DEPARTMENT OF HEALTH & SOCIAL SERVICES
Behavioral Health Services Division

SOLANO COUNTY

MARCH 16, 2021
4:30 – 6:00 PM

MENTAL HEALTH ADVISORY BOARD

MINUTES

Mental Health Advisory Board Present: Supervisor Monica Brown, Denise Coleman, Daniel Cotton, Jules D. Hatchett, Heather Theaux-Venezio, Chair and Michael Wright.

Absent: Rachelle Jackson (excused)

Behavioral Health Services Division Present: Tracy Lacey, Senior Mental Health Manager and Sandra Sinz, Behavioral Health Director.

Absent: Emery Cowan, Behavioral Health Services Administrator and Leticia De La Cruz Salas, Behavioral Health Services Administrator.

DISCUSSION & ACTION ITEMS	
I.	CALL TO ORDER/ROLL CALL The meeting was called to order by Heather Theaux-Venezio at 4:31 pm. A quorum was attained.
II.	ITEMS FROM THE PUBLIC There were no items from the Public on matters not listed on the Agenda.
III.	APPROVAL FEBRUARY 16, 2021 MINUTES Heather Theaux-Venezio motioned to approve the February 16, 2021 Minutes. The motion was properly moved by Monica Brown and seconded by Jules D. Hatchett. The motion carried with a vote of 6 in favor and 0 against.
IV.	APPROVAL OF MARCH 16, 2021 AGENDA Heather Theaux-Venezio motioned to approve the March 16, 2021 Agenda. The motion was properly moved by Michael Wright and seconded by Denise Coleman. The motion carried with a vote of 6 in favor and 0 against.
V.	AB-32 & AB-1264 PRESENTATION – ASSEMBLYMEMBER CECILIA AGUIAR-CURRY'S STAFF Tracy Krumpen and Alice Montes were in attendance and Ms. Montes provided an overview on two assembly bills sponsored by the Assemblymember: AB-32 Telehealth and AB-1264 Project ECHO. Ms. Montes encouraged Board to submit questions to her related to those bills at alice.montes@asm.ca.gov. AB-32 Telehealth – to provide telehealth mental health services and telephonic for those who do not have access to a computer that enables Medi-Cal to bill. o Jules D. Hatchett asked if location with access to computer or a telephone will be provided for clients that do not have resources, i.e. homeless population. o Heather Theaux-Venezio reported that Emergency Departments volume has decreased due to access in low acuity area and is being utilized for true emergencies. o Denise Coleman asked if they will provide video enabled phones for Peer Support Specialists and Board & Care facilitates to use for members with disabilities, i.e. deaf, blind, etc.

	AB-1264 Project ECHO Grant Program – Connects primary care clinicians and school-based professionals with youth mental health specialists at eight hospitals on how to screen, treat, and provide mental health support. Is requesting approximately for $225k for each hospital to implement the program. Can take three to six months to get the program up and running and allow time to properly training. o Heather asked why they do not provide this in smaller counties. Research shows that children end up in local emergency departments and not tertiary pediatric hospitals, i.e. Children's Hospital in Oakland and UC Davis. When you need to transfer children with behavioral health and psychiatric cases, their answer is no. o Heather request is there a requirement that they partner with community facilities to come up with workflows, referral pattern. o Heather wants to know what the measurables are for this bill. Ms. Montes will follow-up with her. o The Board mentioned how important it is that counties that do not have facilities in their county geography are still involved because counties place in a number of facilities outside of their own counties. Alice Montes said she would follow-up with those who had questions and encouraged Board to reach out with questions.
VI.	SCHEDULED CALENDAR 1. Routine Business a. Laura's Law Assisted Outpatient Treatment (AOT) Referrals Sandra Sinz gave an update on AOT and Diversion referrals from the last month. b. MH Related Legislation c. LPS/PES Meeting Discussion There were no updates at this meeting. 2. New Business
VII.	PUBLIC COMMENTS There were no items from the Public on matters listed on the Agenda.
VIII.	STAFF REPORTS 1. Director's Report Sandra Sinz gave updates on hiring, FY 21/22 budget, promising year of legislation and funding for mental health services, and IMD inclusion when you have more than 16 beds. Refer to Director's Report and CBHDA Legislative and Budget Priorities attachments for more information. o Supervisor Monica Brown discuss request to lift the IMD inclusion across the board at her 6:00 pm meeting and discuss with Cecilia Aguiar-Curry's office. o Hazel Bright, NAMI will send Ms. Brown information and she will present to the Board of Supervisors. 2. MHSA Report Tracy Lacey provided highlights on: Suicide Prevention Plan Update, in process of scheduling 13 focus groups with at-risk populations with one of them being for family who has lost a loved as a result of suicide for end of March/April, community meetings in May for May is Mental Health Month, suicide increase in 19 to – 29 year-old and African American community, ICCTM project in partnership with UC Davis and the community for reducing health disparities, QIC action plan for the LGTBQ ethnic visibility poster campaign for Latino and Filipino and will be expanding into with African American and Native American, Student Services Act Grant and how to welcome students back to school and utilize wellness centers.
IX.	COMMITTEE REPORTS 1. Executive Board There were no updates at this meeting.

	2. Membership There were no updates at this meeting. 3. Outreach and Education There were no updates at this meeting.
X.	BOARD DISCUSSION 1. Heather Theaux-Venezio wanted to inform Board that she plans on attending a Psychiatric Advanced Directives webinar on March 18, 2021 and will report out next month. The County MHP is required to offer Advanced Directive paperwork to clients upon admission. 2. Michael Wright expressed that we would like for case managers to work with and listen to the clients' parents and individuals that are actively involved with the clients' wellbeing. 3. Jules D. Hatchett wanted to know how the NPLH beds are assigned and prioritized – this will be using the SPDAT as a risk/needs tool and prioritization through the Coordinated Entry system so that individuals in most need are placed first. Anyone in a NPLH unit must have a severe mental health condition.
XI.	ADJOURNMENT The meeting was adjourned at 5:57 pm by Heather Theaux-Venezio.

ASSEMBLY BILL No. 1264

Introduced by Assembly Member Aguiar-Curry

February 19, 2021

An act to add and repeal Article 5.3 (commencing with Section 124000) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, relating to public health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1264, as introduced, Aguiar-Curry. Project ECHO (registered trademark) Grant Program.

Existing law establishes within state government the California Health and Human Services Agency. Existing law also establishes various public health programs, including grant programs, throughout the state for purposes of promoting maternal, child, and adolescent health.

This bill would require the agency, upon appropriation by the Legislature, to establish, develop, implement, and administer the Project ECHO (registered trademark) Grant Program. Under the grant program, the bill would require participating children's hospitals to establish yearlong pediatric behavioral health teleECHO (trademark) clinics for specified individuals, including primary care clinicians and educators, to help them develop expertise and tools to better serve the youth that they work with by addressing their mental health needs stemming from the coronavirus pandemic. The bill would require the agency to ensure that the grant program includes a maximum of 8 grants that support pediatric behavioral health teleECHO (trademark) clinics to be administered and operated by an eligible children's hospital, and that grant funding be made available, at a minimum, to participants for specified purposes, such as recruiting efforts and funding salaries and

fringe benefits for pediatric behavioral health teleECHO (trademark) clinic personnel. The bill would require a pediatric behavioral health teleECHO (trademark) clinic to target specified audiences, including school-based health care professionals who serve kindergarten and grades 1 to 12, inclusive, and would require a participant to perform prescribed duties, such as preparing a report that evaluates the grant program. The bill would repeal these provisions on January 1, 2027.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) California is facing an unprecedented public health crisis as a result of the novel coronavirus (COVID-19) pandemic.

(2) Mental health experts agree that the impacts of the pandemic and statewide stay-at-home orders will have long-lasting impacts on the mental health of all Californians.

(3) A 2013 study from the University of Kentucky, College of Medicine, found that almost one-third of children who experienced isolation or quarantine during the 2002–04 severe acute respiratory syndrome pandemic and the 2009 H1N1 flu pandemic demonstrated symptoms that met the overall threshold for post-traumatic stress disorder (PTSD) and showed significantly higher rates of PTSD symptoms of all kinds compared to children who did not experience isolation or quarantine.

(4) The stay-at-home orders that have been issued across California in response to the COVID-19 pandemic are of a much longer duration, and more widespread, than those that were issued during either of these previous pandemics, which suggests that the negative impacts on children's mental health will also be more severe and widespread.

(5) School-based professionals and primary care clinicians are in the best position to implement widespread interventions and mental health supports for children, but many do not have the training or expertise needed to address the mental health needs that children will experience in the coming months and years.

(6) Project ECHO (Extension for Community Healthcare Outcomes) (registered trademark) is an innovative educational

model and knowledge-sharing network that allows specialists to share their expertise with health care providers and educators in rural and underserved communities. Project ECHO (registered trademark) serves as a model to help pediatric and adolescent mental health teams share their expertise with primary care clinicians and school-based professionals who are on the front-line for the purpose of supporting the mental health needs of children and adolescents.

(7) This low-cost and high-impact intervention is accomplished by linking expert interdisciplinary specialist teams with primary care clinicians, other health care professionals, and educators through pediatric behavioral health teleECHO (trademark) clinics. Experts mentor the clinicians and professionals to help them manage their patient cases, clients, and students, as appropriate, and share their expertise through mentoring, guidance, feedback, and didactic education. This enables primary care clinicians and other professionals to develop the skills and knowledge they need to treat their patients, clients, and students, as appropriate, with common and complex conditions in their own communities thereby reducing travel costs, wait times, and avoidable complications.

(8) The ECHO model (trademark) is not a form of telemedicine. The specialist does not assume the care of the patient, client, or student. Rather, the ECHO model (trademark) is a guided practice model under which the primary care physician or school-based professional retains responsibility for managing the patient, client, or student, and the primary care physician or professional operates with increasing independence as their skills and self-efficacy grow.

(b) For purposes of helping primary care clinicians, other health care professionals, including school-based professionals, and educators meet the mental health needs of children and adolescents stemming from the COVID-19 pandemic, it is the intent of the Legislature to require the California Health and Human Services Agency to establish, develop, implement, and administer a grant program to fund a maximum of eight grants that support pediatric behavioral health teleECHO (trademark) clinics to be administered and operated by eligible children's hospitals.

SEC. 2. Article 5.3 (commencing with Section 124000) is added to Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, to read:

Article 5.3. Project ECHO (registered trademark) Grant Program

124000. For purposes of this article, the following definitions apply:

(a) "Eligible children's hospital" means any hospital that is identified in Section 10727 of the Welfare and Institutions Code.

(b) "Grant program" means the grant program established under this article.

(c) "Participant" means an applicant that has been approved to implement the grant program.

124001. (a) (1) Upon appropriation by the Legislature for this purpose, the California Health and Human Services Agency shall establish, develop, implement, and administer the Project ECHO (registered trademark) Grant Program. Under the grant program, participating children's hospitals shall establish yearlong pediatric behavioral health teleECHO (trademark) clinics for primary care clinicians, other health care professionals, including school-based health professionals, and educators to help them develop expertise and tools to better serve the children and adolescents that they work with by addressing their mental health needs stemming from the coronavirus (COVID-19) pandemic.

