Abbreviated Analysis

California Assembly Bill 1859: Mental Health Services

Summary to the 2021–2022 California State Legislature

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Prepared by

California Health Benefits Review Program

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SUMMARY

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)[1] conduct an evidence-based assessment of California Assembly Bill 1859.

The bill requires health care service plans and health insurance policies regulated by the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) in effect as of January 1, 2023, that include coverage for mental health services to:

1. Approve the provision of mental health services for enrollees/insureds who are detained for 72-hour treatment and evaluation (a 5150 hold).
2. Schedule an initial outpatient appointment for the enrollee/insured described in #1 above with a licensed mental health professional scheduled for a date that is within 48 hours of the person's release from detention.
3. Ensure the location of the facilities providing the covered mental health services to the enrollee/insured described in #1 above be within reasonable proximity of the business or personal residences of the enrollee/insured.
4. Provide that the enrollee/insured described in #1 above who receives covered mental health services[2] from a noncontracting provider shall pay no more than the same cost-sharing amount as if the services were received from a contracting provider. At the time of payment by the plan to the noncontracting provider, inform them and enrollee/insured of the cost-sharing amount owed by the enrollee/insured.

The full text of AB 1859 can be found in Appendix A.

In 2020, CHBRP analyzed AB 2242 (Levine): Mental Health Services, with language identical to that of AB 1859 except for the effective date. This abbreviated report summarizes the information from the AB 2242 report and updates where new information is available.

Background. In California, the Lanterman-Petris-Short (LPS) Act authorizes peace officers, mental health professionals, members of a mobile crisis team, and certain other professionals to place an involuntary psychiatric hold on persons — adults or children — who, for reasons related to mental health conditions (i.e., imminent danger to self, danger to others, grave disability), are likely to cause or suffer specific kinds of harm. During involuntary psychiatric holds (known as "5150s"), patients are detained for up to 72 hours for the purposes of assessment, crisis stabilization, and evaluation for additional treatment needs. 5150s may be initiated in community settings by peace officers (e.g., homes or public places) or in health care settings by a mental health professional, but patients must be evaluated and admitted to an LPS-designated facility for a 5150 to be active. These facilities are primarily licensed psychiatric hospitals, licensed psychiatric health facilities, certified crisis stabilization units, and VA hospitals with a locked psychiatric ward. Often there is not capacity at an LPS-designated facility to directly accept patients identified in the community. Patients are often referred to an emergency department (ED) of an acute care hospital for stabilization or clearance prior to transfer to an LPS-designated facility. Patients that are stabilized in the ED and discharged or who are admitted to a non-LPS designated facility are not included in the population counted as persons with a 5150 hold.

Prevalence in California. The total number of 72-hour involuntary detentions in fiscal year (FY) 2018-2019 was 136,163, including 21,952 for

[1] Refer to CHBRP's full report for full citations and references.
[2] AB 1859 defines covered mental health services as mental health services that are urgently needed to prevent serious deterioration of the enrollee's/insured's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee/insured can receive services from a contracting provider.

children aged 17 years and younger and 114,211 for adults aged 18 years and older.

Population affected. If enacted, AB 1859 would apply to the health insurance of approximately 14,776,000 enrollees (38% of all Californians). This represents 64% of the 22,810,000 million Californians who will have health insurance regulated by the state that may be subject to any state health benefit mandate law, which includes health insurance regulated by DMHC or CDI.

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

Summary of cost, public health, and long-term impacts from 2020 report on AB 2242.

1. Cost: An increase in total net annual expenditures of $1,559,000, or about 0.001%, for enrollees with DMHC-regulated plans and CDI-regulated policies.
2. Public health: The number of people with commercial insurance who would receive an outpatient appointment within 48 hours of discharge would increase but the impacts of this on ED visits, hospital readmission, or suicide are unknown due to insufficient, inconclusive, or limited evidence.
3. Long-term utilization and cost impacts: Would likely be similar in subsequent years as in the first year postmandate.

Timing of follow-up visits. CHBRP estimated the timeframes for follow-up appointments for individuals who had an inpatient psychiatric admission with a length of stay ≤ 3 days using the same methodology as in its 2020 report on AB 2242, but updated using 2019 data. This analysis shows declines in the proportion of individuals meeting the criteria who had a follow-up appointment within 48 hours, 3-30 days, and within 90 days; there was a decline from 63% having an outpatient follow-up visit within 90 days in 2017 to 49% in 2019. A second analysis using the 2019 data included additional inpatient diagnoses related to suicide and additional types of mental health professionals beyond psychiatrists (e.g., psychologists). This analysis shows 54% of individuals meeting these new criteria having an outpatient follow-up visit within 90 days. In both cases, about one in five patients meeting these criteria is estimated to have an outpatient follow-up visit within 48 hours.

Medical effectiveness. CHBRP's report on AB 2242 reached the following conclusions that are applicable to AB 1859.

