SENATE COMMITTEE ON HEALTH
Senator Akilah Weber Pierson, Chair

BILL NO: AB 1825
AUTHOR: Krell
VERSION: April 16, 2026
HEARING DATE: July 1, 2026
CONSULTANT: Reyes Diaz

SUBJECT: Health care: state hospitals

SUMMARY: Adds the behavioral health department of the county of supervision as an entity the California Department of Corrections and Rehabilitation (CDCR) is required to notify and work with when releasing a prisoner to community supervision. Requires CDCR, the county of supervision, and the county's behavioral health department to coordinate an exit plan for each individual being released, including targeted Medi-Cal services, prior to the release date.

Existing law:
1) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which qualified low-income individuals receive health care services. [WIC §14001.1]

2) Requires each county to establish and administer a full-service partnership (FSP) program that includes services such as mental health, supportive, and substance use disorder (SUD) treatment services; outpatient behavioral health; ongoing engagement; and, housing interventions. [WIC §5887(a)]

3) Deems an individual with a serious mental illness as presumptively eligible for an FSP if they meet criteria, one of which is that they are transitioning to the community after six months or more in a secured treatment or residential setting, including, but not limited to, a mental health rehabilitation center, institution for mental disease, or secured skilled nursing facility. [WIC §5887(d)(2)(A)(ii)]

4) Requires a prisoner, as a condition of parole, to be provided necessary treatment by the California Department of State Hospitals (DSH) if specific criteria are met, such as that the prisoner has a severe mental health disorder that is not in remission or that cannot be kept in remission without treatment; the condition was one of the causes of, or an aggravating factor in, the commission of a crime resulting in imprisonment; and, as a result of the severe mental disorder, the prisoner represents a substantial danger of physical harm to others. [PEN §2962]

5) Requires the California Department of Corrections and Rehabilitation (CDCR), upon a determination that an individual is eligible for release to community supervision, to notify the probation department of the county of supervision of the pending release within five working days of the court order and work with the county of supervision to coordinate the orderly and safe release of the prisoner. [PEN §2966]

6) Requires a qualifying inmate of a public institution to be eligible to receive targeted Medi-Cal services for 90 days, or the number of days approved in the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions for an eligible population of

qualifying inmates if different than 90 days, prior to the date they are released from a public institution, if otherwise eligible for those services. [WIC §14184.800]

This bill:

1) Adds the behavioral health department of the county of supervision as an entity CDCR is required to notify pending the release of an eligible individual to community supervision, and as an entity CDCR is required to work with to coordinate the orderly and safe release of a prisoner pursuant to Existing Law 5) above.

2) Requires CDCR, the county of supervision, and the county's behavioral health department to work at coordinating an exit plan, as part of the prisoner's orderly and safe release, that includes, but is not limited to:
   a) The submission of a Medi-Cal application; and,
   b) A recommendation to the supervising county's behavioral health department by a licensed behavioral health professional who is, or has been within the previous 30 days, supervising the treatment of, or treating, the individual for a mental health disorder for any of the following: suicide prevention; SUD treatment; Medi-Cal enhanced care management; an FSP; Assisted Outpatient Treatment (AOT); the Community Assistance, Recovery, and Empowerment (CARE) Act; a forensic assertive community treatment program; evaluating if the offender meets the definition of gravely disabled for involuntary detention and determining if the supervising county should pursue a court-ordered mental health evaluation using the existing legal process under the Lanterman-Petris-Short Act; and, early psychosis intervention services.

3) Adds an individual with a serious mental illness transitioning to the community after six months or more in a State Hospital to the presumptive eligibility criteria for an FSP described in Existing Law 3) above.

4) Adds a qualifying inmate of a State Hospital as a person eligible to receive targeted Medi-Cal services for 90 days under CalAIM.

FISCAL EFFECT: According to the Assembly Appropriations Committee:
The County Behavioral Health Directors Association estimates costs to county behavioral health programs of $209,000 to $889,000 statewide to coordinate with CDCR on an offender's exit plan, making clinical determinations, and providing subsequent treatment. These costs are potentially reimbursable by the state, subject to a determination by the Commission on State Mandates (General Fund);
DSH states this bill will increase DSH's Offenders with Mental Health Disorders (OMHD) patient population by increasing OMHD commitments and decreasing OMHD decertifications. The average cost of treatment for a patient at DSH is $1,121 per day ($409,165/year). The average length of stay for OMHD patients is 259 days, for an average cost of $290K per patient. Although it is difficult to determine the extent to which this bill will increase DSH's OMHD patient population and related costs, DSH estimates an increase in new OMHD commitments to DSH up to 5% and a reduction of OMHD decertifications up to 10% of its population of 1,132 OMHDs (including those on conditional release), which would result in costs of up to tens of millions of dollars annually to activate additional beds to treat the increased OMHD population (General Fund). DSH notes that it has limited available capacity to activate beds for this purpose;
Costs to CDCR of an unknown amount, potentially absorbable or in the low hundreds of thousands of dollars annually; and,

Costs to DHCS of an unknown but likely significant amount, to the extent providing coverage for an inmate of DSH is allowable.
The Legislative Analyst's Office recently warned of General Fund structural deficits of around $35 billion per year in the 2027-28 fiscal year and ongoing.