(2) The agency shall ensure that the grant program includes a maximum of eight grants that support pediatric behavioral health teleECHO (trademark) clinics to be administered and operated by an eligible children's hospital. Each one-time grant shall not exceed two hundred twenty-five thousand dollars ($225,000), and one grant shall be available to each eligible children's hospital to fund a one yearlong project. If any funding is available following an initial application period, the agency shall offer a secondary application period to exhaust available funding, subject to the funding limitations described in this paragraph.

(3) A participating children's hospital shall consult with the county behavioral health agencies in each county where its project will be implemented to obtain information on appropriate referrals to local public children's behavioral health programs for the purposes of providing this information to its project participants.

(b) The agency shall ensure that grant funding be made available, at a minimum, to participants for all of the following purposes:

(1) Planning and developing curriculum.

(2) Printing and duplication costs.
(3) Recruiting.
(4) Funding all of the following:
(A) Salaries and fringe benefits for pediatric behavioral health teleECHO (trademark) clinic personnel.
(B) Supplies and equipment, including capital and noncapital.
(C) Travel costs associated with Replication Training at the ECHO (registered trademark) Institute and recruitment of pediatric behavioral health teleECHO (trademark) clinic participants.
(D) Facilities and administrative fees.
(E) Consultant fees.
(c) A pediatric behavioral health teleECHO (trademark) clinic shall target one of the following audiences or a subset of that audience:
(1) Primary care providers.
(2) School-based health care professionals who serve kindergarten and grades 1 to 12, inclusive.
(3) School-based mental health professionals who serve kindergarten and grades 1 to 12, inclusive.
(4) School administrators who serve kindergarten and grades 1 to 12, inclusive.
(5) Educators who serve kindergarten and grades 1 to 12, inclusive.
(d) Under the grant program, a participant shall perform specified duties in furtherance of the legislative objectives of this program, as directed by the agency. At a minimum, a participant shall do all of the following:
(1) Prioritize working with community providers and school-based professionals who predominantly serve low-income populations or those serving in rural or underserved areas of the state.
(2) Adhere to the four principles of the ECHO (registered trademark) model in the pediatric behavioral health teleECHO (trademark) clinics, which includes all of the following:
(A) Use technology to leverage scarce resources.
(B) Share best practices to reduce disparity.
(C) Employ case-based learning to master complexity.
(D) Use an internet web-based database to monitor outcomes.

(3) Prepare a report evaluating the grant program upon the conclusion of the one-year program, and submit that report to the agency for review.

124002. This article shall remain in effect only until January 1, 2027, and as of that date is repealed.

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AMENDED IN ASSEMBLY FEBRUARY 12, 2021

CALIFORNIA LEGISLATURE—2021–22 REGULAR SESSION

ASSEMBLY BILL No. 32

Introduced by Assembly Member Aguiar-Curry
(Coauthors: Assembly Members Arambula, Bauer-Kahan, Burke, Cunningham, Cristina Garcia, Petrie-Norris, Quirk-Silva, Blanca Rubio, and Santiago)

December 7, 2020

An act to amend Section *2290.5 of the Business and Professions Code, to amend Section* 1374.14 of the Health and Safety Code, to amend Section 10123.855 of the Insurance Code, and to amend Section 14087.95 of, and to add Sections ~~14092.4~~ *14092.4, 14132.721,* and 14132.722 to, the Welfare and Institutions Code, relating to telehealth.

LEGISLATIVE COUNSEL'S DIGEST

AB 32, as amended, Aguiar-Curry. Telehealth.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, Medi-Cal services may be provided pursuant to contracts with various types of managed care health plans, including through a county organized health system. Under existing law, in-person contact between a health care provider and a patient is not required under the Medi-Cal program for services appropriately provided through telehealth. Existing law provides that neither face-to-face contact nor a patient's physical presence on the premises of an enrolled community clinic is required for services provided by the clinic to a Medi-Cal beneficiary during or immediately

following a proclamation declaring a state of emergency. Existing law defines "immediately following" for this purpose to mean up to 90 days following the termination of the proclaimed state of emergency, unless there are extraordinary circumstances.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a contract issued, amended, or renewed on or after January 1, 2021, between a health care service plan or health insurer and a health care provider to require the plan or insurer to reimburse the provider for the diagnosis, consultation, or treatment of an enrollee, subscriber, insured, or policyholder appropriately delivered through telehealth services on the same basis and to the same extent as the same service through in-person diagnosis, consultation, or treatment. Existing law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, to specify that coverage is provided for health care services appropriately delivered through telehealth on the same basis and to the same extent as in-person diagnosis, consultation, or treatment. Existing law exempts Medi-Cal managed care plans that contract with the State Department of Health Care Services under the Medi-Cal program from these provisions, and generally exempts county organized health systems that provide services under the Medi-Cal program from Knox-Keene.

This bill would delete the above-described references to contracts issued, amended, or renewed on or after January 1, 2021, would require these provisions to apply to the plan or insurer's contracted entity, as specified, and would delete the exemption for Medi-Cal managed care plans. The bill would subject county organized health systems, and their subcontractors, that provide services under the Medi-Cal program to the above-described Knox-Keene requirements relative to telehealth. The bill would authorize a provider to enroll or recertify an individual in *specified* Medi-Cal programs through telehealth and other forms of virtual communication, *and would authorize a county eligibility worker to determine eligibility for, or recertify eligibility for, the Medi-Cal Minor Consent program remotely through virtual communication,* as specified.

This *bill would require health care services furnished by an enrolled clinic through telehealth to be reimbursed by Medi-Cal on the same basis, to the same extent, and at the same payment rate as those services*

are reimbursed if furnished in person. The bill would prohibit the State Department of Health Care Services from restricting the ability of an enrolled clinic to provide and be reimbursed for services furnished through telehealth. The bill would require the ~~State Department of Health Care Services~~ *department* to indefinitely continue the telehealth flexibilities in place during the COVID-19 pandemic state of emergency. The bill would require the department, 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. The bill would require the department, by December 2024, to complete an evaluation to assess the benefits of telehealth in Medi-Cal, including an analysis of improved access for patients, changes in health quality outcomes and utilization, and best practices for the right mix of in-person visits and telehealth. The bill would require the department to report its findings and recommendations from the evaluation to the appropriate policy and fiscal committees of the Legislature no later than July 1, 2025.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) The Legislature has recognized the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the provider, and enacted protections in Section 14132.72 of the Welfare and Institutions Code to prevent the State Department of Health Care Services from restricting or limiting telehealth services.

(2) The use of telehealth was expanded during the COVID-19 pandemic public health emergency and has proven to be an important modality for patients to stay connected to their health care providers. Telehealth has been especially critical for California's Medi-Cal patients.

(3) Patients have reported high satisfaction with telehealth, noting how easy it is to connect with their care teams without having to take time off work, find childcare, or find transportation to an in-person appointment.

(4) In addition to video access, audio-only care is essential because many patients have reported challenges accessing video technology due to limitations with data plans and internet access.

(5) Primary care and specialty care providers have found telehealth to be a critical access point to address a variety of health care needs, including helping patients manage chronic disease, adjust pain medications, and for followup visits after a procedure, among others.

(6) Behavioral health providers have found that offering telehealth has engaged patients in necessary care they would never have received if required to walk into a clinic.

(7) Health care providers have reported significant decreases in the number of missed appointments since telehealth became available, helping to ensure that patients receive high-quality care in a timely manner.

(8) Telehealth is widely available to individuals with health insurance in the commercial market, and existing law in Section 1374.14 of the Health and Safety Code and Section 10123.855 of the Insurance Code requires commercial health care service plans and health insurers to pay for services delivered through telehealth services on the same basis as equivalent services furnished in person. Medi-Cal must evolve with the rest of the health care industry to achieve health equity for low-income Californians.

(9) The expanded telehealth options that patients and providers have relied on during the COVID-19 pandemic should continue to be available to Medi-Cal recipients after the public health emergency is over.

(b) It is the intent of the Legislature to continue the provision of telehealth in Medi-Cal, including video and audio-only technology, for the purposes of expanding access and enhancing delivery of health care services for beneficiaries.

SEC. 2. Section 2290.5 of the Business and Professions Code is amended to read:

2290.5. (a) For purposes of this division, the following definitions shall apply:

(1) “Asynchronous store and forward” means the transmission of a patient’s medical information from an originating site to the health care provider at a distant site.

(2) "Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) "Health care provider" means any of the following:

(A) A person who is licensed under this division.

(B) An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3.

(C) A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 1374.73 of the Health and Safety Code and Section 10144.51 of the Insurance Code.

(4) "Originating site" means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

(5) "Synchronous interaction" means a real-time ~~interaction~~ *interaction, including, but not limited to, audiovideo, audio only, such as telephone, and other virtual communication,* between a patient and a health care provider located at a distant site.

(6) "Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Before the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.

(c) This section does not preclude a patient from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(e) This section shall not be construed to alter the scope of practice of a health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

(f) All laws regarding the confidentiality of health care information and a patient's rights to the patient's medical information shall apply to telehealth interactions.

(g) All laws and regulations governing professional responsibility, unprofessional conduct, and standards of practice that apply to a health care provider under the health care provider's license shall apply to that health care provider while providing telehealth services.

(h) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

(i) (1) Notwithstanding any other law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity, as described in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(2) By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph (1).

(3) For the purposes of this subdivision, "telehealth" shall include "telemedicine" as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

~~SEC. 2.~~

SEC. 3. Section 1374.14 of the Health and Safety Code is amended to read:

1374.14. (a) (1) A contract between a health care service plan and a health care provider for the provision of health care services to an enrollee or subscriber shall specify that the health care service plan shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an enrollee or subscriber appropriately delivered through telehealth services on the same basis and to the same extent that the health care service

plan is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(2) This section does not limit the ability of a health care service plan and a health care provider to negotiate the rate of reimbursement for a health care service provided pursuant to a contract subject to this section. Services that are the same, as determined by the provider's description of the service on the claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person equivalent exists, a health care service plan and the provider shall ensure the rate is consistent with subdivision (h) of Section 1367.

(3) This section does not require telehealth reimbursement to be unbundled from other capitated or bundled, risk-based payments.

(4) If a health care service plan delegates responsibility for the performance of the duties described in this section to a contracted entity, including a medical group or independent practice association, then the delegated entity shall comply with this section.

(5) The obligation of a health care service plan to comply with this section shall not be waived if the plan delegates services or activities that the plan is required to perform to its provider or another contracting entity. A plan's implementation of this section shall be consistent with the requirements of the Health Care Providers' Bill of Rights, and a material change in the obligations of a plan's contracting network providers shall be considered a material change to the provider contract, within the meaning of subdivision (b) Section 1375.7.

(b) (1) A health care service plan contract shall specify that the health care service plan shall provide coverage for health care services appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.

(2) This section does not alter the obligation of a health care service plan to ensure that enrollees have access to all covered services through an adequate network of contracted providers, as required under Sections 1367, 1367.03, and 1367.035, and the regulations promulgated thereunder.

(3) This section does not require a health care service plan to cover telehealth services provided by an out-of-network provider, unless coverage is required under other law.

