attendance certain emergency information. This bill would authorize an LEA to have an appropriate mental health professional provide brief initial interventions at a school campus when necessary for all referred pupils, including pupils with a health care service plan, health insurance, or coverage through a	**Support**

*Indicates positions that were determined by the Legislation Committee's Policy Platform.

Bill	Author	Summary	Position
		Medi-Cal managed care plan, but not those covered by a county mental health plan.	
SB 516	Eggman	**Certification for intensive treatment: review hearing.** Current law authorizes a court to order the evaluation of a person who is alleged to be a danger to self or others as a result of a mental disorder, or the evaluation of a criminal defendant who appears to be a danger to self or others, or to be gravely disabled, as a result of chronic alcoholism or the use of narcotics or restricted dangerous drugs. Current law requires the hearing to be conducted by either a court-appointed commissioner or a referee, or a certification review hearing officer. Current law authorizes the person to be detained for involuntary care, protection, and treatment related to the mental disorder or impairment by chronic alcoholism if, at the conclusion of the certification review hearing, the person conducting the hearing finds that there is probable cause that the person certified is a danger to self or others or is gravely disabled as a result of a mental disorder or impairment by chronic alcoholism, as specified. This bill would authorize the evidence presented in support of the certification decision to include information on the person's medical condition and how that condition bears on certifying the person as a danger to themselves or to others or as gravely disabled. The bill would require the hearing officer to consider the information in the determination of probable cause.	**Oppose**
SB 782	Glazer	**Assisted outpatient treatment programs.** Current law authorizes participating counties to pay for the services provided from moneys distributed to the counties from various continuously appropriated funds, including the Mental Health Services	**Oppose**

*Indicates positions that were determined by the Legislation Committee's Policy Platform.

Bill	Author	Summary	Position
		Fund, when included in a county plan, as specified. Current law authorizes a court to order a person who is the subject of a petition filed pursuant to those provisions to obtain assisted outpatient treatment if the court finds, by clear and convincing evidence, that the facts stated in the petition are true and establish that specified criteria are met, including that the person has a history of lack of compliance with treatment for their mental illness, and that there has been a clinical determination that the person is unlikely to survive safely in the community without supervision. Current law authorizes the petition to be filed by the county behavioral health director, or the director's designee, in the superior court in the county in which the person who is the subject of the petition is present or reasonably believed to be present, in accordance with prescribed procedures. This bill would additionally authorize the filing of a petition to obtain assisted outpatient treatment under the existing petition procedures, for a conservatee or former conservatee, as specified, who would benefit from assisted outpatient treatment to reduce the risk of deteriorating mental health while living independently.	

*Indicates positions that were determined by the Legislation Committee's Policy Platform.

Positions Pending 2021

AB 1178 (Irwin D) **Medi-Cal: serious mental illness: drugs.**
Current Text: Introduced: 2/18/2021 html pdf
Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, the provision of prescription drugs is a Medi-Cal benefit, subject to the list of contract drugs and utilization controls. After a determination of cost benefit, current law requires the Director of Health Care Services to modify or eliminate the requirement of prior authorization as a control for treatment, supplies, or equipment that costs less than $100, except for prescribed drugs. This bill would delete the prior authorization requirement for any drug prescribed for the treatment of a serious mental illness, as defined, for a period of 365 days after the initial prescription has been dispensed for a person over 18 years of age who is not under the transition jurisdiction of the juvenile court.
Position

AB 1331 (Irwin D) **Mental health: Statewide Director of Crisis Service**
Current Text: Introduced: 2/19/2021 html pdf
Summary: The Lanterman-Petris-Short Act, authorizes, among other things, the involuntary commitment and treatment of persons with specified mental health disorders and the appointment of a conservator of the person, of the estate, or of both, for a person who is gravely disabled as a result of a mental health disorder. The act is administered by the Director of Health Care Services. This bill would require the director to appoint a full-time Statewide Director of Crisis Services, who would be responsible for various tasks relating to behavioral health crisis care in the state including, among other things, coordinating behavioral health programs and services statewide to ensure continuity of services and access points and to enhance cross-agency information exchange and resource sharing.
Position

SB 221 (Wiener D) **Health care coverage: timely access to care.**
Current Text: Amended: 3/9/2021 html pdf
Last Amend: 3/9/2021
Summary: Current regulations require a health care service plan or an insurer to ensure that their contracted provider networks have adequate capacity and availability of licensed health care providers to offer enrollees and insureds appointments that meet specified timeframes.