PRIOR VOTES:

Senate Public Safety Committee:	6 - 0
Assembly Floor:	74 - 0
Assembly Appropriations Committee:	15 - 0
Assembly Health Committee:	16 - 0
Assembly Public Safety Committee:	9 - 0

COMMENTS:

1) *Author's statement.* According to the author, the OMHD program is a key tool to help ensure that formerly incarcerated individuals can safely and smoothly transition back to our California communities. But reforms on both the front end and the back end will better protect public safety. Specifically, the existing criteria used to determine eligibility for the OMHD program have been broadly interpreted, allowing offenders with severe conditions to successfully challenge their status in court and reenter society, even though they pose a serious risk to themselves and the community. Furthermore, once these individuals are released, they lack access to appropriate services. This bill takes a multi-layered approach, addressing these issues by requiring specific criteria to be evaluated when determining OMHD status, further defining what constitutes an exit plan, and expanding Medi-Cal eligibility. This ensures that those who need treatment receive it and prioritizes the safety of our communities.

2) *CalAIM.* According to DHCS, CalAIM puts people's needs at the center of care by providing coordinated support to meet each Medi-Cal beneficiary's physical, developmental, behavioral, and dental health needs as well as long-term services and health-related social supports. CalAIM shifts Medi-Cal to a population health approach, prioritizing prevention, addressing social drivers of health, and transforming services for communities who historically have been under-resourced and faced structural racism in the health care system. CalAIM includes specific initiatives on equity designed to provide equal access to health and well-being, such as targeted services for individuals transitioning from incarceration to community re-entry, from homelessness to housing, and from institutional to home-based care, and reduces variation across counties and plans, while recognizing the importance of local innovation and supports, community activation, and engagement.

   Through the Justice-Involved Initiative, DHCS states California is taking significant steps to improve poor health outcomes in this population as they prepare to re-enter their community. In 2023, California became the first state in the nation approved to offer a targeted set of Medicaid services to youth and adults in state prisons, county jails, and youth correctional facilities (State Hospitals are not included) for up to 90 days prior to release. Through a federal Medicaid 1115 demonstration waiver approved by the Centers for Medicare & Medicaid Services, DHCS partners with state agencies, counties, and community-based organizations to establish a coordinated community reentry process that assists people leaving incarceration connect to the physical and mental health services they need prior to release. Pre-release Medi-Cal services include reentry care management services; physical and behavioral health clinical consultation services provided through telehealth or in person,

as needed, to diagnose health conditions, provide treatment as appropriate, and support pre-release care managers' development of a post-release treatment plan and discharge planning; laboratory and radiology services; medications and medication administration; medication assisted therapy for all Food and Drug Administration-approved medications, including coverage for counseling; and, services provided by community health workers with lived experience. In addition to these pre-release services, qualifying members can receive covered outpatient prescribed medications and over-the-counter drugs and durable medical equipment upon release, consistent with approved state plan coverage authority and policy.

3) *FSPs.* According to DHCS, FSPs provide comprehensive and intensive care for people at any age with the most complex needs under a model known as "whatever it takes." Since the revamping and renaming of the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA), under SB 326 (Eggman, Chapter 790, Statutes of 2023), counties must, except for in specified cases, use 35% of BHSA funds for FSPs. Counties have the flexibility to move 7% of funds to/from FSPs into another category (Housing Interventions or Behavioral Health Services Supports) for a maximum total shift of 14%. Since the passage of SB 326, FSP teams must be capable of supporting individuals living with co-occurring mental health and substance use conditions.

4) *OMHD.* According to CDCR, the OMHD commitment was created to provide a mechanism to detain and treat persons with a severe mental health disorder who reach the end of a determinate prison term and are dangerous to others as a result of a severe mental health disorder. The law became effective on July 1, 1986. OMHD is a two-phase commitment. During the first phase, the CDCR Chief Psychiatrist certifies the person as OMHD and the Board of Parole Hearings (BPH) imposes a parole condition that the person serve their parole at a State Hospital. The second phase continues mental health treatment after the supervised person is discharged from parole, which involves a civil commitment for involuntary treatment. Current law mandates BPH to order a person who meets the OMHD criteria to receive mental health treatment provided by DSH by imposing a special condition of parole. Mental health treatment is mandated to be inpatient until DSH certifies that the supervised person can be safely and effectively treated in the community on an outpatient basis. A supervised person with a severe mental health disorder has the right to a series of due process hearings. Thus, BPH conducts OMHD certification and placement and annual review hearings, which are conducted by BPH's Deputy Commissioners. Certification and annual review hearings are held to determine whether the supervised person meets the OMHD commitment criteria. Placement hearings address whether the supervised person should receive inpatient treatment provided by DSH or whether the supervised person can be safely and effectively treated in the community on an outpatient basis.

