Date of Hearing: April 26, 2022

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 1859 (Levine) – As Introduced February 8, 2022

SUBJECT: Mental health services.

SUMMARY: Requires a health care service plan (health plan) or a health insurance policy issued, amended, or renewed on or after January 1, 2023, that includes coverage for mental health (MH) services to, among other things, approve the provision of MH services for persons who are detained for 72-hour treatment and evaluation under the Lanterman-Petris-Short (LPS) Act and to schedule an initial outpatient appointment for that person with a licensed MH professional within 48 hours of the person's release from detention. Prohibits a noncontracting provider of covered MH services from billing the enrollee or insured for more than the cost-sharing amount the enrollee or insured would pay to a contracting provider for those services. Specifically, **this bill**:

1) Requires a health plan or policy issued, amended, or renewed on or after January 1, 2023, that includes coverage for MH services to do all of the following:

    a) Approve the provision of MH services for enrollees or insureds under the plan who are detained for 72-hour treatment and evaluation, as specified;

    b) Schedule an initial outpatient appointment for the enrollee with a licensed MH professional. Requires the appointment to be scheduled within 48 hours of the enrollee's release from detention;

    c) Ensure that the location of facilities providing the covered MH services for the enrollee or insured is within reasonable proximity of the business or personal residences of the enrollee or insured, and located so not to result in unreasonable barriers to accessibility;

    d) Provide that if an enrollee or insured receives covered MH services from a noncontracting provider, the enrollee or insured pays no more than the same cost-sharing amount that the enrollee or insured would pay for the same covered services received from a contracting provider.

        i) Prohibits an enrollee or insured from owing the noncontracting provider more than the in-network cost-sharing amount for covered mental health services. Requires the plan or insurer to inform the enrollee or insured and the noncontracting provider of the in-network cost-sharing amount owed.

        ii) Prohibits a noncontracting provider from billing or collecting any amount from the enrollee or insured for covered mental health services, except for the in-network cost-sharing amount.

        iii) Specifies that, covered MH services are MH services that are urgently needed to prevent serious deterioration of the enrollee or insured's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee or insured can receive services from a contracting provider.

2) Exempts Medi-Cal managed care plans from provisions of this bill.

EXISTING LAW:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans and the California Department of Insurance (CDI) to regulate health insurers.

2) Establishes the federal Patient Protection and Affordable Care Act (ACA), which enacts various health care coverage market reforms including the availability of health insurance exchanges (exchanges) and new individual and small group products offered on and off the exchanges beginning 2014.

3) Requires health plans and health insurers providing health coverage in the individual and small group markets to cover, at a minimum, essential health benefits (EHBs), including the 10 EHB benefit categories in the ACA, as specified in state law, which include the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; MH and substance use disorder (SUD) services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care.

4) Requires health plans to provide basic health care services, including: physician services; hospital inpatient and ambulatory care services; diagnostic laboratory and diagnostic and therapeutic radiologic services; home health services; preventive health services; emergency health care services; and, hospice care.

5) Requires emergency health care services to be available and accessible to enrollees on a twenty-four hour a day, seven days a week, basis within the health plan area. Requires emergency health care services to include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the health plan.

6) Requires every health plan contract issued, amended, or renewed on or after January 1, 2021 to provide coverage for medically necessary treatment of MH and SUD under the same terms and conditions applied to other medical conditions, as specified.

7) Defines medically necessary treatment of MH or SUD as a service or product addressing the specific needs of that patient, for the purposes of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner as specified.

8) Requires health plans to ensure that all services be readily available at reasonable times to each enrollee consistent with good professional practice, and to the extent feasible, a health plan to make all services readily accessible to all enrollees consistent with existing law on timely access to health care services.