Current regulations require a health care service plan or an insurer to ensure that for an enrollee requesting a nonurgent appointment with a nonphysician mental health care provider, or an insured requesting a nonurgent appointment with a nonphysician mental health care or substance use disorder provider, appointments are offered within 10 business days of the request for an appointment. Current regulations also authorize appointments for preventive care services and periodic followup care, including periodic office visits to monitor and treat mental health or substance use disorder conditions, as specified, to be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the provider's scope of practice. These regulations of the Department of Managed Care are limited in application to mental health care providers, while those regulations of the Department of Insurance are applicable to both mental health care and substance use disorder providers. This bill would codify the regulations adopted by the Department of Managed Health Care and the Department of Insurance to provide timely access standards for health care service plans and insurers for nonemergency health care services.

Position

SB 293 **(Limón D) Medi-Cal specialty mental health services.**

Current Text: Introduced: 2/1/2021 html pdf

Summary: Current 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 specialty mental health services, and Early and Periodic Screening, Diagnostic, and Treatment services for an individual under 21 years of age. This bill would require, on or before January 1, 2023, the department, in consultation with specified groups, including representatives from the County Welfare Directors Association of California, to identify all forms currently used by each county mental health plan contractor for purposes of determining eligibility and reimbursement for specialty mental health services provided under the Early and Periodic Screening, Diagnostic, and Treatment Program, and to develop standard forms for the intake of, assessment of, and the treatment planning for, Medi-Cal beneficiaries who are eligible for those services to be used by all counties.

Position

SB 565 **(Jones R) State Department of State Hospitals: facility expansion: report.**

Current Text: Amended: 3/8/2021 html pdf

Last Amend: 3/8/2021

Summary: Would require the State Department of State Hospitals, on or before July 1, 2022, to develop a plan to expand the capacity of its facilities to reduce wait times for a person committed to a department facility pursuant to the Lanterman-Petris-Short Act to 60 days or less. The bill would require the department, on or before July 1, 2022, to submit to the Legislature a copy of the plan and a report regarding the anticipated cost of implementing the plan. The bill would require the department, on or before January 1, 2027, to implement that plan.

Position

SB 578 **(Jones R) Lanterman-Petris-Short Act: hearings.**

Current Text: Amended: 3/5/2021 html pdf

Last Amend: 3/5/2021

Summary: The Lanterman-Petris-Short Act authorizes the involuntary commitment and treatment of persons with specified mental health disorders for the protection of the persons so committed, and authorizes a conservator of the person, of the estate, or of the person and the estate to be appointed for a person who is gravely disabled as a result of a mental health disorder or impairment by chronic alcoholism, and designates procedures for hearing a petition for that purpose. Existing law authorizes a party to a hearing under the act to demand that the hearing be public, and be held in a place suitable for attendance by the public. This bill would require a hearing held under the act to be presumptively closed to the public, but would authorize the individual who is the subject of the proceeding to demand that the hearing be public, and be held in a place suitable for attendance by the public.

Position

SB 749 **(Glazer D) Mental health program oversight: county reporting.**

Current Text: Introduced: 2/19/2021 html pdf

Summary: Would require the Mental Health Services Oversight and Accountability Commission, in consultation with state and local mental health authorities, to create a comprehensive tracking program for county spending on mental and behavioral health programs and services, as specified, including funding sources, funding utilization, and outcome data at the program, service, and statewide levels. The bill would require the counties to report specified data for the preceding

fiscal year to the commission on or before July 31 of each year. The bill would also require the commission to report the results of the county reporting to the Governor's office and the Legislature on or before September 1 of each year, and to publish that information on its internet website in a location accessible to the public.

Position

AB 1178 (Irwin)
Medi-Cal: Serious Mental Illness Drugs

SUMMARY

AB 1178 will improve access to crucial medications for Medi-Cal patients with Serious Mental Illnesses (SMI) by removing unnecessary barriers.