(c) A health care service plan may offer a contract containing a copayment or coinsurance requirement for a health care service delivered through telehealth services, provided that the copayment or coinsurance does not exceed the copayment or coinsurance applicable if the same services were delivered through in-person diagnosis, consultation, or treatment. This subdivision does not require cost sharing for services provided through telehealth.

(d) Services provided through telehealth and covered pursuant to this chapter shall be subject to the same deductible and annual or lifetime dollar maximum as equivalent services that are not provided through telehealth.

(e) The definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply to this section.

~~SEC. 3.~~

SEC. 4. Section 10123.855 of the Insurance Code is amended to read:

10123.855. (a) (1) A contract between a health insurer and a health care provider for an alternative rate of payment pursuant to Section 10133 shall specify that the health insurer shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an insured or policyholder appropriately delivered through telehealth services on the same basis and to the same extent that the health insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(2) This section does not limit the ability of a health insurer and a health care provider to negotiate the rate of reimbursement for a health care service provided pursuant to a contract subject to this section. Services that are the same, as determined by the provider's description of the service on the claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person equivalent exists, a health insurer and the provider shall ensure the rate is consistent with subdivision (a) of Section 10123.137.

(3) If a health insurer delegates responsibility for the performance of the duties described in this section to a contracted

entity, including a medical group or independent practice association, then the delegated entity shall comply with this section.

(4) The obligation of a health insurer to comply with this section shall not be waived if the insurer delegates services or activities that the insurer is required to perform to its provider or another contracting entity. An insurer's implementation of this section shall be consistent with the requirements of the Health Care Providers' Bill of Rights, and a material change in the obligations of an insurer's contracting network providers shall be considered a material change to the provider contract, within the meaning of subdivision (b) Section 10133.65.

(b) (1) A policy of health insurance that provides benefits through contracts with providers at alternative rates of payment shall specify that the health insurer shall provide coverage for health care services appropriately delivered through telehealth services on the same basis and to the same extent that the health insurer is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.

(2) This section does not alter the existing statutory or regulatory obligations of a health insurer to ensure that insureds have access to all covered services through an adequate network of contracted providers, as required by Sections 10133 and 10133.5 and the regulations promulgated thereunder.

(3) This section does not require a health insurer to deliver health care services through telehealth services.

(4) This section does not require a health insurer to cover telehealth services provided by an out-of-network provider, unless coverage is required under other law.

(c) A health insurer may offer a policy containing a copayment or coinsurance requirement for a health care service delivered through telehealth services, provided that the copayment or coinsurance does not exceed the copayment or coinsurance applicable if the same services were delivered through in-person diagnosis, consultation, or treatment. This subdivision does not require cost sharing for services provided through telehealth.

(d) Services provided through telehealth and covered pursuant to this chapter shall be subject to the same deductible and annual

or lifetime dollar maximum as equivalent services that are not provided through telehealth.

(e) The definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply to this section.

~~SEC. 4.~~

SEC. 5. Section 14087.95 of the Welfare and Institutions Code is amended to read:

14087.95. (a) A county contracting with the department pursuant to this article shall be exempt from Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code for purposes of carrying out the contracts.

(b) (1) Notwithstanding subdivision (a), a county contracting with the department pursuant to this article shall comply with Section 1374.14 of the Health and Safety Code.

(2) If a county subcontracts for the provision of services pursuant to this article, as authorized under Section 14087.6, the subcontractor shall comply with Section 1374.14 of the Health and Safety Code.

~~SEC. 5. Section 14092.4 is added to the Welfare and Institutions Code, immediately following Section 14092.35, to read:~~

~~14092.4. For the purposes of enrolling patients in programs administered through Medi-Cal, including the Family Planning, Access, Care, and Treatment (Family PACT), presumptive eligibility Programs, accelerated enrollment programs, and the Medi-Cal Minor Consent program, a provider may determine program eligibility, enroll, and recertify patients remotely through telehealth and other virtual communication modalities, including telephone, based on the current Medi-Cal program criteria. The department may develop program policies and systems to support implementation of offsite eligibility determination, enrollment, and recertification.~~

SEC. 6. Section 14092.4 is added to the Welfare and Institutions Code, immediately following Section 14092.35, to read:

14092.4. (a) To enroll individuals in Medi-Cal programs that permit onsite enrollment and recertification of individuals by a provider or county eligibility worker as applicable, the following shall apply:

(1) For the Family Planning, Access, Care, and Treatment (Family PACT), Presumptive Eligibility for Pregnant Women, and

Every Woman Counts programs, a provider may enroll or recertify an individual remotely through telehealth and other virtual communication modalities, including telephone, based on the current Medi-Cal program eligibility form or forms applicable to the specific program.

(2) For the Medi-Cal Minor Consent program, a county eligibility worker may determine eligibility for, or recertify eligibility for, an individual remotely through virtual communication modalities, including telephone.

(b) The department may develop program policies and systems to support implementation of remote eligibility determination, enrollment, and recertification, consistent with this section.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

SEC. 7. Section 14132.721 is added to the Welfare and Institutions Code, immediately following Section 14132.72, to read:

14132.721. (a) Notwithstanding any other law, health care services furnished by an enrolled clinic through telehealth shall be reimbursed by Medi-Cal on the same basis, to the same extent, and at the same payment rate as those services are reimbursed if furnished in person, consistent with this section.

(b) Consistent with the protections for health care providers set forth in the Telehealth Advancement Act of 2011, including Section 14132.72, the department shall not restrict the ability of an enrolled clinic to provide and be reimbursed for services furnished through telehealth. Prohibited restrictions include all of the following:

(1) Requirements for face-to-face contact between an enrolled clinic provider and a patient.

(2) Requirements for a patient's or provider's physical presence at the enrolled clinic or any other location.

(3) Requirements for prior in-person contacts between the enrolled clinic and a patient.

(4) Requirements for documentation of a barrier to an in-person visit or a special need for a telehealth visit.

(5) Policies, including reimbursement policies, that impose more stringent requirements on telehealth services than equivalent

services furnished in person. This paragraph does not prohibit policies that require all of the clinical elements of a service to be met as a condition of reimbursement.

(6) Limitations on the means or technologies through which telehealth services are furnished.

(c) Notwithstanding the in-person requirements of Section 14132.100, if an enrolled clinic is also a federally qualified health center or a rural health center, the definition of "visit" set forth in subdivision (g) of Section 14132.100 includes a telehealth encounter to the same extent it includes an in-person encounter.

(d) This section does not eliminate the obligation of a health care provider to obtain verbal or written consent from the patient before delivery of health care via telehealth or the rights of the patient, pursuant to subdivisions (b) and (c) of Section 2290.5 of the Business and Professions Code.

(e) This section does not conflict with or supersede the requirements for health care service plan contracts set forth in Section 1374.14 of the Health and Safety Code and the requirements for health insurance policies set forth in Section 10123.855 of the Insurance Code.

(f) This section does not limit reimbursement for or coverage of, or reduce access to, services provided through telehealth before the enactment of this section.

(g) The department shall require Medi-Cal managed care plans, through contract or otherwise, to adhere to the requirements of this section.

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

(i) The department shall seek any necessary federal approvals and obtain federal financial participation in implementing this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized.

(j) For purposes of this section:

(1) "Enrolled clinic" means any of the following:

(A) A clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code.

(B) An intermittent clinic exempt from licensure under subdivision (h) of Section 1206 of the Health and Safety Code.

(C) A hospital or nonhospital-based clinic operated by the state or any of its political subdivisions, including the University of California, or a city, county, city and county, or hospital authority.

(D) A tribal clinic exempt from licensure under subdivision (c) of Section 1206 of the Health and Safety Code, or an outpatient setting conducted, maintained, or operated by a federally recognized Indian tribe, tribal organization, or urban Indian organization, as defined in Section 1603 of Title 25 of the United States Code.

(2) "Telehealth" has the same meaning as in subdivision (a) of Section 2290.5 of the Business and Professions Code, which includes audio-only telephone communication technologies.

~~SEC. 6. Section 14132.722 is added to the Welfare and Institutions Code, immediately following Section 14132.72, to read:~~

SEC. 8. Section 14132.722 is added to the Welfare and Institutions Code, immediately following Section 14132.721, to read:

14132.722. (a) The department shall indefinitely continue the telehealth flexibilities in place during the COVID-19 pandemic, including those implemented pursuant to Section 14132.723.

(b) (1) By January 2022, the department shall convene an advisory group that includes representatives from community health centers, designated public hospitals, Medi-Cal managed care plans, consumer groups, labor organizations, behavioral health providers, counties, and other Medi-Cal providers.

(2) The advisory group shall provide input to the department on the development of a revised Medi-Cal telehealth policy that promotes all of the following principles:

(A) Telehealth shall be used as a means to promote timely and patient-centered access to health care.

(B) Patients, in conjunction with their providers, shall be offered their choice of service delivery mode. Patients shall retain the right to receive health care in person.

(C) Confidentiality and security of patient information shall be protected.

(D) Usual standard of care requirements shall apply to services provided via telehealth, including quality, safety, and clinical effectiveness.

(E) The department shall consider disparities in the utilization of, and access to, telehealth, and shall support patients and providers in increasing access to the technologies needed to use telehealth.

(F) When the care provided during a telehealth visit is commensurate with what would have been provided in person, payment shall also be commensurate.

(c) (1) By December 2024, the department shall complete an evaluation to assess the benefits of telehealth in Medi-Cal. The evaluation shall analyze improved access for patients, changes in health quality outcomes and utilization, and best practices for the right mix of in-person visits and telehealth.

(2) The department shall report its findings and recommendations on the evaluation to the appropriate policy and fiscal committees of the Legislature no later than July 1, 2025.

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Sandra Sinz, Deputy Director
Behavioral Health Director
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Memorandum

To: Local Mental Health Board, Solano County

From: Sandra Sinz, LCSW, Behavioral Health Director

Date: March 16, 2021

RE: Monthly report of significant issues

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1. **We are preparing the FY 21/22 budget.** We were doing well at Mid-Year Budget and exceeded our salary savings. Notably, this is the first time in my tenure that we sought budget savings through intentional freeze of positions. Generally we have 10% salary savings through the normal course of business. In next year's budget I am hoping that we won't need to intentionally freeze positions because so far we are budgeting 10% for salary savings, which should happen from normal turnover and recruitment time.

    - We are not expecting the cuts to MHSA that were anticipated a few months ago.

2. **Mobile Crisis program is still pending launch.** Uplift is recruiting and training. We are aiming for April implementation.

3. **Department State Hospitals Felony Diversion grant**. The contract with State DSH is going to the BOS next month. It will include a two year contract with Caminar to expand case management services to the clients enrolled in this program. We are required to serve 23 clients by June 2022 and this grant brings $3.2M.

4. **Laura's Law AOT –** No referrals in February but 2 so far in March. **Diversion** had 6 referrals in February and already 10 in March to date.

5. **Additional Behavioral Health leadership.** Sandra Sinz promoted from Deputy Director to Chief Deputy Director. Largely this will add leadership capacity to Behavioral Health because the Deputy Director position will be backfilled. Depending upon the strengths of the best applicant, some of the oversight of the division may be split between Sandra and the pending hire. The recruitment is posted and we will be pulling the list of applicants next week.

    - Part of the expectation in Sandra's new role is to promote more integration activities across the department.