1. There is *inconclusive evidence* of effects of timely access to mental health outpatient visits on hospital readmissions, although the most pertinent studies (i.e., those that assess people with commercial health insurance) suggest that receiving follow-up outpatient mental health services within 30 days of discharge is associated with a small reduction in hospital readmissions.
2. The impact of receiving follow-up outpatient care within two days of discharge is unknown because none of the studies assessed the impact of receiving follow-up care during this time interval. There is *insufficient evidence* of the effect of timely follow-up outpatient care on ED visits and medication adherence.
3. There is *insufficient evidence* to determine whether receiving timely follow-up outpatient mental health services, after discharge from inpatient mental health care, improves mental health outcomes.
4. There is *inconclusive evidence* that scheduling visits for follow-up outpatient mental health services, after discharge from inpatient mental health care, affects use of mental health services including hospital readmissions.
5. There is *insufficient evidence* to determine whether access to outpatient mental health providers in close proximity to a patient's business or residence increases use of outpatient mental health services following discharge from inpatient mental health care or improves mental health outcomes.
6. There is *limited evidence* that reducing cost sharing for follow-up outpatient mental health services increases use of these services.
7. There is *insufficient evidence* to determine if reducing cost sharing for follow-up outpatient mental health services improves mental health outcomes.

CHBRP's review of more recent studies relevant to AB 1859 published after the report on AB 2242 yielded the following additional findings:

8. There is *insufficient evidence* of effects of timely follow-up care with a mental health provider on suicide rates, a mental health outcome.
9. There is *insufficient evidence* that scheduling timely follow-up care with a mental health provider increases the use of outpatient services.

BACKGROUND ON 5150 HOLDS AND RELATED MENTAL HEALTH SERVICES IN CALIFORNIA

The following section provides an overview of 72-hour involuntary psychiatric holds (commonly known as "5150s" in reference to the California code number).

The Involuntary Hold (5150) Process

In California, the Lanterman-Petris-Short (LPS) Act authorizes peace officers, mental health professionals, members of a mobile crisis team, and certain other professionals to place an involuntary hold on persons — adults or children — who, for reasons related to mental health, are likely to cause or suffer specific kinds of harm. During involuntary holds, or 5150s, patients are detained for up to 72 hours, stabilized, and evaluated for additional treatment needs. When a peace officer initiates a hold, the individual may be transported to a hospital with an emergency department (ED) or directly to an LPS-designated facility (e.g., a licensed psychiatric hospital, a licensed psychiatric health facility, a certified crisis stabilization unit). When LPS-designated facilities are full, patients often await transfer to a psychiatric facility at a local ED. In the ED, certified mental health providers (e.g., psychiatrists, psychologists, licensed clinical social workers) can then apply for a patient to be involuntarily detained on a 5150 hold, which can be certified upon transfer to an LPS-designated facility. Individuals subject to a 5150 hold have the right to refuse medical and psychiatric treatment, including psychiatric medication, except in an emergency).[3,4]

5150 Initiation

Persons may not be placed under an involuntary hold solely on the basis of having a mental illness. In order for a 5150 to be initiated, a person must meet at least one of three criteria as a result of a mental health disorder:

- **Danger to self** — the person must be acutely suicidal (or expresses significant harm to self) or engage in behavior that puts him/her at serious danger to self; dangerous behavior can be intentional or unintentional.
- **Danger to others** — the person expresses harm to others or demonstrates behavior that puts the safety of others at risk of serious harm; dangerous behavior can be intentional or unintentional.
- **Grave disability** — the person is unable to provide for his or her own food, clothing, or shelter. A person is not gravely disabled if someone else is willing and able to provide these basic necessities.[4,5]

5150s may be initiated in community settings (e.g., homes or public places) or in a health care setting, but patients must be evaluated and admitted to an LPS-designated facility for a 5150 to be certified and valid. Often there is not capacity at an LPS-designated facility to directly accept patients identified in the community. Patients are often referred to an ED of an acute care hospital for stabilization or clearance prior to transfer to an LPS-designated facility. Patients who are stabilized in the ED and discharged or who are admitted to a non-LPS designated facility are not included in the population counted as persons with a 5150 hold. Studies of persons undergoing involuntary holds suggest that most adults placed on

[3] Welfare and Institutions Code 5325.2.
[4] California Department of Health Care Services (DHCS). *Rights for Individuals In Mental Health Facilities Admitted Under the Lanterman-Petris-Short Act*. May 2014. Available at: https://www.dhcs.ca.gov/services/Documents/DHCS_Handbook_English.pdf.
[5] Being homeless, on its own, for example, would likely not meet the criteria for grave disability as many homeless persons are mentally capable of seeking out basic needs. Behaviors leading to an assessment of "grave disability" must be shown to be the result of a mental disorder and not merely the result of a lifestyle or attitude choice.

involuntary psychiatric holds are initiated in the ED or through emergency medical services (Roy et al., 2019; Trivedi et al., 2019), whereas most involuntary holds for children are initiated in prehospital settings by police, school police, or psychiatric response teams (Santillanes et al., 2017).

Patient Evaluation and Inpatient Transfers

Patients with a 5150 must be evaluated at facilities designated to receive persons with involuntary mental health holds, which are primarily licensed psychiatric hospitals, licensed psychiatric health facilities, certified crisis stabilization units, and VA hospitals with a locked psychiatric ward. Once a patient arrives at an LPS-designated facility and the 5150 is confirmed, one of several scenarios will occur:

- A patient will improve and be discharged home as they no longer meet the criteria for a 5150 (the hold is lifted at the time of discharge);
- A patient will be voluntarily admitted to a psychiatric or medical ward for further treatment; or
- A patient will continue to meet the 5150 criteria and will be put on a 14-day involuntary hold[6] in order for treatment to be administered.