BACKGROUND

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services (DHCS), to provide health care services to qualified low-income Californians. Existing law also considers prescription drugs as a Medi-Cal benefit, making the medications subject to prior authorization, which requires a physician to ask for approval before the drugs may be dispensed. Often, this requirement extends to refills of medications even though the prescriber has not made any changes in the prescribing. According to the National Alliance on Mental Illness, more than 5 million Californians have a mental health condition. In California, 1.3 million adults have a serious mental health condition such as schizophrenia or bipolar disorder.[1]

Serious mental illness (SMI) may include, but is not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, a major affective disorder, and any other severely disabling mental disorder.

Antipsychotic drugs are used to reduce or relieve symptoms of psychosis that can occur in individuals with bipolar disorder, depression, or schizophrenia. These medications can be essential for an individual with SMI to avoid disruptions in their every-day activities, making it important for these patients to adhere to their recommended drug regimens.

NEED FOR BILL

Multiple studies have highlighted access problems among patients who need antipsychotic drugs and the consequences of not addressing the issue. A study of 10 state Medicaid programs comparing drug access problems among psychiatric patients found patients who experienced treatment access problems were 360% more likely to experience a negative outcome including emergency visits, hospitalizations, homelessness, suicidal ideation, or incarceration. In California, the study found that 57.9% of patients with a psychiatric diagnosis experienced an access problem leading to a negative outcome[2].

Revising prior authorization requirements to mental health drugs to ensure that such restrictions have clinical value will reduce the incidence of these patients suffering a mental health crisis, which often lead to hospitalizations, homelessness and worse. . A 2014 study of treatment adherence among individuals experiencing homelessness found that refill non-adherence rate was 47.1% for psychiatric medications. Non-adherence rates for individuals experiencing homelessness were higher with drugs used in schizophrenia, with around 70% of individuals unable to follow their regimen[3]. To prevent negative outcomes and provide greater support to individuals experiencing homelessness, the state must revise the existing process Medi-Cal patients navigate to obtain antipsychotic drugs.

Data from Medi-Cal indicate this vulnerable population struggles to refill their antipsychotic prescriptions. Data from the Prospective Drug Utilization Review Alert Transactions system for the 4th quarter of 2019, show that of the 64,140 alerts providers received related to underutilization (late refill) of an Rx, nearly 80% of those alerts were for mental health drugs, mostly antipsychotics. This means patients who have already cleared the prior authorization process to obtain the antipsychotic their provider prescribed, they are then struggling to refill their medicine.

[1]Substance Abuse and Mental Health Services Administration (SAMHSA) 2018-2019 NSDUH State-Specific and 2019 Detailed Tables
[2]West, Joyce C., et al. "Medicaid Prescription Drug Policies and Medication Access and Continuity: Findings From Ten States." *Psychiatric Services*, 13 Jan. 2015, ps.psychiatryonline.org/doi/full/10.1176/ps.2009.60.5.601#jt07t3.
[3]Unni, Elizabeth J., et al. "Medication Non-Adherence in the Homeless Population in an Intermountain West City." *INNOVATIONS in Pharmacy*, vol. 5, no. 2, Jan. 2014, doi:10.24926/iip.v5i2.342.

AB 1178 (Irwin)
Medi-Cal: Serious Mental Illness Drugs

Because refilling needed medications is particularly difficult for this vulnerable population, this bill is narrowly focused on the ambulatory population over the age of 18 who are not under the transition jurisdiction of the juvenile court, and who have already received a first prescription for a drug prescribed for the treatment of a serious mental illness. The existing Medi-Cal program rules, alerts and clinical guidelines related to medication interactions with certain drugs and antipsychotics, concomitant use with anticholergenic medications, restrictions on prescriptions for patients under 18 years of age, and for patients over 65 years of age who reside in skilled nursing facilities, will not be altered by this bill.

THIS BILL

AB 1178 makes the following four changes:

- Prevents prior authorization from being required for any drug prescribed for the treatment of a serious mental illness (SMI) for 365-days after the initial prescription is dispensed for a person over 18 years of age and is not under the transition jurisdiction of the juvenile court.
- A drug prescribed for the treatment of SMI is automatically approved if there is a record of a paid claim that documents a diagnosis of a SMI within 365 days before the date of that prescription for a person over 18 years of age and is not under the transition jurisdiction of the juvenile court.
- Allows a 90-day supply of a medication for treatment of SMI, if the patient is over age 18 who are not under the transition jurisdiction of the juvenile court, has met prior authorization, step therapy or fail first requirements, and has filled a 30-day supply of the prescription in the previous 90 days.
- Allows early refill for lost or stolen medications for treatment of SMI and for an early refill for prescriptions with less than 7 days of therapy remaining for medications for treatment of SMI.