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, after a 72-hour involuntary hospitalization, the process of obtaining follow-up care on a voluntary basis is often frustrating and complicated for the discharged person, who often is still experiencing significant mental anguish and is ill-equipped to take necessary steps to obtain follow-up care. Although there is currently no mandated standard of care after a 5150 hold, prompt follow-up with outpatient MH providers after discharge from a psychiatric hospitalization is critical for maintaining continuity of treatment and preventing repeat hospitalizations. A recent State Audit conducted by the California State Auditor (Auditor) concluded that in California, many individuals were subjected to repeated instances of involuntary treatment without being connected to ongoing care that could help them live safely in their communities. For instance, the Auditor found that almost 7,400 people in Los Angeles County experienced five or more short-term involuntary holds from fiscal years 2015-16 to 2017-18, but only 9% were enrolled in the most intensive and comprehensive community-based services available in 2018-19. According to the California Health Benefits Review Program (CHBRP), 24% of enrollees who had a 72-hour hold have a follow-up visit within 48 hours of the hold, but 37% have no follow-up visit within 90 days. There is a clear need to expedite and streamline the process for follow-up MH treatment. The author states that this bill will help improve MH outcomes and ensure timely access to care by requiring that a patient released from involuntary MH hospitalization receive authorization and an appointment for care within 48 hours of their release. To improve access, this bill requires that the location of the facilities providing the MH services be within reasonable proximity of the business or residence of the patient. This bill will help create parity in the provision of MH care services compared to physical health care services, provide urgent support to an individual suffering from a MH emergency, and help save the lives of residents in California.

2) **BACKGROUND.**

   a) **Existing Network Adequacy Requirements.** California law sets forth various network adequacy requirements on health plans and insurers. For example, health plans are subject to the following:

      i) Timely Access. Timely Access Laws and Regulations require that health plans meet a set of standards which include specific time frames under which enrollees must be able to access care. These requirements generally include the following standards for appointment availability:

         (1) Urgent care without prior authorization: within 48 hours;
         (2) Urgent care with prior authorization: within 96 hours;
         (3) Non-urgent primary care appointments: within 10 business days;
         (4) Non-urgent specialist appointments: within 15 business days;
         (5) Non-Urgent mental health appointments: within 15 business days for psychiatrist, within 10 business days for non-physician mental health provider; and,
         (6) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition: within 15 business days.

         Existing regulations also authorize the applicable waiting time for a particular appointment to be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting

within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

ii) Geographic Access. Health plans are also generally required to ensure geographic access such that there are a sufficient number of providers located within a reasonable distance from where each enrollee lives or works. For example, primary care physicians (PCPs) and hospitals should be located within 15 miles or 30 minutes from work or home.

Health plans must also ensure provider capacity such that health plan networks have enough of each of the right types of providers to deliver the volume of services needed. For example, plan networks should include one PCP for every 2,000 beneficiaries.

DMHC recently published its Timely Access Report for Measurement Year 2020 and the key findings are as follows:

i) Full Service Health Plans: For non-urgent and urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 98% to a low of 53%. For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 98% to a low of 69%. For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 97% to a low of 35%.

ii) Behavioral Health Plans: For non-urgent and urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 79% to a low of 75%. For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 88% to a low of 83%. For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 72% to a low of 64%.

b) LPS Act. The LPS Act was signed into law in 1967 and provides for involuntary commitment for varying lengths of time for the purpose of evaluation and treatment, provided certain requirements are met. Additionally, the LPS Act provides for LPS conservatorships, resulting in involuntary commitment for the purposes of treatment if an individual is found to meet the criteria of being a danger to themselves or others or is gravely disabled as defined. The LPS Act provides for a conservator of the person, of the estate, or of both the person and the estate for a person who is gravely disabled because of a mental health disorder or impairment by chronic alcoholism or use of controlled substances. The person for whom such a conservatorship is sought has the right to demand a court or jury trial on the issue of whether they meet the gravely disabled requirement. The purpose of an LPS conservatorship is to provide individualized treatment, supervision, and placement for the gravely disabled person. Current law also deems a person as not being gravely disabled for purposes of a conservatorship if they can survive safely without involuntary detention with the help of responsible family, friends, or others who indicate they are both willing and able to help. The LPS Act, along with the court ordered outpatient services available through Laura's Law provides a

robust system for mandating intensive inpatient and outpatient care, along with general oversight, for those who may not be able to care for themselves.