Discharge and Outpatient Follow Up

Prompt follow up with outpatient mental health providers after discharge from a psychiatric hospitalization is important for maintaining continuity of treatment and preventing repeat hospitalizations (Holt, 2018). **AB 1859 requires access to follow-up mental health care within 48 hours after a person detained on a 5150 is released.** However, this standard differs from nationally established benchmarks for follow-up care, and several health plans stated in their responses to CHBRP's carrier survey that they considered timely follow up after an inpatient hospitalization to be 7 days after discharge. The National Committee for Quality Assurance (NCQA) develops measures of health care quality known as HEDIS measures. Data on various measures are gathered from health plans/insurers and used to evaluate performance and drive quality improvements. Relevant to AB 1859 is the HEDIS measure *Follow-Up After Hospitalization for Mental Illness (FUH)*. This measure assesses the timing of follow-up care of adults and children 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a mental health practitioner. The measure identifies the percentage of members who received follow-up care within: (1) 7 days of discharge, and (2) 30 days of discharge. Data on these measures for California health plans/insurers are reported by the Office of the Patient Advocate (OPA).[7] California data for 2020 show that the average percent of enrollees receiving a follow-up visit within 7 days after a mental health inpatient stay ranged from 36% to 75%; for 30-day follow up, the percentages ranged from 64% to 87%.

Outpatient follow-up care after a 5150 is greatly affected by where the patient is discharged from and whether that patient was undergoing treatment for a mental health condition prior to hospitalization. Patients discharged from an inpatient psychiatric hospital may have faster access to outpatient follow-up care since they are already connected to a mental health provider network; similarly, patients are more likely to have a timely appointment (i.e., within 48 hours) if they already have an established treatment relationship with a mental health professional. Patients who do not meet these two conditions are often instructed to schedule appointments with mental health providers and are sometimes assisted by hospital navigators but must often wait 30 to 60 days for an available appointment.[8] Once a patient is released from a 5150 hold, they generally have the right to choose if they want follow-up treatment or not; an

[6] Otherwise known as a 5250 (Welfare and Institutions Code).
[7] OPA. *Follow-up Visit Within 7 Days After Mental Illness Hospital Stay* and *Follow-up Visit Within 30 Days After Mental Illness Hospital Stay*. Available at: https://reportcard.opa.ca.gov/rc/HMO_PPO_combinedMeasure.aspx?Category=HMO_PPOHEDIS&Topic=MentalHealthCare&Measure=FollowupVisitAfterMentalIllnessHospitalStay7 and https://reportcard.opa.ca.gov/rc/HMO_PPO_combinedMeasure.aspx?Category=HMO_PPOHEDIS&Topic=MentalHealthCare&Measure=FollowupVisitAfterMentalIllnessHospitalStay30. Accessed March 18, 2022.
[8] Personal communication with content expert Lorin Scher, MD. (March 18, 2020).

exception is for court-ordered assisted outpatient treatment (AOT) for seriously mentally ill persons at substantial risk of deterioration as a direct result of poor psychiatric treatment compliance.[9]

[9] Welfare and Institutions Code (WIC) Sections 5345 – 5349.5, known as Laura's Law.

POLICY CONTEXT

Bill-Specific Analysis of AB 1859, Mental Health Services

AB 1859 addresses health plan/insurer approval of mental health services for persons who are involuntarily detained for a 72-hour treatment and evaluation hold, generally in a psychiatric hospital, when they, as a result of a mental health disorder, are a danger to others, or themselves, or gravely disabled. This is commonly referred to as a "5150" hold based on the relevant California code number.[10] These holds are intended to stabilize the person and reduce the risk that they will harm themselves or someone else. Although the person cannot be required to attend outpatient mental health appointments after release from a 5150 hold, prompt follow up with outpatient mental health providers after discharge from a psychiatric hospitalization is important for maintaining continuity of treatment and preventing repeat hospitalizations (Holt, 2018).

The bill requires health care service plans and health insurance policies regulated by the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) in effect as of January 1, 2023, that include coverage for mental health services to:

1. Approve the provision of mental health services for enrollees/insureds who are detained for 72-hour treatment and evaluation (a 5150 hold).
2. Schedule an initial outpatient appointment for the enrollee/insured described in #1 above with a licensed mental health professional scheduled for a date that is within 48 hours of the person's release from detention.
3. Ensure the location of the facilities providing the covered mental health services to the enrollee/insured described in #1 above be within reasonable proximity of the business or personal residences of the enrollee/insured.
4. Provide that the enrollee/insured described in #1 above who receives covered mental health services[11] from a noncontracting provider shall pay no more than the same cost-sharing amount as if the services were received from a contracting provider. At the time of payment by the plan to the noncontracting provider, inform them and enrollee/insured of the cost-sharing amount owed by the enrollee/insured.

The full text of AB 1859 can be found in Appendix A.

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Interaction With Existing Requirements

Health benefit mandates may interact and align with the following state and federal mandates or provisions.

[10] WIC section 5150 addresses the detention of mentally disordered persons for evaluation and treatment. Available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5150. Accessed April 1, 2022.

[11] AB 1859 defines covered mental health services as mental health services that are urgently needed to prevent serious deterioration of the enrollee's/insured's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee/insured can receive services from a contracting provider.