SUPPORT

California Access Coalition (Co-Sponsor)
Psychiatric Physicians Alliance of California (Co-Sponsor)

OPPOSITION

None registered.

CONTACT

Susanna Schlendorf
(925) 998-4442
Office of Assemblymember Jacqui Irwin
(916) 319-2044

[1]Substance Abuse and Mental Health Services Administration (SAMHSA) 2018-2019 NSDUH State-Specific and 2019 Detailed Tables
[2]West, Joyce C., et al. "Medicaid Prescription Drug Policies and Medication Access and Continuity: Findings From Ten States." *Psychiatric Services*, 13 Jan. 2015, ps.psychiatryonline.org/doi/full/10.1176/ps.2009.60.5.601#jt07t3.
[3]Unni, Elizabeth J., et al. "Medication Non-Adherence in the Homeless Population in an Intermountain West City." *INNOVATIONS in Pharmacy*, vol. 5, no. 2, Jan. 2014, doi:10.24926/iip.v5i2.342.

CALIFORNIA HOSPITAL ASSOCIATION
Leadership in Health Policy and Advocacy

NAMI California
National Alliance on Mental Illness

AB 1331 (Irwin): Improve Behavioral Health Crisis Care With Statewide Focus, Leadership

The Issue

In California, people experiencing a behavioral health crisis are increasingly unable to get the care they need. In virtually no corner of the state can they or their families be assured they will get the right care, in the right place, at the right time.

The state has never had a comprehensive, integrated network of services on which people in a mental health or substance use disorder crisis can rely. Instead, we have a complex patchwork of state and local agencies involved at different touch points, with services that vary based on the county and whether a person is covered by Medi-Cal or private insurance. As a result, people in a behavioral health crisis too often face arrest, involuntary detention, hospitalization and re-hospitalization, homelessness, and even early death.

A comprehensive and integrated crisis network of voluntary care — one that is available statewide — is one of the first lines of defense in protecting civil rights and civil liberties, as well as preventing tragedies of public and patient safety. Effective crisis care saves lives and dollars, but we must invest in a systemic approach and establish leadership at the state level.

An estimated **1.4 million Californians** live with a serious mental illness, while millions of others struggle with day-to-day problems that occasionally rise to the crisis level.

In many communities, behavioral health crisis services are delivered too late — by law enforcement or in hospital emergency departments. Although emergency department doors are always open to anyone in need, hospitals are not typically equipped with the array of community-based resources needed to serve this population and get them the long-term support they need. Once discharged, too few people get the intensive follow-up care they need to prevent a crisis from recurring.

What's Needed

Assembly Bill 1331 (Irwin, D-Thousand Oaks), which is co-sponsored by CHA and the National Alliance on Mental Illness California, would establish a new position at the Department of Health Care Services to focus on establishing and monitoring a comprehensive crisis care system that ensures Californians receive the care they deserve in the most expedient way possible. This new leader would build a system that:

- Promotes successful and evidence-based behavioral health service delivery
- Convenes state and local leaders to develop a cohesive approach to statewide crisis care
- Ensures continuity of services and access points through statewide coordination of programs
- Collects and analyzes data on the effectiveness of existing behavioral health programs
- Maximizes competencies and infrastructure to advance prevention and early intervention

Senator Scott Wiener, 11th Senate District

Senate Bill 221 – Timely Mental Health Care

SUMMARY

Senate Bill 221 will establish clear timely access standards for mental health care follow-up appointments needed by patients in ongoing, medically necessary treatment for mental health and substance use disorders. This bill closes a critical loophole in the state's timely access requirements by ensuring HMOs and health insurers provide patients with timely follow-up care, addressing widespread, lengthy delays.

BACKGROUND/EXISTING LAW

Current law and regulations have been interpreted to require HMOs under the jurisdiction of the Department of Managed Health Care (DMHC) and health insurers under the jurisdiction of the California Department of Insurance (CDI) to offer enrollees initial appointments with non-physician mental health and substance use disorder (MH/SUD) providers within ten (10) business days, but not to establish similarly clear standards for offering needed follow-up care from these same providers.