6. **CBHDA Legislative and Budget Priorities** – please see this PPT handout for a summary. There is a lot of BH related legislation as well as potential new funds available. This includes $750M in State General Fund over 3 years to invest in critical gaps across the continuum.

CBHDA
BUDGET & LEGISLATIVE PRIORITIES

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cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

California's County Behavioral Health Agencies Overview

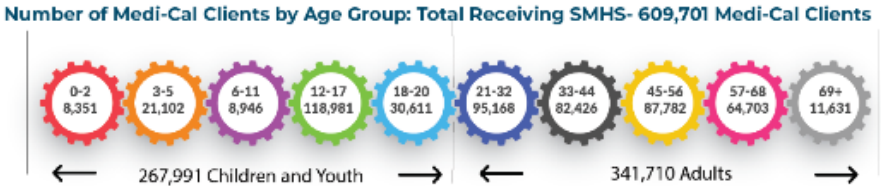
- California's 59 County and City Behavioral health departments (including City of Berkeley and Tri-Cities Mental Health Authority) provide mental health and substance use disorder services, primarily to California's low-income populations with serious mental illness and substance use disorders, through Medi-Cal and other programs.
- We serve the behavioral health needs of all ages – from early childhood to end of life.
- Services focus on assessment, treatment, rehabilitation, recovery, and case management for those in need. We value an approach focused on prevention using early identification and intervention with clients, but provide specialty services at all levels of care.
- County behavioral health departments embrace a biopsychosocial, non-clinic based approach, providing mobile, field-based, and community services in schools and homes. Treatment plans are individualized and driven by each client's unique needs. We provide both culturally and linguistically responsive care in the least restrictive environment.

Who Do We Serve

County behavioral health departments serve diverse populations including:

- Medi-Cal beneficiaries who meet medical necessity criteria for covered services
- Uninsured individuals
- Individuals with commercial insurance (to the extent resources are available)
- Individuals experiencing a mental health crisis
- LPS Conservatees
- Foster youth
- Children in schools
- Justice-Involved populations
- Individuals experiencing homelessness
- Individuals experiencing a substance use disorder
- Individuals experiencing co-occurring behavioral health disorders

"Behavioral health" includes both mental health and substance use conditions



California's County Behavioral Health Agencies Overview

What We Do

County behavioral health departments provide Medi-Cal Specialty Mental Health services

- Mental health services
  - Assessment
  - Client plan development
  - Rehabilitation
  - Collateral
  - Individual and group therapy
- Crisis intervention and stabilization
- Residential services
- Day treatment
- Case management
- Medication support
- Inpatient services for all Medi-Cal beneficiaries

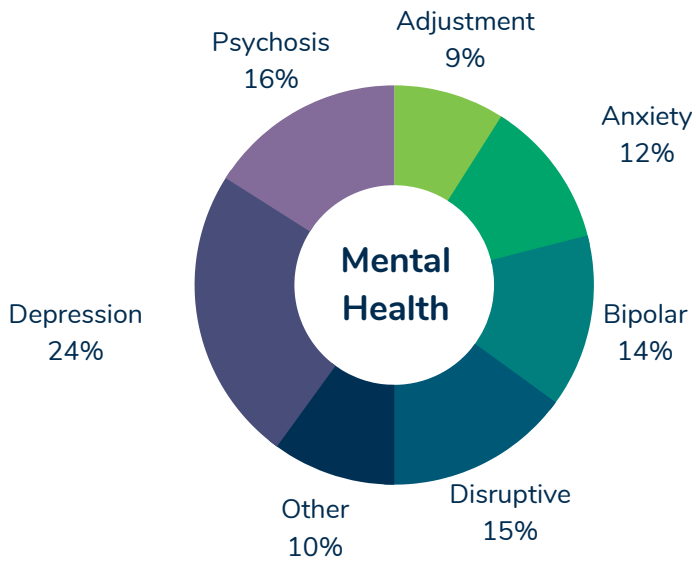
County behavioral health departments provide Medi-Cal substance use disorder treatment

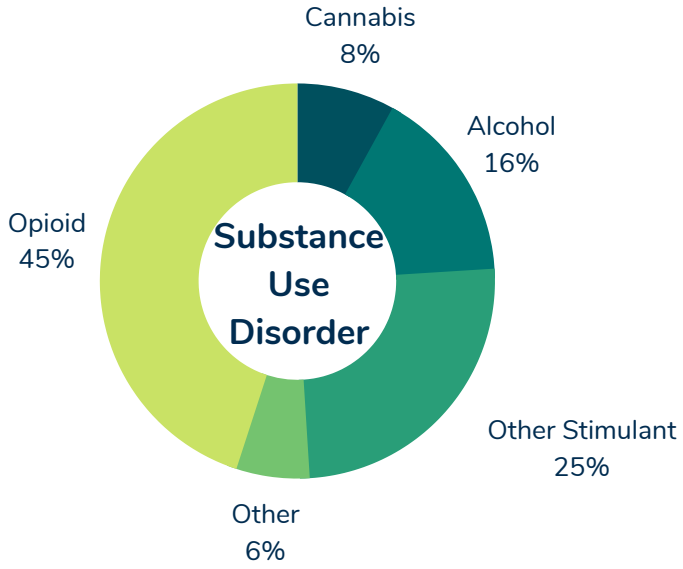
- Outpatient and intensive outpatient treatment
- Opioid Treatment Programs (OTP)
- Medication Assisted Treatment (MAT)+
- Youth and perinatal residential treatment
- Adult residential treatment*
- Withdrawal management*
- Recovery services*
- Case management*
- Physician consultation*

+California is in the process of expanding coverage for office-based MAT. Currently this is an optional benefit within the Drug Medi-Cal Organized Delivery System (DMC-ODS) and also reimbursable as a fee for service (FFS) pharmacy benefit.

*These services are covered only in counties that participate in the DMC-ODS demonstration program.

Medi-Cal Population Served, by Diagnosis



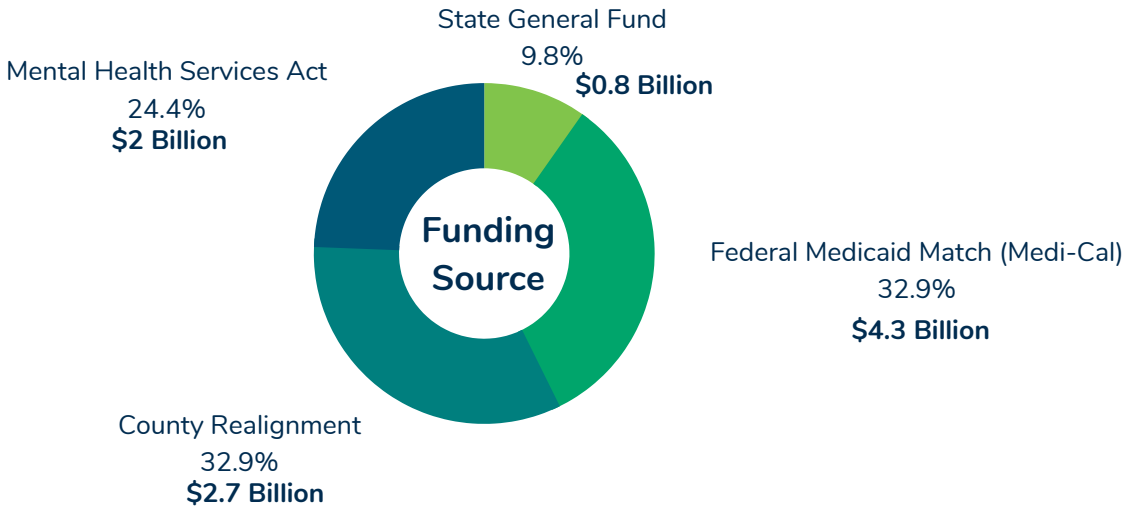


California's County Behavioral Health Agencies Overview

What mental health and substance use disorder services do counties provide that are not funded under the Medi-Cal program?

- Services to uninsured individuals
- Full Service Partnership – a whatever it takes approach to recovery
- Prevention services, including, but not limited to: substance use disorder prevention, stigma reduction, suicide prevention
- Fostering innovation through special initiatives such as: early psychosis interventions and peer support services
- Crisis intervention, including mobile crisis services, urgent and emergency services for individuals in crisis, and management of the Lanterman-Petris-Short Act, including services to individuals in residential and locked settings, excluded from Medi-Cal services.
- Housing development, assistance, and navigation, including SUD recovery residence stays

How is Behavioral Health Funded?



- Mental Health Services Act
- County Realignment Funds (1991, 2011)
- Substance Abuse Prevention and Treatment Block Grant
- Mental Health Block Grant
- Federal Medicaid Match
- State General Fund (to a limited extent)
- Competitive Grants

*Data from the Overview of the Public Mental Health Services Funding and Mental Health Services Act, Legislative Analyst's Office, August 21, 2019

2021
Budget and Legislative Priorities
SUMMARY

Budget Priorities

- **$750 Million Behavioral Health Continuum - SUPPORT**
  - The Governor's January Budget proposes a $750 million General Fund (GF), available over three years, for DHCS to invest in critical gaps across the community-based behavioral health continuum.
  - The Governor's proposed $750 million GF will help counties to develop additional capacity to address, gaps in the community behavioral health continuum, including facilities that can treat individuals with co-occurring medical needs, forensic needs, and youth in crisis with new facilities at all levels along the continuum.
- **CalAIM Behavioral Health Initiatives & Quality Improvement Program - SUPPORT**
  - The California Advancing and Innovating in Medi-Cal (CalAIM) initiative is a major strategic priority for county behavioral health.
  - As part of this initiative, the Governor's proposed budget includes $21.8 million in GF in FY 2021-22, which the administration indicates will grow to $86 million over three years, to support county behavioral health implementation of CalAIM proposals.
  - This Behavioral Health Quality Improvement Program funding is essential to support the extensive operational and systems changes that behavioral health plans must undertake for behavioral health payment reform, medical necessity changes, and other CalAIM proposals.
- **$4.7 Million in One-Time Funding for Peer Support Specialist Certification - SPONSOR**
  - Last year, Governor Newsom signed SB 803 (Beall) which will allow county behavioral health peers services as a billable service under Medi-Cal following the development of statewide certification standards.
  - This budget request would allocate $4.7 million for the one-time state costs associated with standing up statewide peer certification standards, along with federal Medicaid matching funds.

2021
Budget and Legislative Priorities
SUMMARY

Budget Priorities

- **$250 Million for Expanding Board and Cares - SUPPORT**
  - The Budget includes $250 million one-time General Funds for the Department of Social Services to issue grants to support the acquisition and rehabilitee of Adult Residential Facilities (ARF) and Residential Care Facilities for the Elderly (RCFEs) with a specific focus on preserving and expanding housing for low-income seniors who are homeless or at risk of becoming homeless.

  - These funds will also target facilities serving individuals with behavioral health needs who rely on ARFs and RCFEs to remain safely in the community.

- **School Mental Health Initiatives - SUPPORT**
  - **$80.5 Million for the Mental Health Student Services Act (MHSSA) under the MHSOAC**
    - The Administration proposed $25 million to support the MHSSA, which will fund less than one-third of the unfunded applications in the first round of funding.