i) 5150's. Typically one first interacts with the LPS Act through what is known as a 5150 hold, which allows a peace officer or other authorized individual as specified to commit a person for an involuntary detention of up to 72 hours for evaluation and treatment if they are determined to be, as a result of a MH disorder, a threat to self or others, or gravely disabled. The peace officer or other authorized individual who initially detains the individual must determine and document that the individual meets this standard. When making the determination, the peace officer or other authorized person may consider the individual's historical course, which includes evidence presented by a person who has provided or is providing MH or related support services to the person on the 5150 hold; evidence presented by one or more members of the family of the person on the 5150 hold; and, evidence presented by the person on the 5150 hold, or anyone designated by that person, if the historical course of the person's mental disorder has a reasonable bearing on making a determination that the person requires a 5150 hold.

ii) CHBRP states that a 5150 hold may be initiated in community settings by peace officers (e.g., homes or public places) or in health care settings by a mental health professional, but patients must be evaluated and admitted to an LPS-designated facility for a 5150 to be active. These facilities are primarily licensed psychiatric hospitals, licensed psychiatric health facilities, certified crisis stabilization units, and Veterans Affairs hospitals with a locked psychiatric ward. Often there is not capacity at an LPS-designated facility to directly accept patients identified in the community. Patients are often referred to an emergency department (ED) of an acute care hospital for stabilization or clearance prior to transfer to an LPS-designated facility. Patients that are stabilized in the ED and discharged or who are admitted to a non-LPS designated facility are not included in the population counted as persons with a 5150 holds. Prompt follow up with outpatient mental health providers after discharge from a psychiatric hospitalization is important for maintaining continuity of treatment and preventing repeat hospitalizations. This bill requires access to follow-up mental health care within 48 hours after a person detained on a 5150 is released. However, according to CHBRP, this standard differs from nationally established benchmarks for follow-up care, and several health plans stated that they considered timely follow up after an inpatient hospitalization to be seven days after discharge. Outpatient follow-up care after a 5150 is greatly affected by where the patient is discharged from and whether that patient was undergoing treatment for a MH condition prior to hospitalization. Patients discharged from an inpatient psychiatric hospital may have faster access to outpatient follow-up care since they are already connected to a mental health provider network; similarly, patients are more likely to have a timely appointment (i.e., within 48 hours) if they already have an established treatment relationship with a MH professional. Patients who do not meet these two conditions are often instructed to schedule appointments with MH providers and are sometimes assisted by hospital navigators but must often wait 30 to 60 days for an available appointment.

c) CHBRP analysis. AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the University of California to assess legislation proposing a mandated benefit or service and

prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on essential health benefits, and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. CHBRP provided an update to AB 2242 (Levine) of 2020. CHBRP states in its analysis of this bill the following:

i) **Impact on expenditures.** An increase in total net annual expenditures of $1,559,000, or about 0.001%, for enrollees with DMHC-regulated plans and CDI-regulated policies.

ii) **EHBs.** Since MH services are EHBs, this bill does not appear to exceed the definition of EHBs in California.