PROBLEM

In the absence of clear timely access standards for follow-up appointments with non-physician MH/SUD providers – like social workers and therapists – large numbers of Californians requiring ongoing courses of treatment for mental health and substance use disorders have been unable to access care within the timeframes that are clinically appropriate for their diagnoses. According to a December 2020 survey, 88% of the mental health therapists at California's largest HMO reported that weekly individual psychotherapy treatment is unavailable for patients who need it and 51% of therapists reported that their patients wait more than 4 weeks, on average, for a follow-up appointment.[i]

In the California Health Care Foundation's most recent survey on the health care priorities and experiences of California residents, 52% of those who tried to make an appointment believe they waited longer than was reasonable to get one.[ii] Californians' ranked access to mental health treatment as the state's top health care priority in CHCF/KFF's 2019 survey.[iii] This problem has been exacerbated by the significant increase in demand for MH/SUD services driven by the COVID-19 pandemic, with national survey data showing that the rate of anxiety and depression has tripled over the last year and a recent CDC study finding that one in four people age 18 to 24 has seriously considered suicide in the past 30 days.[iv]

Recent science indicates that, without timely access to follow-up mental health treatment, patients can suffer longer recovery times and worse outcomes including a more chronic course of their disorders.[v] Delays in accessing appropriate treatment can lead to increased morbidity and mortality rates, increased time away from work, increased strain on families, increased risk of decompensation, and accelerating crises requiring more costly and intensive care. California's investigative journalists have amassed a large store of evidence documenting these kinds of bad outcomes in recent years, including multiple insured patients with diagnosed mental health conditions who committed suicide after experiencing significant delays in their frequency of care, such as the tragic cases of Elizabeth Brown, Barbara Ragan and others.[vi]

SOLUTION

SB 221 will close the loophole in existing law by detailing an appropriate timely access standard for follow-up appointments with non-physician MH/SUD providers, while giving the treating clinician an option to create alternative timeframes for follow-up appointments when that is warranted.

SUPPORT

- National Union of Healthcare Workers

FOR MORE INFORMATION

Angela Hill, *Legislative Director*
Phone: (916) 651-4011
Email: angela.hill@sen.ca.gov

Nune Gairpian, *Senate Fellow*
Phone: (916) 651-4011
Email: nune.gairpian@sen.ca.gov

[i] NUHW Survey of 4,000 Mental Health Therapists Practicing at Kaiser Permanente Facilities across California, December 2020

[ii] https://www.chcf.org/wp-content/uploads/2020/02/HealthPolicySurvey2020.pdf

[iii] The Health Care Priorities and Experiences of California Residents (chcf.org)

[iv] https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6932a1-H.pdf

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[v] Lower versus higher frequency of sessions in starting outpatient mental health care and the risk of a chronic course; a naturalistic cohort study | BMC Psychiatry | Full Text (biomedcentral.com)

[vi] For families across California, a desperate struggle to get mental health care | CalMatters
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Senate Bill 293

Youth Mental Health Access

MONIQUE LIMÓN
REPRESENTING SENATE DISTRICT 19

THIS BILL

SB 293 will directly increase access to Specialty Mental Health Services (SMHS) for children in Medi-Cal by standardizing the forms counties require contracting providers to complete under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) SMHS benefit.

BACKGROUND

The EPSDT program is a state-administered Medicaid benefit entitling low-income infants, children, and adolescents under the age of 21 enrolled in Medicaid, as well as foster youth, to a comprehensive array of healthcare services. This includes services to prevent, diagnose, and treat beneficiaries at the right place and the right time, by the right providers. The benefit covers services such as eye exams, vaccinations, mental services, etc. One of the largest components of the benefit is individualized treatment for mental health and substance use issues, which includes crisis-based services, counseling and therapy, intervention, and medication management.

The Department of Health Care Services (DHCS) is responsible for ensuring that Medicaid-eligible children and their families are aware of EPSDT services, and that they have access to medically necessary treatment services. As such, Medi-Cal is the largest mental health payer in California.