California Policy Landscape

California law and regulations

California's mental health parity law[12] was signed in 1999 and implemented in 2000. It requires coverage of the diagnosis and medically necessary treatment of severe mental illness (SMI) for enrollees of any age and of serious emotional disturbances (SED) of a child under the same terms and conditions applied to other medical conditions. SMI includes diagnoses of schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, and others. A child is identified as having an SED if they "(1) have one or more mental disorders identified in the most recent edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms" and (2) meet criteria specified in current law regarding substantial impairment as a result of their mental disorder.

Senate Bill 855 (Wiener, Mental Health Parity) passed in 2020 amends the existing California mental health parity law by expanding the mental health and substance use disorders (MH/SUD) required to be covered by plans and policies, defining medical necessity, and placing additional requirements on plans and policies. SB 855 requires: 1) coverage of treatment, when medically necessary, for any MH/SUD diagnosis identified in the most recent editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and the International Classification of Diseases (ICD); and 2) health plans and policies to cover out-of-network services delivered to enrollees based on billed charges (rather than a discounted allowed amount or negotiated price) immediately if the plan was not able to provide in-network services in a timely manner based upon existing DMHC or CDI geographic access and timeliness requirements.

A comprehensive list of California's mandates regarding mental health benefits and other health mandates in current law is included in CHBRP's resource *Health Insurance Benefit Mandates in California State and Federal Law*.[13] In most instances, the California mental health parity act supersedes these mandates with more restrictive requirements.

Additionally, DMHC-regulated plans and most small-group and individual market CDI-regulated policies[14] are required to cover Basic Health Care Services, which include inpatient care, physician services, laboratory tests, preventive care, mental health care, and emergency care, and must be covered regardless of a patient's diagnosis.[15]

AB 2179 (Cohn), Chapter 797, Statutes of 2002, directed DMHC and CDI to adopt regulations to ensure enrollee access to necessary health care services in a timely manner. These timely access standards and network adequacy requirements are addressed in the California Health and Safety Code and the California Code of Regulations, as well as in the Insurance Code.[16] If care following release after detention from a 5150 hold requires urgent care access, the timely access standards are 2 days if prior authorization is not required by the health plan and 4 days if prior authorization is required by the health plan; timely access for nonurgent care is 10 business days for mental health treatment with a nonphysician provider.[17] In addition, CDI requires access to mental health professionals within 30 minutes

[12] Health and Safety Code 1374.72; Insurance Code (IC) 10144.5.
[13] CHBRP's resource *Health Insurance Benefit Mandates in California State and Federal Law* is available at http://chbrp.org/other_publications/index.php#revize_document_center_rz44.
[14] Small-group and individual market CDI-regulated policies subject to the Essential Health Benefits (EHBs) are subject to Basic Health Care Services because the chosen EHB benchmark plan is regulated by DMHC.
[15] IC 10112.27(a)(2)(A)(i); 28 CCR 1300.67.
[16] Health and Safety Code sections 1367.03 and 1367.035, and title 28 of the California Code of Regulations, section 1300.67.2.2, subsections (g)(2) and (g)(2)(G); IC 10133.54.
[17] DMHC. *Timely Access to Care*. Available at: https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccesstoCare.aspx. Accessed April 1, 2022.

or 15 miles of a covered person's residence or workplace,[18] while DMHC does not have such geographic access requirements for mental health professionals.

AB 457 (Santiago, Protection of Patient Choice in Telehealth Provider Act) was enacted in 2021, and its provisions include that health plans/insurers 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.

Section 1367.005 of the Health and Safety Code outlines Essential Health Benefits (EHBs) under the Affordable Care Act for an individual or small group health care service plan. Mental health services are one of the 10 EHBs under federal law.

Similar requirements in other states

While several other states also have mental health parity laws, CHBRP is unaware of similar requirements or similar proposed legislation in other states related to the other AB 1859 provisions.

Federal Policy Landscape

Federal Mental Health Parity and Addiction Equity Act

The federal Mental Health Parity and Addiction Equity Act (MHPAEA) addresses parity for mental health benefits.[19] The MHPAEA requires that if mental health or substance use disorder (SUD) services are covered, cost-sharing terms and treatment limits be no more restrictive than the predominant terms or limits applied to medical/surgical benefits. The MHPAEA applies to the large-group market, but the Affordable Care Act (ACA) requires small-group and individual market plans and policies purchased through a state health insurance marketplace to comply with the MHPAEA. This federal requirement is similar to the California mental health parity law,[20] although the state law applies to some plans and policies not subject to the MHPAEA.

Affordable Care Act

A number of Affordable Care Act (ACA) provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how AB 1859 may interact with requirements of the ACA as presently exists in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).[21,22]

Any changes at the federal level may impact the analysis or implementation of this bill, were it to pass into law. However, CHBRP analyzes bills in the current environment given current law and regulations.

The ACA extended the parity requirements of the MHPAEA to nongrandfathered plans and policies in the small-group and individual markets.

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[18] CDI. *Provider Network Adequacy*. Available at: http://www.insurance.ca.gov/01-consumers/110-health/10-basics/pna.cfm. Accessed April 1, 2022.
[19] Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the ACA.
[20] H&SC Section 1374.72; IC Section 10144.5 and 10123.15.
[21] The ACA requires nongrandfathered small-group and individual market health insurance — including but not limited to Qualified Health Plans (QHPs) sold in Covered California — to cover 10 specified categories of EHBs. Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website: www.chbrp.org/other_publications/index.php.
[22] Although many provisions of the ACA have been codified in California law, the ACA was established by the federal government, and therefore, CHBRP generally discusses the ACA as a federal law.