    - CBHDA supports the stakeholder budget request to augment the amount proposed to $80.5 million, in order to fully fund the MHSSA program.

  - **$389 Million for Incentive Program under Managed Care Plans**
    - The January Budget seeks to invest $389.0 million ($194.5 million GF, $194.5 million FFP) in a Medi-Cal Managed Care Plan (MCP) incentive program designed to develop partnerships between MCPs, schools and county behavioral health departments, to increase the number of K-12 students receiving preventive, early intervention, and behavioral health services from school-affiliated behavioral health providers.

- **Mental Health Service Act (MHSA) Flexibilities – SUPPORT & SPONSOR**
  - The Administration's proposed January budget included an extension of some MHSA flexibilities authorized last year for another fiscal year. Flexibilities proposed to be extended include the ability for counties to use existing previously approved Three-Year plans for another year if the pandemic has prevented the ability to secure a new plan, among other flexibilities.

  - The budget trailer bill did not extend the provision safeguarding of funds subject to reversion for an additional year and CBHDA is requesting the extension of that protection to include all Innovation funds, and funds that have been encumbered in an approved Three-Year plan but have been unable to be spent because of COVID-19.

2021
Budget and Legislative Priorities
SUMMARY

Budget Priorities

- **Community Care Demonstration Project for Felony Incompetent to Stand Trial (CCDP-IST) - OPPOSE**
  - CCDP-IST would pilot realigning the responsibility of providing care and treatment for individuals charged with felonies and deemed incompetent to stand trial (FIST) through a risk-based model in three counties.
  - CBHDA is concerned that the proposal would shift liability related to limited statewide capacity to serve individuals determined to be felony ISTs, and do so in a risk-based financial model, which would not tie state funding to the numbers of individuals restored in community.
  - CBHDA is interested in continuing to explore alternative options for addressing the high numbers of individuals with FISTs, including, but not limited to, investing more to augment existing diversion pilots, and improving local capacity to provide community-based restoration.

Legislative Priorities

- **AB 552 (Quirk Silva): Integrated School-Based Behavioral Health Partnership Program**
  - AB 552 will establish the Integrated School-Based Behavioral Health Partnership Program, a collaboration between schools & county behavioral health agencies to provide early intervention for, and access to, behavioral health care for all students.
  - This bill will address a key barrier identified by school partners in developing school-based behavioral health partnerships by establishing a process to include students with private commercial insurance, and their health plans, in school-based behavioral health services.

- **SB 14 (Portantino): Pupil & Youth Behavioral Health, School Employee and Pupil Training, Excused Absence**
  - This bill will provide behavioral health support to student and staff at schools by requiring the California Department of Education to provide training to school staff on how to identify students' behavioral health needs and connect them with available mental health and substance use disorder services.
  - The bill will also allow for the extension of the training on the signs and symptoms of behavioral health conditions to high school students in grades 10-12.
  - Finally, this bill will ensure that absences from school for a behavioral health issue or appointment will be considered an excused absence to align with how schools treat absences for physical health ailments or appointments.

2021
Budget and Legislative Priorities
SUMMARY

Legislative Priorities

- **AB 681 (Ramos): LPS Data Collection**
  - Building off of the State Auditor's recommendation from a July 2020 report, this bill would require the Department of Justice (DOJ) to transmit the data they receive from psychiatric facilities for those on an involuntary hold and admitted to their facility for being a danger to self or danger to others to the Department of Health Care Services (DHCS), and would expand reporting from psychiatric facilities to include individuals placed on involuntary holds because they were found to be gravely disabled and youth aged 12 and under, data that is not collected today.

  - This bill would require DHCS to provide an annual report to the Legislature of the aggregated statewide data received under this bill, stratified by county, race/ethnicity, gender, and Medi-Cal enrollment status, and include recommendations to the Legislature on how to reduce disparities in mental health treatment across the state.

- **AB 686 (Arambula): California Community-Based Behavioral Health Outcomes and Accountability Review**
  - This bill will increase the public and stakeholder's understanding of the impact of the community-based behavioral health system, and the accountability of county behavioral health agencies by developing robust statewide outcome and performance measures. The measures will cover adults with serious mental illness, children and youth with serious emotional disturbances, individuals with substance use disorders, and other populations served by county behavioral health, and be modeled after similar outcomes and accountability structures for CalWORKs and child welfare.

- **AB 1051 (Bennett): Speciality Mental Health Services - Foster Youth**
  - AB 1299 (Ridley-Thomas), Chapter 603, Statutes of 2016, sought to address concerns regarding delays in access to appropriate specialty mental health services for foster youth when placed across county lines, by adopting a "presumptive transfer," of Medi-Cal payment and service delivery responsibility.

  - This bill would strengthen and update the presumptive transfer law to reflect the progress in county and state efforts to shorten lengths of stay in residential treatment facilities by requiring a youth-centered, case-by-case decision to be made regarding responsibility for the provision of or arrangement for specialty mental health services for each foster youth who is placed out of county in a short term residential therapeutic program, while ensuring that facilities serving these children are paid in a timely fashion.

Governor's Behavioral Health Continuum Infrastructure Funding Proposal - SUPPORT

Background

Over time, funding restrictions have limited the ability of county behavioral health agencies to finance any considerable expansion of the public behavioral health safety net. For example, the mechanism used by counties under Medi-Cal strictly limits reimbursement to cost. Under the MHSA, only a small portion of funds are eligible for expenditure on capital investments – the same pot which is also to be used for information technology and workforce investments. For SUD services, there is even less opportunity for investment.

These restrictions have led to a chronic underinvestment in the behavioral health delivery system. Counties consistently face challenges with "throughput," or transitions between levels of care, for behavioral health clients, which, in turn, challenges the ability to ensure individuals are in the right level of care to meet their needs. Currently, counties with Psychiatric Health Facilities and county-operated psychiatric units have 50% or more of patients on administrative days, meaning that they could be stepped down to a lower level of care—but a placement is not available. Aside from a lack of available step-down placements, providers also have additional discretion to decline to accept admissions within behavioral health care. As the state has sought to shift more forensic populations to custody and care the local level, it has become increasingly challenging to find willing and available treatment providers with the expertise to work with forensic populations. Furthermore, the state made prior investments in crisis infrastructure almost a decade ago, but did not complement that investment in urgent crisis services with additional ongoing treatment capacity for those individuals at higher and lower levels of care.

Since the beginning of the pandemic, county behavioral health systems have also experienced a continued spike in fentanyl related overdoses, in some cases outpacing COVID-19 deaths, as well as more children and youth in acute crisis. A report from February 2021 by the Kaiser Family Foundation finds that Americans are experiencing a four-fold increase in anxiety and depression symptoms, with young adults reporting that they have experienced twice the rate of new or increased substance use and suicidal thoughts when compared with all adults.[1]

1. "The Implications of COVID-19 for Mental Health and Substance Use." Kaiser Family Foundation, 10 Feb. 20201, www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.

Governor's Behavioral Health Continuum Infrastructure Funding Proposal - SUPPORT

Proposed Bill

Governor Newsom's January Budget included $750 million General Fund (GF), available over three years, for the Department of Health Care Services (DHCS) to invest in critical gaps across the community-based behavioral health continuum. CBHDA strongly supports this proposal. DHCS intends to align this proposal with an application for a Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Institutions for Mental Disease (IMD) Waiver from the federal government which would allow Medi-Cal funding for residential treatment and psychiatric hospitalizations in facilities above 16 beds with limited lengths of stay, while also requiring the state to meet strict requirements to expand community-based capacity and treatment to reduce the reliance upon IMDs.

The Governor's proposed $750 million GF will help counties to develop additional capacity to address critical gaps in the community behavioral health continuum, including facilities that can treat individuals with co-occurring medical needs, forensic needs, and youth in crisis. Counties believe strongly that in order to support increased demand for services and prepare the state for the ongoing behavioral health needs stemming from the stress of the pandemic, new facilities will be necessary at all levels along the continuum, from wellness centers through to high-level acute services. Ultimately, this investment in critical infrastructure will help to save lives, and prevent avoidable hospitalizations, justice involvement and homelessness among individuals with serious mental illness and substance use disorders.

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Budget, Legislative, & Policy Priority: California Advancing and Innovating in Medi-Cal (CalAIM)

The CalAIM initiative is a top strategic priority for county behavioral health plans. CalAIM includes multiple policy proposals focused on delivery system reforms for Medi-Cal specialty mental health (MH) and substance use disorder (SUD) services:

· Behavioral health payment reform · Medical necessity changes
· Renewal of the Drug Medi-Cal Organized Delivery System (DMC-ODS)
· Integration of MH and SUD services

CBHDA strongly supports the BH components in DHCS' revised CalAIM proposal. We urge the state to proactively identify and address health equity throughout CalAIM. If effectively implemented, the CalAIM behavioral health (BH) proposals promise to correct longstanding inefficiencies in the way Medi-Cal MH & SUD services must be delivered and reimbursed. These changes will ensure optimal use of state and federal dollars to improve access and quality of specialty BH care for vulnerable Californians with serious mental illness or substance use disorders.

IMD Waiver & Investments in Behavioral Health Continuum

DHCS plans to pursue a Medicaid demonstration waiver that would secure additional federal reimbursement for acute inpatient psychiatric services.

- **CBHDA strongly supports the administration's commitment to seek federal reimbursement for psychiatric services delivered in facilities with more than 16 beds** (known as "Institutions for Mental Disease" or IMDs). This waiver would enable counties to reinvest state and local dollars that are currently used to fund Medi-Cal inpatient services, and instead expand community-based MH programs. Savings could support both upstream prevention activities and subacute care needed to help people transition from inpatient or residential stays.

To help ensure that California can meet CMS requirements to maintain and expand community-based BH services, the Governor has proposed $750 million in one-time funding for capital investments and capacity-building across the BH continuum.

- CBHDA strongly supports this proposed investment. We look forward to partnering with the administration and the legislature to maximize the value of this unprecedented investment and to seek federal funds for IMD services.

Behavioral Health Quality Improvement Program (BH-QIP)

The Governor's proposed budget includes $21.8 million in general funds in FY 2021-22, which the administration indicates will grow to $86 million over three years, for the BH-QIP. These dollars will support county BH implementation of CalAIM proposals.

- **CBHDA strongly supports the BH-QIP proposal.** This funding is essential for implementation of the extensive operational and systems changes that BH plans must undertake for BH payment reform, medical necessity changes, and other CalAIM proposals.

Sponsored Budget Proposal
Certified Peer Support Specialists and Peer Support Services in Medi-Cal
(Champion: Assemblymember Joaquin Arambula)

Budget Request

- A one-time state general fund contribution of $4.7 million and available federal match, to be spent over 2 years, to allow the Department of Health Care Services, in coordination with an entity representing counties, to build a statewide behavioral health peer specialist certification program using newly established statewide certification standards.

- Legislation authorizing the certification program, SB 803 (Beall, Chapter 150, Statutes of 2020), requests the state fund the certification program startup costs with counties covering ongoing costs, including the non-federal share of Medi-Cal services delivered by counties. The certification program's ongoing costs will be covered by fees, and available federal Medicaid match.