However, Counties currently receive limited guidance from the state on how to comply with documentation requirements related to the EPSDT program. As a result, paperwork requirements vary, with each of the 58 counties utilizing different sets of paperwork to administer the same types of services. This creates substantial confusion for providers and results in children experiencing critical gaps in care and a lack of coordinated care, while also increasing overall costs to the entire healthcare delivery system. For example, providers estimate that paperwork for these patients consumes 40-50% of their time to complete, and providers that serve children from multiple counties must navigate many different sets of forms.

At the same time, California is suffering a severe shortage of child and adolescent mental health professionals. For example, the American Academy of Child & Adolescent Psychiatry (AACAP) recommends a ratio of at least 47 child and adolescent psychiatrists (CAPs) per 100,000 children and adolescents in the population, but California has less than 18 CAPs per 100,000. Even pre-pandemic, children in Medi-Cal were scarcely accessing SMHS. According to the Medi-Cal Dashboard, the current rate for county mental health services for children and adolescents is approximately 4 percent, whereas national estimates put the prevalence of mental health disorders among children at between 13 and 20 percent. This means that as many as 1.8 million children in California are living with an untreated mental health condition – a number

that exceeds the entire population of West Virginia.

PURPOSE

The COVID-19 pandemic has dramatically increased the incidence of serious mental health and substance use issues among children and adolescents, making access to SMHS more important than ever. Addressing the need created by the pandemic will require existing providers to serve more Medi-Cal enrollees in communities throughout California.

The current system of 58 separate sets of forms and processes for determining eligibility for SMHS services imposes an enormous burden on county mental health providers and limits their ability to meet this need. The onerous paperwork requirements also create serious issues on workforce recruitment and retention, causing many in the industry to move to different jurisdictions or leave to serve different populations, as they often feel frustrated that they are spending more time on paperwork than serving patients.

SB 293 will require DHCS to streamline and standardize intake, assessment, and treatment plans for use with contracted SMHS providers in all 58 counties, by July 1, 2022.

SUPPORT

California Alliance of Child and Family Services (Co-Sponsor)
California Children's Hospital Association (Co-Sponsor)
California Council of Community Behavioral Health Agencies (Co-Sponsor)
Casa Pacifica Centers for Children & Families
Seneca Family of Agencies
Alum Rock Counseling Center
Fresno Barrios Unidos

STAFF CONTACT

Jimmy Wittrock, Legislative Director
Jimmy.wittrock@sen.ca.gov
Office: 916-651-4019

SENATOR BRIAN W. JONES
@SENBRIANJONES

Senate Bill 565 Fact Sheet – State Hospital Expansion

SUMMARY

SB 565 requires the Department of State Hospitals to expand their facilities to reduce wait times for individuals awaiting treatment under the Lanterman-Petris-Short (LPS) Act.

BACKGROUND

The LPS Act permits involuntary mental health treatment when, because of mental illness, individuals pose a risk of harm to themselves or others or cannot provide for their own basic needs. Under the LPS Act, counties can refer individuals to state hospital facilities to receive treatment, often an individual's only option.

However, state hospitals have been suffering from a shortage of beds caused by increasing county referrals and an obligation to treat large numbers of individuals involved with the criminal justice system. Data from the Department of State Hospitals show that the total capacity in its facilities as of November 2019 was just under 6,300 beds and that 84% of these beds were occupied by individuals who were involved with the criminal justice system. Because of this shortage of beds, individuals treated under the LPS Act are placed on a waitlist, sometimes delaying treatment for multiple years. Despite allocating some additional beds for individuals receiving their care through the LPS Act, the Department of State Hospitals projects that this waitlist will continue to grow.

PROBLEM

According to a 2020 California State Auditor Report, individuals treated under the LPS Act waited on average one year for admission to a state hospital facility, with some waiting several years. The State Auditor specified this delay in admission was caused by an acute lack of beds and predicts the problem will only worsen. When the State does not provide timely access to treatment at state hospital facilities to those who need it, it fails to adequately care for these vulnerable individuals.

SOLUTION

SB 565 requires the Department of State Hospitals to increase the capacity of its facilities to reduce wait times for LPS patients to 60 days or less by January 1, 2027. Additionally, this bill requires the Department of State Hospitals to develop a plan to accomplish this facility expansion by July 1, 2022, and submit a report on the estimated cost of this plan to the legislature by August 1, 2022.