Essential Health Benefits

Mental health services are one of the 10 EHBs. Health plans and insurers that are required to cover EHBs must meet the MHPAEA (described above), which previously did not apply to the individual market and small-group markets in California. Because mental health services are an EHB category, AB 1859 would not require coverage for a new state benefit mandate that appears to exceed the definition of EHBs in California.

Analytic Approach and Key Assumptions

The main provisions of AB 1859 are listed below, along with CHBRP's approach/assumptions for each:

1. *Approve the provision of mental health services for enrollees/insureds who are detained for 72-hour treatment and evaluation (a 5150 hold).*

   CHBRP assumes this provision applies to outpatient services after the 72-hour hold ends. Based on an analysis of current practice, CHBRP has determined that all plans and insurers are currently in compliance with this provision. Therefore, this provision is not expected to have a change in health plan/insurer or provider activities.[23]

2. *Schedule an initial outpatient appointment for the enrollee/insured described in #1 above with a licensed mental health professional scheduled for a date that is within 48 hours of the person's release from detention*.

   CHBRP assumes that patients and families, as well as providers (especially inpatient facilities), and some health plans/insurers currently are involved to some degree in scheduling follow-up outpatient appointments.[24] CHBRP assumes this provision applies only to scheduling the visit and does not require any efforts by the health plan/insurer to ensure the follow-up visit is attended. When scheduling these appointments becomes the responsibility of health plans/insurers, per this provision of AB 1859, CHBRP assumes they will incur an additional administration cost for scheduling visits, as stated in survey responses from several health plans. The increased demand for outpatient mental health services due to COVID-19 was also noted in the survey responses of several health plans, making the requirement of scheduling follow-up visits within 48 hours of discharge postmandate more challenging.

3. *Ensure the location of the facilities providing the covered mental health services to the enrollee/insured described in #1 above be within reasonable proximity of the business or personal residences of the enrollee/insured*.

   Both CDI and DMHC require reasonable geographic proximity of services.

   While AB 1859 is silent on whether a telehealth visit would meet its requirements, in response to CHBRP's carrier survey, several health plans said that given the difficulty in scheduling mental health outpatient visits, they would consider either an in-person or a telehealth visit as meeting the requirement of the bill. CHBRP also surveyed California regulators regarding this issue. DMHC indicated that health plans could meet the bill's requirement for scheduling an outpatient appointment within reasonable proximity via telehealth if telehealth services are appropriately provided.

4. *Provide that the enrollee/insured described in #1 above who receives covered mental health services from a noncontracting provider shall pay no more than the same cost-sharing amount as if the services were received from a contracting provider. At the time of payment by the plan to*

[23] Per responses from CHBRP's survey of health plans and insurers, as well as CHBRP's content expert.
[24] CHBRP is not aware if plans/insurers are routinely notified by hospitals that an enrollee/insured has been admitted for an involuntary hold and is expected to be discharged within 72 hours of the hold commencing.

the noncontracting provider, inform them and enrollee/insured of the cost-sharing amount owed by the enrollee/insured.

CHBRP assumes that this provision reduces cost sharing for the enrollees/insureds who see out-of-network providers for their follow-up outpatient visit. DMHC indicated there is a precedent for this type of cost-sharing provision since existing timely access regulations require plans to arrange for covered, non-emergency services with a contracting provider if a contracting provider is unavailable within the required timeframe. Per DMHC, when an enrollee is referred to a noncontracting provider in this scenario, the plan must ensure that the enrollee's costs for services with the noncontracting provider do not exceed the enrollee's applicable in-network cost-sharing amount. DMHC also referenced AB 72 (Bonta, 2016), which protects enrollees from balance billing for certain non-emergency services received at a contracting facility. Per DMHC, when an enrollee receives covered services from a contracting facility at which, or as a result of which, the enrollee receives services from a noncontracting provider, the enrollee's financial responsibility is limited to the in-network cost-sharing amount.

Prevalence of Involuntary Holds in California

The California Department of Health Care Services (DHCS) reports annual data regarding the number and rate of 72-hour involuntary detentions (i.e., 5150 holds) for the state each fiscal year.[25] Statewide totals and rates of 72-hour involuntary detentions in fiscal year (FY) 2018-2019[26] are presented in Table 1; results are shown separately for children aged 17 years and younger and adults aged 18 years and older. As shown in Table 1, adults in California had almost twice the rate of 5150s as compared with children.

These detention totals reflect the total number of 5150s reported to DHCS each year, not the number of individuals who had a 5150, which studies suggest may be substantially lower than the number of reported 5150s due to the high frequency of repeat detentions among this population.

Table 1. 72-Hour Involuntary Detentions in California by Age Group, Fiscal Year 2018-2019

Age Group	Rate/10,000 Californians	Number of 72-Hour Detentions
Adults (age 18+)	38.2	114,211
Children (ages 17 and younger)	22.3	21,952

Source: California Department of Health Care Services, 2022.