5) *Double referral.* This bill was heard in the Senate Public Safety Committee on June 16, 2026, and passed with a 6-0 vote.

6) *Related legislation.* AB 1782 (DeMaio) would have reduced the number of factors the chief psychiatrist of CDCR must use to certify to BPH the involuntary commitment of an OMHD. *AB 1782 failed passage in the Assembly Public Safety Committee.*

   AB 1897 (Haney) would permit an incarcerated person who disagrees with a BPH determination that they qualify as an OMHD to file a petition for a hearing on the matter in the superior court of the county of commitment to state prison, rather than in the county in

which the person is incarcerated or being treated. *AB 1897 is set for hearing on June 30, 2026, in the Senate Public Safety Committee.*

7) *Prior legislation.* AB 348 (Krell, Chapter 688, Statutes of 2025) establishes specific criteria that would make a person with a serious mental illness presumptively eligible for an FSP, including the person is transitioning to the community after six months or more in a state prison or county jail, has been detained five or more times as a danger to themselves or others, or gravely disabled, over the last five years, or is currently experiencing unsheltered homelessness. AB 348 specifies that a county is not required to enroll an individual if doing so would conflict with contractual Medi-Cal obligations or court orders, or would exceed county FSP capacity or funding.

   SB 326 (Eggman, Chapter 790, Statutes of 2023) recasts the MHSA as the BHSA and modifies state and local spending requirements, including the establishment of the FSP program in statute. SB 326 also creates additional oversight and reporting requirements for counties.

8) *Support.* The California State Association of Psychiatrists (CSAP), as sponsor, states that BPH currently can require treatment for individuals whose severe mental disorder contributed to the commission of a violent offense and who, as a result of that disorder, may represent a substantial danger of physical harm to others. However, the absence of clear standards for evaluating dangerousness and the lack of structured exit planning can result in abrupt termination of OMHD classification and direct discharge to the community without adequate clinical coordination or safeguards. A violence risk assessment is most effective when it incorporates well-established factors, including recent threats or acts of violence toward others or oneself, patterns of violent behavior, prior violent offenses, treatment compliance and response, and prior State Hospital commitments. CSAP says establishing these factors in statute will help ensure that risk evaluations are thorough, consistent, and informed by evidence-based practices, and that this bill recognizes the importance of coordinated reentry planning by requiring collaboration with county behavioral health departments and consideration of programs, such as AOT, CARE Court, or Forensic Assertive Community Treatment when individuals are released to the community. CSAP further argues this bill strengthens continuity of care by requiring structured exit plans and by allowing individuals in State Hospitals to enroll in Medi-Cal and receive Medi-Cal services during the 90 days prior to release, aligning them with policies already available to people leaving prisons and jails. These provisions support effective coordination and timely access to psychiatric care, medication, and community-based services—interventions that are essential for stabilizing serious mental illness and reducing the likelihood of relapse or re-offense. Other supporters largely echo CSAP's sentiments.

9) *Opposition.* The California Behavioral Health Planning Council (CBHPC) states that they acknowledge and support the bill's intent to promote a recovery-oriented approach for individuals with behavioral health challenges as they transition from incarceration back into communities. CBHPC recognizes the importance of strengthening pathways that help these individuals access behavioral health services that are essential to their stability, recovery, and long-term well-being. CBHPC further argues that although this bill aims to strengthen the continuity of care for people exiting carceral settings, the bill raises significant concerns regarding patient choice and voluntary treatment. It places increased emphasis on the use of behavioral health interventions, such as AOT, the CARE Act, and grave disability proceedings without clear safeguards to ensure that these tools remain limited and are

recommended only when clinically necessary and appropriate. Any use or recommendation of such interventions should be grounded in individualized clinical assessments, including appropriate due-process protections, and occur only after less restrictive alternatives have been exhausted or clearly determined to be ineffective in meeting the individual's needs. CBHPC believes that California should prioritize voluntary pathways to treatment and strengthen access to community based behavioral health supports that promote recovery, preserve individual rights, and delivered in the least restrictive and most appropriate setting.

SUPPORT AND OPPOSITION:

Support: California State Association of Psychiatrists (sponsor)
California Behavioral Health Association
California District Attorneys Association
California Medical Association
California Police Chiefs Association

Oppose: California Behavioral Health Planning Council

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