- Behavioral health peer support specialist certification is conducted at the state level in other states; however, because this law was established as an optional Medi-Cal specialty behavioral health benefit in California, raising up and ongoing financing for this critical workforce will be the responsibility of counties.

- This one-time contribution will result in the ability of counties to leverage millions of new federal funds annually to support cost-effective peer support services as a unique Medi-Cal benefit by adding peer support specialists as Medi-Cal billable providers, provided a county behavioral health plan opts-in and provides the non-federal share of Medi-Cal payments.

Background

Last year, the Legislature passed and the Governor signed SB 803 (Beall) which establishes a peer support specialist certification program at the state level for mental health and substance use disorder services and adds peer support services as a covered Medi-Cal benefit for counties that choose to opt-in. Behavioral health peer support is an evidence-based, cost-effective model of care proven to reduce costly hospitalizations, homelessness, increase participation in treatment, and improve service experience and effectiveness. Peer support specialists are individuals who self-identify as having lived experience of a mental health and or substance use condition and who are trained to use their lived experience along with skills learned in formal training to assist others in their recovery from mental illness and substance use disorders. Forty-eight states have already recognized their value and have a certification process in place or in development for behavioral health peer support specialists.

Peer Support Specialists Save States Millions

- A study from Pierce County, Washington, found that involuntary hospitalizations were reduced by 32% in a single year through the utilization of peers.

- In Texas, one long-term study focusing on substance use disorder peer specialists, also called recovery coaches, found healthcare utilization dropped after 12 months of recovery coaching. In total, recovery coaching saved $3,422,632 in healthcare costs, representing a 72% reduction in costs over 12 months, according to the Texas Health and Human Services Agency.

Peer Support Specialists Represent a Critical Response to COVID 19

Certifying peer support specialists to provide peer support services in Medi-Cal is more important than ever with the COVID-19 pandemic. Nearly 11% of American adults seriously considered suicide this June, according to CDC data. The sharp rise in behavioral health disorders triggered by COVID-19 is likely to linger long after the end of the pandemic itself, thus highlighting the need for an effective, comprehensive, and economically viable behavioral health care response. Peer support specialists are a workforce that mirror the cultural and linguistic diversity of communities they serve and have personal lived experience in successfully navigating their own behavioral health crises and training to help and support others on the path to recovery. The ability of peers to connect with those in need and exemplify the path to wellbeing will be vital in the aftermath of the pandemic.

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Support:
County Behavioral Health Directors Association (co-sponsor)
California Association of Mental Health Peer Run Organizations (co-sponsor)
County of Los Angeles (co-sponsor)
The Steinberg Institute (co-sponsor)

Opposition:
None known

Budget Priority
Rehabilitation of Board and Care Facilities - SUPPORT

Background

California is facing a board and care crisis due to the low reimbursement rates paid by Supplemental Security Income/State Supplementary Payment (SSI/SSP) to clients who live in board and care facilities. Without this important level of care, individuals with severe mental illness who require a more supported living environment may experience longer institutional stays or become high risk for experiencing homelessness.

Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs) (also known as "Board and Care facilities") are licensed by the Department of Social Services (DSS)—Community Care Licensing, and provide non-medical care for clients who cannot live independently. There are three main populations who live in board and care facilities: individuals with a serious mental illness, developmental disabilities, and older adults. Low-income older adults and clients with a serious mental illness living in a board and care facility are highly at risk of experiencing chronic homelessness and these clients are most at risk of seeing their facilities close given that the SSI rate covers less than half of the cost to run the facility. Because of these funding shortfalls, county behavioral health agencies have typically paid "patches", or supplemental payments, to make up the difference. Despite these efforts to augment funding, board and cares are closing at a rapid pace, and counties lack funding to invest in infrastructure improvements.

For example, Los Angeles County lost over 45 facilities and 1,226 beds between January 2016 and December 2019, representing 20% of the county's capacity to serve clients with a serious mental illness. San Francisco City and County s lost 25% of its available Board and Care facilities, displacing 124 clients.

Board and Care facilities are also an integral part of addressing individuals with serious mental illness who are experiencing homelessness. In a survey of 16 board and care operators in San Francisco in 2018, 94% of respondents said they had clients in their facilities who were formerly homeless. Of the Adult Residential Facility operators, 5 of the 6 respondents said that the majority or all of their clients were from hospitals and/or formerly homeless. CBHDA conducted a survey of members in October 2019 and found that 68% of the surveyed counties identified infrastructure as a critical need to improve the quality of the care provided at board and care facilities.

Additionally, due to COVID-19, there has been additional financial strain upon these facilities due to the need for extra staff, cleaning protocols, and physical distancing. In order to stabilize this critical level of housing for vulnerable populations, both capital and operational assistance will be needed on an ongoing basis.

Budget Priority
Rehabilitation of Board and Care Facilities - SUPPORT

Proposed Bill

The Budget includes $250 million one-time General Funds for the DSS to issue grants to support the acquisition and rehabilitation of ARFs and RCFEs with a specific focus on preserving and expanding housing for low-income seniors who are homeless or at risk of becoming homeless.

These funds will also target facilities serving individuals with behavioral health needs who rely on board and care facilities to remain safely in the community. This one-time funding is available for physical upgrades and capital improvements.

CBHDA strongly supports this proposal and looks forward to working with the Administration to ensure that individuals with serious mental illness are able to access high-quality care in board and cares.

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Budget Priority
Behavioral Health Services in Schools

Background

As California continues to grapple with ensuring community-wide health and safety during the COVID-19 pandemic, we are experiencing an unprecedented rise in behavioral health needs, particularly among children and youth. According to the Centers for Disease Control and Prevention, the proportion of children's mental health–related emergency department (ED) visits among all pediatric ED visits increased and remained elevated during the pandemic, compared with 2019. The proportion of mental health–related visits for children aged 5–11 and 12–17 years increased approximately 24%. and 31%, respectively throughout the pandemic. These national statistics align with the experience of county behavioral health departments which have reported a two-fold and three-fold increase in youth mental health crisis in 2020.

Prior to the COVID-19 public health emergency, an evaluation of the National Survey of Drug Use and Health (NSDUH) (2012-2015) found that 35% of adolescents, who receive mental health services, received these services exclusively from school settings. For these adolescents and other children, COVID-19 related school closures have disrupted their treatment. The Administration's investment in school-based services is more important than ever to address the behavioral health crisis created by the pandemic and support the planned transition back to in-person learning.

Mental Health Student Services Act (MHSSA):
Support for increasing proposed $25 million to fully fund the MHSSA at $80.5 million

The Administration proposed to allocate $25 million (MHSA Administrative Funds) for the MHSSA. The MHSSA administered by the Mental Health Services Oversight and Accountability Commission (MHSOAC) invests in school mental health through supporting mental health partnerships between county behavioral health departments and school districts, charter schools, and county offices of education. In 2019, the MHSOAC was able to fund 18 of 38 school-county partnership applicants with funds allocated to the MHSSA. The proposed $25 million will fund less than one-third of the unfunded applications, according to the MHSOAC.

CBHDA joins other stakeholders, including Children NOW, to request the Legislature augment the amount proposed by the Administration and allocate $80.5 million, the amount needed to fully fund the MHSSA program. The remaining unfunded 20* county/school applications represent turn-key partnerships ready to meet the mental health needs of students on campuses at a critical time.

Budget Priority
Behavioral Health Services in Schools

School Mental Health Managed Care Incentive Program: Support for $389 million in Medi-Cal funds to expand Medi-Cal services in schools with requested modifications

This Governor's January budget proposal seeks to implement a $389.0 million ($194.5 million GF, $194.5 million federal match) local assistance incentive program through Medi-Cal Managed Care Plans (MCPs), to invest in and develop partnerships with schools and county behavioral health departments, to increase the number of K-12 students receiving preventive, early intervention, and behavioral health services from school-affiliated behavioral health providers. To build infrastructure, partnerships, and capacity statewide, the Department of Health Care Services proposes a one-time initiative to build school partnership capacity through incentive payments which would flow through MCPs. Supported interventions, include but are not limited to:

- Local planning efforts to review existing plans and documents that articulate student needs in the area; compile data; map existing behavioral health providers and resources; identify gaps, disparities and inequities.

- Encourage the participation of MCPs in school-based mental health services by building stronger partnerships between schools, MCPs, and county behavioral health departments so that more Medi-Cal reimbursable services are provided to students.

- Implement culturally appropriate and community-defined interventions and systems to support initial and continuous linkage to behavioral health services in schools.

CBHDA strongly supports the Administration's intent of increasing access to Medi-Cal supported behavioral health services in schools.
However, currently, 85% of county behavioral health agencies provide specialty mental health services (SMHS) on school campuses and 55% of agencies provide substance use disorder (SUD) services on campus.

In recognition of the extensive school-based behavioral health services already provided by county behavioral health agencies, and their expertise in forming school-based mental health programs with Medi-Cal funding, CBHDA urges the proposal require the Medi-Cal plan, with established partnerships and programs in local schools serve as the lead entity in establishing the three-way partnerships outlined in the Administration's proposal, even if the established plan is the county behavioral health plan.

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Sponsored Budget Proposal
Public Health Emergency Mental Health Service Act Flexibilities
Budget Trailer Bill Language

Budget Request

Safeguard from reversion Innovation funds and funds encumbered in a Mental Health Services Act (MHSA) approved Three-Year plan but that remain unspent because of the COVID-19 pandemic.

Background

The Administration's proposed January budget included an extension of several MHSA flexibilities authorized last year for another fiscal year (FY). Flexibilities proposed to be extended include:

- The ability for county behavioral health agencies to access prudent reserve funds without involving the Department of Health Care Services (DHCS).
- The ability to spend Community Services and Support (CSS) funds more flexibly by allowing less than a majority of CSS funds to be used for Full Service Partnerships.
- The ability for counties to use existing previously approved Three-Year plans for another year, if the pandemic has prevented the ability to secure a new plan.

The proposed budget trailer bill did not extend the safeguarding of funds subject to reversion for an additional year. This last flexibility has only been authorized through FY 2020-21.

Recommendation

CBHDA requests that a limited amount of MHSA funds be safeguarded from reversion through FY 2021-22, including all Innovation funds and funds that have been encumbered in an approved Three-Year plan, but which counties have been unable to spend because of COVID-19.

The pandemic has impacted the ability of county behavioral health agencies to secure approved Three-Year plans and updates resulting in the need for the above described flexibility. While using funds allocated to CSS and Prevention and Early Intervention based on existing Three Year plans continues to be a much appreciated flexibility, applying this flexibility to Innovation funds is not typically possible because these funds are expended based on a distinct state-level approval process, as well as an approved project tied to a specific budget. In addition, because counties have focused on the public health emergency, including providing mutual aid to local public health departments, supporting individuals in crisis in need of emergency and crisis services, and transitioning county behavioral health services to tele-behavioral health modalities, many have struggled with the capacity to begin or plan for new programs, including new Innovation projects, particularly given the budget and other uncertainties of the past year.

Sponsored Budget Proposal
Public Health Emergency Mental Health Service Act Flexibilities
Budget Trailer Bill Language

Preparation for an Innovation project application can include up to a year of technical assistance provided by the Mental Health Services Oversight and Accountability Commission (MHSOAC) staff. The MHSOAC has already expressed concerns with their own capacity to address a large volume of expected submissions of Innovation projects by the end of the current fiscal year. This situation, which has been exacerbated by the pandemic, will result in funds potentially being subject to reversion, solely due to insufficient time to secure MHSOAC approval for Innovation projects.