Populations at Risk for Involuntary Holds

A retrospective study of 251 adult patients with 72-hour involuntary psychiatric holds in an ED at a large tertiary care center in Florida found that persons with a preexisting psychiatric disorder alone or persons presenting with both a psychiatric disorder and an SUD accounted for over 85% of involuntary holds (51.4% and 34.3%, respectively), followed by persons with an SUD alone (9.2%). Persons without a preexisting psychiatric disorder or SUD accounted for a small proportion of patients on involuntary holds (5.2%) (Lachner et al., 2020). Depression was the most common psychiatric disorder and alcohol the most common SUD; suicidal ideation was the reason for involuntary hold in almost three quarters (73.3%) of patients in the analysis (Lachner et al., 2020; Roy et al., 2019).

[25] Data are inclusive of public and private institutions and for all persons with a 5150, regardless of insurance type.
[26] This is the most recent fiscal year for which complete data are available. California Involuntary Detentions Data Report Fiscal Year (FY) 2019/2020, DHCS, https://www.dhcs.ca.gov/Documents/CSD_YV/MHSA/IDR/IDR-FY1920.pdf, accessed April 1, 2022.

Co-occurring SMI and SUD are commonly observed among persons with an involuntary hold. In the United States, almost 40% of the 20 million adults with a SUD reported a mental illness, and almost 20% of the 42 million adults with a mental illness reported a co-occurring SUD (NIDA, 2018). In California, an analysis of 2015 national mental health outcome measures reported to SAMHSA found that 34.4% of adults and 9.2% of children who were utilizing county mental health services had co-occurring SMI/SED and SUD (Holt, 2018).

Outpatient Mental Health Treatment Post Discharge

Insurance Type

The California Health Care Foundation estimated that, in 2015, 50% to 72% of persons aged 6 years and older with commercial insurance in California had access to an outpatient mental health appointment within 7 days after discharge for a psychiatric hospitalization and 68% to 83% had access to an outpatient appointment within 30 days of discharge.[27] Corresponding estimates of follow-up appointments among persons using Medi-Cal specialty mental health services suggest that timely access to outpatient mental health appointments after a psychiatric discharge may be lower among Medi-Cal recipients: 40% to 58% of adults and children reported receiving a follow-up appointment within 7 days of discharge and 58% to 75% had a follow-up appointment within 30 days of discharge (Holt, 2018).

The percentage of nonphysician mental health/SUD professionals accepting insurance is unknown; however, one study reported that 77% of California psychiatrists responding to a survey about health insurance acceptance had any patients with private health insurance, 55% of respondents had any Medicare patients, and 46% of respondents had any Medi-Cal patients (Coffman et al., 2018).

Mental Health Workforce Supply in California

Coverage does not guarantee access to care for mental health/SUD. Access is also affected by the supply of providers. Among people with mental health/SUD who were seeking care, lack of provider access was a key reason cited for unmet need. Coffman et al. (2018) reported that California had 80,000 behavioral health professionals in 2016 who were disproportionately distributed across the state (measured by per capita ratios). In particular, the San Joaquin Valley and Inland Empire had supplies per capita that were far below the state per capita average ratio. Professionals include psychiatrists, psychologists, licensed social workers (LCSW), licensed marriage and family therapists (LMFT), licensed professional clinical counselors (LPCC), psychiatric mental health nurse practitioners, and psychiatric nurses.

Coffman et al. (2018) projected that — assuming current trends continue — “California will have 50% fewer psychiatrists than will be needed to meet both current patterns of demand and unmet demand for behavioral health services. California will have 28% fewer psychologists, LMFTs, LPCCs, and LCSWs combined to meet both current patterns of demand and unmet demand for behavioral health services” by 2028 (Coffman et al., 2018). Recent attention to the issue of unmet need for mental health care has resulted in the establishment of Governor Newsom’s Behavioral Health Task Force and monies earmarked for mental health workforce pipeline development (Coffman et al., 2019).

Provision of Services via Telehealth

There has been a rapid increase in the use of telehealth services since the COVID pandemic began in March 2020. A Kaiser Family Foundation (KFF) study showed that while telehealth was covered by many employer health plans prior to the pandemic, utilization was relatively low, accounting for less than 1% of

[27] More recent estimates of 7-day and 30-day follow-up appointments after a mental health hospitalization are available for the commercially insured population and are presented in the *Policy Context* section of the report.

outpatient visits for both mental health and SUD and other concerns.[28] KFF found that for the March-August 2020 period, 40% of mental health or SUD outpatient visits were via telehealth, with the rate declining slightly to 36% for the March-August 2021 period. Milliman estimated that 0.3% of outpatient psychiatric visits were conducted by telehealth In 2019 versus 27.0% in 2020.

Disparities[29] and Social Determinants of Health[30] in Persons at Risk for Involuntary Holds in California

Disparities are differences between groups that are modifiable. There are significant disparities in the prevalence of mental health/SUD and use of treatment services by race, gender, age, income, and geographic region. Examples include significantly higher rates of SMI in California Native American (7.0%) and African American (5.8%) populations than in the Asian, Pacific Islander, or white populations (1.7%, 2.4%, and 4.2%, respectively) (Holt, 2018). Similarly, 9.0% of adults earning less than 100% of the Federal Poverty Level (FPL) reported SMI as compared with 1.9% of adults who earned more than 300% of the FPL. Disparities in suicides are evident by race/ethnicity as well as region: rates are highest among whites and Native Americans (18 per 100,000 and 16 per 100,000, respectively) as compared with Hispanics (4 per 100,000), and about twice as high in Northern California (21 per 100,000) as compared with the rest of the state (10 per 100,000) (Holt, 2018). In addition, while reflecting older data prior to the Medi-Cal expansion, an analysis of all adult ED encounters with primary psychiatric complaints from 2009 to 2014 in California found that persons exhibiting frequent use patterns (i.e., four or more visits per year) similar to the 5150 population are significantly more likely to be male, younger than age 50, and have Medi-Cal or Medicare coverage (Moulin et al., 2018).