iv) **Medical effectiveness.** According to CHBRP, there is inconclusive evidence of effects of timely access to MH outpatient visits on hospital readmissions, although the most pertinent studies (i.e., those that assess people with commercial health insurance) suggest that receiving follow-up outpatient MH services within 30 days of discharge is associated with a small reduction in hospital readmissions. The impact of receiving follow-up outpatient care within two days of discharge is unknown because none of the studies assessed the impact of receiving follow-up care during the time interval specified in this bill. There is insufficient evidence of the effect of timely follow-up outpatient care on ED visits and medication adherence. There is insufficient evidence to determine whether receiving timely follow-up outpatient MH services, after discharge from inpatient MH care, improves MH outcomes. There is inconclusive evidence that scheduling visits for follow-up outpatient MH services, after discharge from inpatient MH care, affects use of MH services including hospital readmissions. There is insufficient evidence to determine whether access to outpatient MH providers in close proximity to a patient's business or residence increases use of outpatient MH services following discharge from inpatient MH care or improves MH outcomes. There is limited evidence that reducing cost sharing for follow-up outpatient MH services increases use of these services. There is insufficient evidence to determine if reducing cost sharing for follow-up outpatient MH services improves MH outcomes. CHBRP's review of more recent studies relevant to this bill found there is insufficient evidence of effects of timely follow-up care with a MH provider on suicide rates, a MH outcome and there is insufficient evidence that scheduling timely follow-up care with a MH provider increases the use of outpatient services.

v) **Benefit coverage.** CHBRP estimates no change in benefit coverage due to the bill, with 100% of enrollees estimated to have coverage for 72-hour treatment and evaluation holds and 100% to have coverage for follow-up visits after 72-hour holds at baseline and postmandate.

vi) **Public health and long term impacts.** The number of people with commercial insurance who would receive an outpatient appointment within 48 hours of discharge would increase but the impacts of this on ED visits, hospital readmission, or suicide are unknown due to insufficient, inconclusive, or limited evidence. CHBRP states long term impacts would likely be similar in subsequent years as in the first year postmandate.

3) **SUPPORT.** The Steinberg Institute writes that this bill will help improve MH outcomes and ensure timely access to care by requiring that a patient released from involuntary mental

health hospitalization receives authorization and an appointment for care within 48 hours of their release. This bill will help create parity in the provision of mental health care services compared to physical health care services, provide urgent support to an individual suffering from a MH emergency and help save the lives of residents in California. National Alliance on Mental Illness CA states that individuals with mental illnesses must have timely access to treatments that have been recognized as effective by the Food and Drug Administration and the National Institute of Mental Health.

4) **SUPPORT IF AMENDED.** The County Behavioral Health Directors Association of California (CBHDA) writes that this bill should make clear that all medically necessary mental health services associated with the 5150 process, including crisis intervention services, screening and evaluation of an individual placed on a 5150 hold, whether detained or released, regardless of location of service, should be reimbursed by the plan and insurer. Under parity laws, costs relative to the transportation of the insured when additional medically necessary services are needed to stabilize the individual, including urgent care, residential or hospital services should also be reimbursed by the plan and insurer. CBHDA states that by providing clarity in this bill that MH parity requires a plan and insurer to cover these medically necessary services when performed by a noncontracted provider will ensure that private plan and insurer enrollees have access to these critical services and the financial responsibility falls on the appropriate entity.

5) **OPPOSE UNLESS AMENDED.** The California Chamber of Commerce writes that the provisions related to scheduling appointments would increase administrative costs for health plans and insurers. From an employer perspective, it is concerning that an increase in administrative costs could lead to higher premiums for employers and employees.

6) **OPPOSITION.** The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans contend that in the face of continued uncertainty and efforts to fragment the market and promote less comprehensive coverage, California needs to protect the coverage gains we've made and stay focused on the stability and long-term affordability of our health care system. Benefit mandates impose a one-size-fits all approach to medical care and benefit design driven by the Legislature, rather than consumer choice.

7) **RELATED LEGISLATION.**

   a) AB 2242 (Santiago) requires any person detained under the LPS Act for a 72-hour, 14-day, 30-day or a conservatorship to receive a care coordination plan prior to release and requires the care coordination plan to include a first follow-up appointment with an appropriate behavioral health professional. Specifies that under no circumstances may the individual be involuntarily held beyond when they would otherwise qualify for release. Requires on or before July 1, 2023, the Department of Health Care Services to convene a stakeholder group as specified, to create a model care coordination plan to be followed when discharging those held under temporary holds or conservatorships. AB 2242 is pending in Assembly Health Committee.

   b) AB 2830 (Bloom) establishes the Community Assistance, Recovery, and Empowerment (CARE) Act, which would authorize specified people to petition a civil court to create a CARE plan and implement services, to be provided by county behavioral health agencies, to provide behavioral health care, stabilization medication, and housing support to adults

who are suffering from schizophrenia spectrum and psychotic disorders and who lack medical decisionmaking capacity. Specifies the process by which the petition is filed and reviewed, including requiring the petition to be signed under penalty of perjury, and to contain specified information, including the acts that support the petitioner's belief that the respondent meets the CARE criterion. AB 2830 is pending in Assembly Judiciary Committee.