In addition, some projects approved in counties' Three-Year MHSA plans were stalled when project contractors faced barriers in expanding funds due to the COVID-19 emergency. For example, funds directed toward operating or opening Wellness Centers have been put on hold because of prohibitions on indoor gatherings. Programs to perform in-person training and technical assistance have been postponed for similar COVID-related reasons. These projects were prioritized by the local community prior to the pandemic, and CBHDA members want to support these contractors through the pandemic to ensure the long-term stability of the behavioral health safety net. We urge that the Administration and the Legislature to safeguard funds subject to reversion so long as the funds have been encumbered within an approved Three-Year plan due to the unique disruptions of the COVID-19 pandemic.

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Support:
County Behavioral Health Directors Association (co-sponsor)

Opposition:
None known

Community Care Demonstration Project for Felony ISTs (CCDP-IST) OPPOSE

Background

The Department of State Hospitals is responsible for competency restoration services for individuals deemed "incompetent to stand trial" (IST) and charged with a felony. A criminal defendant must be restored to competency before the legal process can continue. To be considered restored and competent to stand trial, a defendant must be able to consult with his or her defense lawyer and have a rational and factual understanding of the legal proceedings.

In 2015, the ACLU filed a lawsuit (Stiavetti v. Ahlin) against the Department of State Hospitals (DSH), arguing that long wait times for state hospital treatment beds was a denial of treatment and violated due process rights. The initial ruling from the Superior Court of California ordered DSH to admit individuals who were found to be IST within 28 days of their referral, however, the state is currently appealing the ruling. Since the start of the COVID-19 public health emergency, the waitlist for individuals awaiting transfer to DSH for felony restoration doubled from ~800 pre-pandemic, to 1,591 individuals due to COVID-19-related state hospital closures.

Proposed Bill

CCDP-IST would pilot realigning the responsibility of providing care and treatment for individuals charged with felonies and deemed incompetent to stand trial (FIST) in three counties. The budget includes $233.2 million GF in FY 2021-2022 and $136.4 million in FY 2022-23 and ongoing to contract with three counties to provide a continuum of services for felony ISTs to be served at the local level rather than at DSH.

Beginning from the date of contract, the counties would assume the responsibility for treatment and restoration of felony IST defendants. On the date of the contract execution, any felony IST awaiting placement, as well as those newly committed would become the responsibility of the pilot counties. Over the course of the pilot, DSH estimates 1,252 FSTS would become the county responsibility, based on historic referral averages from counties. As such, the DSH proposal would cap the state's contribution for services at 1,252, and counties would assume full financial and legal responsibility for any FIST referrals over the cap.

Community Care Demonstration Project for Felony ISTs (CCDP-IST) OPPOSE

Concerns

Funding Amount is Inadequate - The budget proposal would provide counties with $108,000 per individual under the pilot, based on the average Department of State Hospital (DSH) length of stay (155 days) and the current DSH Lanterman-Petris-Short (LPS) bed rate ($699/day). However, in practice, the type and options for suitable treatment facilities are often heavily driven by the courts and regional inpatient treatment bed capacity. For example, the court has the ability to order individuals who fall under FIST into locked settings due to "risk to public safety"considerations. Furthermore, county behavioral health capacity for inpatient or community-based restoration treatment is already limited and has been further restricted by health and safety considerations related to the pandemic. These two factors will limit the ability of county behavioral health agencies to truly manage this population within the allotted budget, and counties estimate this proposal would likely cost much more per individual, due to a lack of lower-level, acceptable treatment options, as well as concerns over longer lengths of stay. One large county's estimate of likely costs under the pilot were more than double the state's estimate, at around $240,000 per individual per year.

Reimbursement for the Proposal is Capped - The proposal caps the funding for FISTs statewide to 1252 individuals annually, limiting the state's financial exposure for a population which would otherwise be the state's responsibility. This is of concern as the proposal does not place any controls or create incentives for criminal justice system partners to address other systemic and procedural issues which have led to an increase in individuals found to be IST with felony convictions. Participating counties would be financially at risk for any individuals ordered FIST over the cap, at a time when the wait list is growing exponentially due to COVID-19 impacts.

Inability to Control Population Costs - The proposal assumes that individuals with FIST determinations would be referred to a variety of settings and that only 22% of individuals currently referred to the DSH actually require a state hospital level of care. This assumption fails to account for the role of court and criminal justice partners in determining charges as well as placement options.

Community Care Demonstration Project for Felony ISTs (CCDP-IST) OPPOSE

Concerns

Needs Not Timed to Ensure Success - CCDP-IST will increase demand for IMD and locked facility services which are already scarce for existing populations under county behavioral health plan responsibility. Currently, local inpatient and locked facility capacity is already strained due to COVID-19 health and safety measures, as well as facility closures, at the same time that demand for acute psychiatric services has also increased. The DSH proposal does include consideration of these factors with a proposed $35 million in one-time funds for local infrastructure investments. However, these infrastructure funds would be granted concurrent with the new contracted responsibility for the population, and, as such, counties would not realize the benefit of these investments until later in the demonstration.

Legal Risk - The state is currently appealing the Stiavetti v. Ahlin lawsuit which ordered DSH to admit ISTs within 28 days of being referred to DSH. Should counties assume the responsibility of this population, they will also assume associated legal liability for ensuring timely care and treatment with scarce resources, treatment and housing capacity, and safeguards.

Alternate Proposal

The Legislative Analyst's Office (LAO) recommends that the Legislature reject this proposal, and instead focus on better resourcing the county behavioral health safety net and existing programs, such as the Jail Based Competency Program, to address the needs of the population at risk. CBHDA recommends the Legislature adopt an alternative proposal which would include expanding and revising the existing mental health diversion grants, increasing capacity to treat forensic populations in the community through forensic Assertive Community Treatment teams, additional investment in forensic treatment and housing capacity, and standardizing the competency evaluation process so individuals are more appropriately and consistently found IST.

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AB 552 (Quirk-Silva)
Integrated School-Based
Behavioral Health Partnership Program

The Problem

More than 50% of mental illness cases begin by age 14. For children whose mental health concerns go unnoticed or untreated, especially those between the ages of 12 and 17, rates of substance abuse, depression, and lower school achievement increase leading to other health-related problems and a lower quality of life. Addressing behavioral health conditions as early as possible, is critical in promoting the health and well-being of students. By providing early intervention services at schools, behavioral health conditions can be identified at the earliest onset.

The COVID-19 pandemic has created a significant barrier for the provision of behavioral health services on school campuses. The result is an unprecedented rise in behavioral health needs among children and youth. According to the Centers for Disease Control and Prevention, the proportion of children's mental health–related emergency department (ED) visits among all pediatric ED visits increased and remained elevated during the pandemic. Compared with 2019, the proportion of mental health–related visits for children aged 5–11 and 12–17 years increased approximately 24% and 31%, respectively throughout the pandemic. Most students have been out of school since March, 2020. Isolation, anxiety over the uncertainty of the immediate and long-term future, lack of peer support, and concerns with family, including those homes that are not safe places for children and youth, have and will continue to take a toll in the years to come. Behavioral health, mental wellness and support will be crucial for this generation of students.

While much discussion has centered around maximizing Medi-Cal funding for schools, according to a survey of county behavioral health agencies, schools are reluctant to bring county behavioral health professionals on campus unless all students can be served. Understandably, school administrators appreciate that the school climate and mental well-being are best supported when all students have access to available resources.

AB 552 (Quirk-Silva)
Integrated School-Based
Behavioral Health Partnership Program

Proposed Bill

AB 552 will establish the Integrated School-Based Behavioral Health Partnership Program to provide early intervention for, and access to, behavioral services for all students in California public schools. The collaborative program between the Local Educational Agencies (LEA) and the county behavioral health agencies (County) would be established through a memorandum of understanding (MOU). The MOU would outline the requirements for the partnership, including:

- The county providing one or more specified behavioral health professionals to serve students with serious emotional disturbances or substance use disorders, or who are at risk of developing a serious behavioral health condition, regardless of payer.

- The Development of a referral process for LEAs to make appropriate referrals to designated County professionals. Requirement for the LEA to provide for a school-based location appropriate for the delivery of behavioral health services.

- The establishment of processes, delivery of services and types of services, as well as requirements for assisting and serving students with private insurance. This bill would set forth procedures for county school-based providers to first attempt to connect the student with their insurance-based provider, and if not served, provide initial services to privately insured students within state mandated timely access standards to mitigate the worsening of a behavioral health condition.

- AB 552 would also require the Partnership Programs to annually report specified information to the Department of Health Care Services and the Mental Health Oversight and Accountability Commission to support a report to the California Legislature every three years regarding student and parent satisfaction, demographics of students served, as well as partnership models and financing.

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Support:
County Behavioral Health Directors Association (co-sponsor)
California Alliance of Child and Family Services (co-sponsor)

Opposition:
None known

AB 681 (Ramos) Mental Health: Information Sharing
LPS Data Collection

The Problem

Currently, there is no comprehensive state-level reporting or information available regarding individuals experiencing a mental health crisis and placed on a 5150 hold. A "5150 hold" is an involuntary psychiatric hold of up to 72-hours set forth in Section 5150 of the Welfare and Institutions Code under the Lanterman-Petris-Short (LPS) Act for individuals who, as a result of their mental disorder, are determined a danger to self, danger to others, or "gravely disabled." The most comprehensive existing state-level data related to 5150s stems from reports sent to the Department of Justice (DOJ) related to a firearm prohibition in existing law for individuals who have been placed on a 5150 due to a danger to self or others determination. Neither of the entities responsible for the oversight and administration of the LPS Act, i.e. the Department of Health Care Services (DHCS), and county behavioral health, respectively, have access to comprehensive and complete information about the individuals subject to 5150 holds throughout the state, which limits appropriate implementation oversight and policy decision-making.

Existing law prohibits individuals who have been subject to a 5150 hold and admitted to a treatment facility as a result of danger to self or others, from possessing or owning a firearm for five years after the person has been released (WIC 8103). Existing law requires those treatment facilities to submit information about patients with 5150s to the Department of Justice (DOJ) within 24 hours of their admission in order to ensure enforcement of this law. However, because the firearms restriction in existing law does not apply, treatment facilities currently do not report information about all patients admitted as a result of 5150's to the DOJ. For example, the DOJ reporting omits information on any individual who is subject to a 5150 hold as a result of "grave disability," which under California law means the individual is unable to provide for their food, clothing, or shelter as a result of their mental illness. Additionally, the DOJ does not receive data for youth aged twelve and under. The exclusion of these patients results in an additional data gap which limits the state's understanding and oversight of the LPS Act with data currently reported to comply with firearm restrictions.