[28] Kaiser Family Foundation. Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic, March 15, 2022. https://www.kff.org/coronavirus-covid-19/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/, accessed April 1, 2022.
[29] Several competing definitions of "health disparities" exist. CHBRP relies on the following definition: Health disparity is defined as the differences, whether unjust or not, in health status or outcomes within a population (Wyatt et al., 2016).
[30] CHBRP defines social determinants of health as conditions in which people are born, grow, live, work, learn, and age. These social determinants of health (economic factors, social factors, education, physical environment) are shaped by the distribution of money, power, and resources and impacted by policy (adapted from: CDC, 2014; Healthy People 2020, 2019). See CHBRP's SDoH white paper for further information: http://chbrp.com/analysis_methodology/public_health_impact_analysis.php.

POPULATION AFFECTED

If enacted, AB 1859 would apply to the health insurance of approximately 14,776,000 enrollees (38% of all Californians). This represents 64% of the 22,810,000 million Californians who will have health insurance regulated by the state that may be subject to any state health benefit mandate law, which includes health insurance regulated by DMHC or CDI. If enacted, the law would apply to the health insurance of enrollees in DMHC-regulated plans and CDI-regulated policies, exempting DMHC-regulated Medi-Cal managed care plans.

CHBRP estimates based on 2018-2019 data that there are 50,985 enrollees who are subject to AB 1859 and would have a 72-hour treatment and evaluation hold at baseline.[31]

[31] DHCS, California Involuntary Detentions Data Report Fiscal Year (FY) 2019/2020, https://www.dhcs.ca.gov/Documents/CSD_YV/MHSA/IDR/IDR-FY1920.pdf, accessed April 1, 2022.

SUMMARY OF COST, PUBLIC HEALTH, AND LONG-TERM IMPACTS

2020 Analysis for AB 2242

In 2020, CHBRP analyzed AB 2242 (Levine): Mental Health Services, with language identical to that of AB 1859 except for the effective date. **CHBRP did not complete a comprehensive cost, public health, or long-term analysis for AB 1859.** There are three studies that inform the medical effectiveness review published since the 2020 report was completed, as well as an updated analysis of timing of outpatient visits following an inpatient psychiatric stay of three days or less. **Therefore, CHBRP is focusing its abbreviated analysis of AB 1859 primarily on an updated medical effectiveness review and the updated analysis on the timing of outpatient visits.**

A brief summary of the cost, public health, and long-term impacts from the 2020 report on AB 2242 is shown below. In the 2020 report,[32] CHBRP estimated:

- No change in benefit coverage due to the bill, with 100% of enrollees estimated to have coverage for 72-hour treatment and evaluation holds and 100% to have coverage for follow-up visits after the 72-hour hold at baseline and postmandate.
- 59,200 enrollees who would be subject to the bill and detained for 72-hour treatment and evaluation holds at baseline, as well as postmandate (no change).
- An increase in total net annual expenditures of $1,559,000, or about 0.001%, for enrollees with DMHC-regulated plans and CDI-regulated policies. This was due to an increase in total health insurance premiums paid by employers and enrollees, adjusted by a decrease in enrollee expenses for covered benefits.
- For public health impacts, an increase in the number of people with commercial insurance who would receive an outpatient appointment within 48 hours of discharge would increase but the impacts of this on ED visits, hospital readmission, or suicide are unknown due to insufficient, inconclusive, or limited evidence.
- Long-term utilization and cost impacts would likely be similar in subsequent years as in the first year postmandate.

2022 Analysis for AB 1859

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

CHBRP estimated the timeframes for follow-up appointments for individuals who had an inpatient psychiatric admission with a length of stay ≤ 3 days using the same methodology[33] as used in the AB 2242 report, but updated using 2019 data (see Table 2). This analysis shows declines in the proportion of individuals meeting these criteria who had a follow-up appointment within 48 hours, 3-30 days, and within 90 days; there was a decline from 63% having an outpatient follow-up visit within 90 days in 2017, to 49% in 2019. A second analysis using the 2019 data included additional inpatient diagnoses related to suicide

[32] Available on CHBRP website at: https://chbrp.org/completed_analyses/index.php?billno=2242&year=&author=&keywords=

[33] For the 2020 report on AB 2242, Milliman analyzed inpatient hospital data using a set of diagnoses associated with individuals who have a 5150 hold and at least one subsequent psychiatric outpatient follow-up visit after an inpatient stay of three days or less. This approach was used because 5150 or involuntary admission status is not captured in the Milliman database.

and additional types of mental health professionals beyond psychiatrists (e.g., psychologists). This analysis shows 54% of individuals meeting these new criteria having an outpatient follow-up visit within 90 days.