8) PREVIOUS LEGISLATION.

a) SB 221 (Wiener), Chapter 724, Statutes of 2021, codifies existing timely access to care standards for health plans and health insurers, applies these requirements to Medi-Cal managed care plans, adds a standard for non-urgent follow-up appointments for nonphysician MH care or SUD providers that is within 10 business days of the prior appointment.

b) SB 855 (Wiener), Chapter 151, Statutes of 2020, revises and recasts California's Mental Health Parity provisions, and requires a health plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of MH and SUD, as defined, under the same terms and conditions applied to other medical conditions and prohibits a health plan or disability insurer from limiting benefits or coverage for MH and SUD to short-term or acute treatment. Specifies that if services for the medically necessary treatment of a MH and SUD are not available in network within the geographic and timely access standards in existing law, the health plan or insurer is required to arrange coverage to ensure the delivery of medically necessary out of network services and any medically necessary follow up services, as specified.

c) AB 2242 (Levine) of 2020 was substantially similar to this bill and held at the request of the author.

d) AB 2193 (Maienschein), Chapter 755, Statutes of 2018, requires health plans and health insurers, by July 1, 2019, to develop, consistent with sound clinical principles and processes, a maternal mental health program, as specified. Requires, by July 1, 2019, a licensed health care practitioner who provides prenatal or postpartum care for a patient, to offer to screen or appropriately screen a mother for maternal mental health conditions.

e) SB 964 (Hernandez), Chapter 573, Statutes of 2014, requires a health plan to annually report specified network adequacy data, as specified, to DMHC as a part of its annual timely access compliance report, and requires DMHC to review the network adequacy data for compliance.

f) AB 2179 (Cohn), Chapter 797, Statutes of 2002, requires DMHC and CDI to develop and adopted regulations to ensure that enrollees have access to needed health care services.

9) POLICY COMMENTS.

a) Existing law currently requires the availability of appointments within a specified timeframe as noted above. This bill currently requires a health plan to schedule an outpatient appointment within 48 hours of an individual's release from detention. Is

this an obligation that health plans can meet? Is it appropriate for the health plan to schedule appointments on behalf of an enrollee? Is this appointment consistent with the discharging facility's treatment plan? If the enrollee has an existing relationship with a contracted MH provider and that provider does not have an appointment available within this bill's timeframe, is the health plan obligated to schedule an appointment with a new MH provider? The Committee recommends that the author consider the obligations of the discharging facility and the treatment plan, if any, in addition to the health plan's obligation to ensure that the recommended services are available and accessible to the enrollee.

b) This bill also requires the health plan to ensure that the location of facilities that provide MH services for those detained are within a reasonable proximity of enrollees. Existing law as it relates to network adequacy ensures that services are available and accessible, and the distances vary depending upon specified providers, for example hospital services are to be available within 15 miles or 30 minutes of an enrollee's work or home. The author should consider how these new provisions are different from the current network adequacy standards and whether these provisions create a new health plan obligation. If the latter is the intent of the author, the Committee recommends that the terms "reasonable proximity" be defined.

REGISTERED SUPPORT / OPPOSITION:

Support

DBSA California
National Alliance on Mental Illness (NAMI-CA)
National Association of Social Workers, California Chapter
Steinberg Institute

Opposition

America's Health Insurance Plans (AHIP)
Association of California Life & Health Insurance Companies
California Association of Health Plans

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