AB 681 (Ramos) Mental Health: Information Sharing
LPS Data Collection

Proposed Bill

AB 681 would implement and improve on the recommendation of the California State Auditor to leverage the data submitted to the DOJ to inform policymakers and oversight entities and improve care and outcomes for individuals placed on 5150s. This bill would require the DOJ to transmit the data they receive from facilities for those held on a 5150 for being a danger to self or danger to others to DHCS. This bill would then require facilities to report directly to DHCS on the gaps in reporting for individuals held for being gravely disabled and youth under 12. AB 681 would require DHCS to report aggregated, deidentified 5150 information annually to allow for stratification by socio-demographic factors, such as age, race, and ethnicity, to allow policymakers to identify potential disparities in 5150 holds across populations.

Limited existing data from individual counties suggests that individuals of color, and in particular, Black Californians, are disproportionately represented among those populations placed on psychiatric holds, likely due to factors of systemic racism which contribute to increased homelessness among Black Californians, limited availability of accessible outpatient treatment, as well as increased interactions with law enforcement. Requiring data to be reported with sociodemographic factors will begin to shine a light on these disparities and allow the state and counties to identify how best to eliminate those disparities and improve the quality of treatment and services available to all Californians.

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Support:
County Behavioral Health Directors Association (co-sponsor)

Opposition:
None known

AB 686 (Arambula)
California Community-Based Behavioral Health Outcomes and Accountability Review

The Problem

The considerable mandatory reporting requirements counties must meet demonstrate their fidelity in expending public behavioral health funds across multiple categorical funding streams and regulatory oversight entities. However, to date, no action has been taken to develop a comprehensive joint plan for a coordinated evaluation of client outcomes for the community-based behavioral health system. Currently in California, there are several significant efforts underway to support the development of measurable outcomes for Medi-Cal beneficiaries, including the Department of Health Care Services (DHCS) newly developed senior staff roles to focus on quality, disparities, and outcomes for the department; current efforts to develop outcomes under CalAIM; and the Mental Health Services Outcome and Accountability Commission's (MHSOAC) continued work on their Transparency Suite to name a few.

Although these efforts are laudable, they focus on distinct, but often interrelated aspects of the public behavioral health delivery system in siloed approaches oriented primarily around funding streams and using existing data sources. These efforts are not sufficiently coordinated to streamline reporting requirements and to ensure the most valuable data is collected and reported on a statewide basis. Furthermore, while behavioral health is certainly a crucial factor in overall health, it is also mission critical to efforts across multiple other state-funded systems where outcomes may be impacted by a lack of available behavioral health services and supports, including, but not limited to: education, social services, child welfare, public health, criminal justice and corrections, homeless services, public health, emergency response, and more.

Without a comprehensive joint plan that includes measures and outcomes across the varied funding streams which support the delivery of both mental health and substance use disorders (SUDs), any standard reporting that is conducted provides only a partial picture of the county public behavioral health system's interventions. Partial data and siloed reporting leads to misunderstandings, inaccuracies, and restricts the ability of state and local partners to align systems and funding with desired statewide outcome goals.

AB 686 (Arambula)
Behavioral Health Outcomes and Accountability Review

Proposed Bill

Historical regulatory and payment rules render the county behavioral health safety net complex by design. County behavioral health agencies and their network of providers are responsible for providing safety net behavioral health and social services to Californians across a broad spectrum of need, including Medi-Cal, uninsured, and privately insured individuals and in coordination with multiple interrelated systems.

- This bill will increase the public and stakeholder's understanding of the impact of the community-based public behavioral health system, and the accountability of county behavioral health agencies by developing robust statewide outcome and performance measures for adults with serious mental illness, children and youth with serious emotional disturbances, individuals with substance use disorders, and other populations served by county behavioral health.

- Under this bill, the leadership of the California Health and Human Services Agency (CHHS) will convene appropriate state agencies, legislative representatives, counties, a diverse team of subject matter experts, client and family representatives, providers, and data scientists to develop measurable and timely publicly reportable outcomes for the public behavioral health delivery system.

- This bill will build on AB 470 (Arambula, Chapter 550, Statutes of 2017) which required updates to the specialty mental health services (SMHS) performance outcomes report for Medi-Cal services. The bill is modeled after the CalWORKs Outcomes and Accountability Review Act of 2017 under which CHHS led a workgroup to establish three core outcome accountability components for CalWORKs: performance indicators, a county/city self-assessment, and a system improvement plan.

- An outcome of the plan will include identifying a standard statewide method to collect Race, Ethnicity, Language, Sexual Orientation and Gender Identity behavioral health client data, as recommended by the AB 470 Advisory Workgroup.

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Support:
County Behavioral Health Directors Association (co-sponsor)
California Council of Community Behavioral Health Agencies (co-sponsor)
California Pan-Ethnic Health Network (co-Sponsor)

Opposition:
None known

AB 1051 (Bennett) Medi-Cal
Specialty Mental Health Services - Foster Youth

The Problem

Foster youth placed in residential treatment settings across county lines often faced unnecessary delays in receiving appropriate mental health services due to changes in Medi-Cal payment responsibility. AB 1299 (Ridley-Thomas), Chapter 603, Statutes of 2016, sought to address these concerns by adopting a new "presumptive transfer," rule which shifted primary responsibility for delivery and payment of services from the sending county, to the new county of residence. AB 1299 also allowed for a waiver of presumptive transfer in certain instances, including when it would disrupt continuity of care or for temporary placements.

Since the passage of AB 1299, California has continued to reform its child welfare services system under the Continuum of Care Reform (CCR). CCR legislation was enacted to move California away from the use of group home settings as long-term placements, and toward a more treatment-based model of care, which prioritized the identification and treatment of foster youth mental health needs. Under CCR, group homes are being replaced by short-term residential therapeutic programs (STRTPs) which are residential facilities that provide short-term intensive, specialized supports and services focused on stabilizing youth with high needs to support their transition into home-based settings.

As short-term placements, STRTP out of the county placements should waive presumptive transfer to ensure responsibility for services does not become convoluted as it transfers back and forth between counties. If waived, the same county is responsible for specialty mental health services before the youth left the county, while the youth is temporarily placed in another county, and after the youth returns. Unfortunately, because presumptive transfer and waiver of presumptive transfer is a new process, confusion in implementing this process has led to disruptions in continuity of care and difficulty in providers securing timely payment.

AB 1051 (Bennett) Medi-Cal
Specialty Mental Health Services - Foster Youth

Proposed Bill

AB 1051 will further efforts to ensure that youth who enter the child welfare services system in one county but are placed in another for temporary residential treatment have timely access to the mental health services to which they are entitled, and that facilities serving these children are paid in a timely fashion. This bill would also strengthen continuity of behavioral health services protections for youth placed out of county.

AB 1051 will require a youth-centered, case-by-case decision to be made regarding responsibility for the provision of or arrangement for specialty mental health services for each foster youth who is placed out of county in an STRTP.

In most instances, because STRTP placements are intended to be short-term, the responsibility for the provision of or arrangement for specialty mental health services will remain with the county of original jurisdiction because this county will likely retain responsibility for care, supervision, and access to appropriate mental health and substance use services for the youth upon their return from the STRTP. Only in those instances 1) when the youth would be better served with a transfer of responsibility for services or 2) when the youth will be relocating more permanently in the county where the youth is temporarily placed in a STRTP will responsibility transfer to the receiving county.

Furthermore, this bill provides a basic, but necessary requirement to inform both the county of original jurisdiction and the county of residence (i.e. the host county for the out-of-county STRTP) when a foster youth is placed outside of their home county in an effort to ensure continuity of behavioral health services and support timely payment for the treatment facilities.

This bill also calls for statewide uniformity in contracting processes between county mental health plans and STRTP providers and requires data to be reported to the Legislature on the provision of specialty mental health services to foster youth placed out of county.

Finally, this bill supports appropriate contracting between STRTP providers and counties to facilitate service delivery and payment of claims for treatment provided to foster youth placed out of county.

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Support:
County Behavioral Health Directors Association (co-sponsor)

Opposition:
None known

SB 14 (Portantino) School Behavioral Health Supports:
School employee and student behavioral health training and excused absences

Background

Child and adolescent behavioral health had been a growing crisis prior to the COVID-19 public health emergency. The Centers for Disease Control (CDC) reported that, nationally, approximately 4.5 million children aged 3-7 have been diagnosed with behavioral health challenge,[1] and research shows that the percentage of children with diagnosed depression and anxiety has steadily risen since 2003[2]. Additionally, between 2007 and 2017, suicide rates for people aged 10-24 increased by 56%, increasing from 6.8 suicides per 100,000 to 10.6 per 100,000.[3] Suicide is now the second leading cause of death for teens in the U.S., after accidents.[4]

The California Mental Health Services Oversight and Accountability Commission (MHSOAC) released a report in November 2020, that details what one educator described as the "crisis filled lives" of children and youth. The report found that one in three California high school students reported feeling chronically sad and hopeless – with more than half of lesbian, gay, bisexual, transgender, and queer (LGBTQ) students reporting feeling this way. Furthermore, one in six high students reported having considered death by suicide in the past year, with the rate for LGBTQ students at 1 in 3. The report also found that racial, ethnic, and cultural disparities concrete the risk factors, prevalence rates, and service gaps in low-income communities of color. COVID-19 has increased these disparities as our students struggle to transition to hybrid learning environments, and county behavioral health plans report increasing numbers of children and youth in acute psychiatric crisis since the start of the pandemic.

California can address the emergent youth behavioral health crisis by investing in school-based behavioral health supports for school personnel and children and youth By bringing awareness of behavioral health to schools, we can support the learning community , identify child and youth with behavioral health needs, and connect those in need with local resources. By enacting SB 14, California would follow states such as New York, Virginia, and Oregon in developing similar programs aimed at protecting the behavioral health needs of pupils.

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2. Bitsko RH, Holbrook JR, Ghandour RM, Blumberg SJ, Visser SN, Perou R, Walkup J. Epidemiology and impact of healthcare provider diagnosed anxiety and depression among US children. Journal of Developmental and Behavioral Pediatrics. Published online before print April 24, 2018
3. Curtin SC, Heron M. Death rates due to suicide and homicide among persons aged 10–24: United States, 2000–2017. NCHS Data Brief, no 352. Hyattsville, MD: National Center for Health Statistics. 2019.
4. Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2019 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html on Mar 12, 2021

SB 14 (Portantino) School Behavioral Health Supports:
School employee and student behavioral health training and excused absences

Proposed Bill

SB 14 would address the growing issue of child and youth mental health in the following three ways:

- This bill would require the California Department of Education (CDE) to identify an evidence-based training program for a local educational agency to use to train classified and certificated school employees having direct contact with pupils in youth behavioral health. The training will provide instruction on how school staff can best identify signs and symptoms of youth behavioral health disorders, maintain confidentiality, consistent with state and federal laws, provide referrals for youth behavioral health services, and safe crisis de-escalation for youth with a behavioral health disorder.

- This bill will establish a complementary training for students grades 10-12th on the signs and symptoms of a behavioral health disorder, stigma reduction, healthy coping strategies, and how to connect with local community resources.

- SB 14 will provide parity for students with behavioral health needs by ensuring that youth absences from school for a behavioral health issue or appointment will be an excused absence in the same fashion as absences for physical health ailments or appointments are treated.

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Support:
County Behavioral Health Directors Association (co-sponsor)
California Council of Community Behavioral Health Agencies (co-sponsor)
NextGen Policy (co-sponsor)

Opposition:
None known