California is experiencing a growing need for adequate and timely healthcare for some of its most vulnerable people. A report on the cost of expanding the state's treatment capacity is the first step to addressing this need.

CONTACT

Brixton Layne
(916) 651-4038
Brixton.Layne@sen.ca.gov

As Proposed to Be Amended

SENATOR BRIAN W. JONES
@SENBRIANJONES

Senate Bill 578 Fact Sheet – Privacy of LPS Conservatorship Proceedings

SUMMARY

SB 578 requires conservatorship proceedings under the Lanterman-Petris-Short (LPS) Act to be held in closed court unless a party to the petition requests it to be public.

BACKGROUND

Case law establishes that LPS conservatorship proceedings are inherently nonpublic in order to protect an individual's confidential medical information, such as mental health history, medical records, and prescription history. Courts have widely acknowledged that this information discussed during LPS conservatorship proceedings can pose a threat to the personal reputations of those involved. Some courts, like the San Francisco Superior Court and the Shasta Superior Court, have mitigated this threat on their own by presumptively holding these proceedings in closed court unless expressly requested by the subject of the proceedings. Other courts, however, such as the Los Angeles Superior Court, have failed to voluntarily provide similar privacy protections. Instead, in their words, they continue to conduct these proceedings publicly to expedite their large caseload.

PROBLEM

According to a July 2020 report from the California State Auditor, Californians involved in LPS conservatorships do not have consistent privacy protections across the state. The Los Angeles Superior Court continues to hold sensitive LPS conservatorship proceedings in open court, contradicting legal precedent practiced elsewhere in California. As noted by the State Auditor, this practice could also be occurring in other courts with similarly large caseloads. The State Auditor's findings make it clear that the courts need more explicit direction in order to standardize conservatee privacy protections across the state.

SOLUTION

SB 578 implements the California State Auditor's recommendations to protect the privacy of individuals who are the subject of LPS conservatorship proceedings by explicitly requiring LPS conservatorship proceedings to be held in closed court. SB 578 still allows flexibility for a party to the petition to request an open courtroom if appropriate.

SB 578 protects the dignity of vulnerable Californians and ensures they retain their right to privacy, no matter what courthouse they visit.

CONTACT

Brixton Layne
(916) 651-4038
Brixton.Layne@sen.ca.gov

Senator Steven M. Glazer, 7th Senate District

SB 749 – Mental Health Program Oversight

Summary

This bill would provide greater oversight of mental health services spending by requiring the Mental Health Services Oversight and Accountability Commission (MHSOAC) to track the spending of mental health services funds and the outcomes for people dealing with mental illness achieved by that spending

Issue

According to a state audit released last summer, Californians have little ability to discern how well the billions of dollars we invest in mental health services are working for those in need. Despite the wide variety of services counties can provide, the State's current public reporting for mental health funds relies on disjointed and incomplete tools—a result of multiple funding sources with different requirements and levels of transparency.

Existing Law

Current law requires the Mental Health Services Oversight and Accountability Commission to oversee the Mental Health Services Act (MHSA) reporting. Other funds counties use for mental health services including Medi-Cal and realignment, have their own reporting requirements to different agencies. For example, funding through Medi-Cal is reported through the Department of Health Care Services with information regarding types of services and some outcomes but this does not provide a broader understanding of county mental health systems.

The state auditor identified the MHSA reporting framework as being the most comprehensive public reporting requirements of the different mental health funding sources. Yet despite the comprehensive reporting MHSA reporting also includes broad categories that do not convey specific information about how counties spend their funds.

Proposal

This bill creates a state framework for collecting information regarding mental health funding through the Mental Health Services Oversight and Accountability Commission. MHSOAC would be required to collaborate with state and local mental health authorities to create a comprehensive tracking program for county spending on mental health programs and the outcomes from that spending.

This bill would require counties to report specified data to the previous fiscal year to the commission by July 31 of each year.

MHSOAC would then be responsible for tracking county funding sources, funding utilization and outcome data at the program, service and statewide levels. MHSOAC would develop categories of mental health programs and services including emergency services, inpatient services, etc., to inform assessments of spending and outcome patterns.

Contact

Policy: Caila Pedroncelli, Legislative Aide
(916) 651-4007 or caila.pedroncelli@sen.ca.gov

Press: Steve Harmon, Communications Director
Steven.Harmon@sen.ca.gov