Table 2. Proportion of Inpatient Psychiatric Admissions with Length of Stay ≤ 3 days with Outpatient Follow-Up Visit by Follow-Up Time

Outpatient Visit Follow-Up Time	Proportion of Inpatient Admissions		
	2017 Data (From AB 2242 Analysis)	2019 Data (Same Method as AB 2242 Analysis)	2019 Data (Expanded Definition of Inpatient Admissions and Outpatient Follow-Up Visits)
In days 0-2 (48 hours)	24%	19%	20%
In days 3-30	31%	22%	26%
In days 31-60	6%	5%	5%
In days 61-90	2%	3%	3%
Subtotal: 0-90 days	*63%*	*49%*	*54%*
No outpatient follow-up visit (within 90 days)	37%	51%	46%
Total	**100%**	**100%**	**100%**

Source: Milliman's 2019 Consolidated Health Cost Guidelines™ Sources Database, 2022.

MEDICAL EFFECTIVENESS

The medical effectiveness review summarizes findings from evidence on the impact of follow-up outpatient mental health services after discharge from inpatient mental health treatment and evaluation.

Research Approach and Methods

Studies of follow-up outpatient mental health services were identified through searches of PubMed, the Cochrane Library, Web of Science, Embase, Scopus, the Cumulative Index of Nursing and Allied Health Literature, and PsycINFO. Websites maintained by the following organizations that produce and/or index meta-analyses and systematic reviews were also searched: the Agency for Healthcare Research and Quality (AHRQ), the International Network of Agencies for Health Technology Assessment (INAHTA), the National Health Service (NHS) Centre for Reviews and Dissemination, the National Institute for Health and Clinical Excellence (NICE), and the Scottish Intercollegiate Guideline Network.

The search was limited to abstracts of studies published in English from 2020 to present. For studies published prior to 2020, CHBRP relied on the literature search conducted in 2020 for the report on AB 2242, a prior bill regarding coverage for outpatient care following an involuntary psychiatric hold.

Of the 40 recently published articles found in the literature review conducted for AB 1859, four were reviewed for potential inclusion in this report and **three studies were included in the medical effectiveness review**. The other articles were eliminated because they did not focus on follow-up outpatient mental health services, were of poor quality, or did not report findings from clinical research studies. The six studies previously included in the medical effectiveness review for AB 2242 were also reconsidered given their relevance to AB 1859. CHBRP included two systematic reviews in the AB 2242 report (Sfetcu et al., 2017; Vigod et al., 2013) and four additional studies of the impact of outpatient care following discharge from inpatient psychiatric care published after the studies included in the Sfetcu et al. (2017) systematic review (Beadles et al., 2015; Busch et al., 2015; Marcus et al., 2017; Trask et al., 2016). A more thorough description of the methods used to conduct the medical effectiveness review and the process used to grade the evidence for each outcome measure is presented in Appendix B.

The conclusions below are based on the best available evidence from peer-reviewed and grey literature. Unpublished studies are not reviewed because the results of such studies, if they exist, cannot be obtained within the 60-day timeframe for CHBRP reports.

Key Questions

1. Is there evidence that receiving follow-up outpatient mental health services, after discharge from an involuntary 5150 psychiatric hold, improves mental health outcomes?
2. Is there evidence that scheduling appointments for follow-up outpatient visits after discharge from an involuntary psychiatric hold increases the percentage of patients who attend follow-up appointments?
3. Is there evidence that having access to follow-up outpatient mental health services in close proximity to the patient's business or residence increases use of mental health services or improves mental health outcomes?
4. Is there evidence that lower cost sharing for follow-up outpatient mental health services increases the use of mental health services or improves mental health outcomes relative to higher cost sharing?

Methodological Considerations

CHBRP did not identify any studies that exclusively assess the impacts of follow-up outpatient visits on people who were placed on an involuntary psychiatric hold. The studies of people admitted for inpatient psychiatric care do not distinguish between people who are hospitalized involuntarily or voluntarily. Findings for people who are hospitalized voluntarily may differ from findings for people subject to psychiatric holds because the former may be more aware of their mental health needs and more willing to seek treatment regardless of the setting in which it is provided.

In addition, few studies of outpatient visits following discharge from inpatient psychiatric care are conducted among commercially insured populations in the United States. Some studies are conducted in other countries whose mental health systems and cultural norms may differ from those in the United States. Many U.S. studies are conducted among Medicaid beneficiaries, Medicare beneficiaries, and veterans who obtain care at Department of Veterans Affairs (VA) health care facilities. Findings from studies of these populations may not be generalizable to the population whose coverage would be affected by AB 1859 because they are older (Medicare), have lower incomes (Medicaid), and are more likely to have disabilities (veterans).

Outcomes Assessed

This literature review focuses on the potential impact of AB 1859 on a variety of measures including hospital readmissions, ED visits, medication adherence, use of mental health services, and mental health outcomes. CHBRP did not find any studies that assessed the impact of access to outpatient providers in close proximity or reduction in cost sharing for outpatient visits on mental health outcomes.

Study Findings

This following section summarizes CHBRP's findings regarding the strength of evidence about the effectiveness of follow-up outpatient mental health services addressed by AB 1859. Each section is accompanied by a corresponding figure. The title of the figure indicates the test, treatment, or service for which evidence is summarized. The statement in the box above the figure presents CHBRP's conclusion regarding the strength of evidence about the effect of a particular test, treatment, or service based on a specific relevant outcome and the number of studies on which CHBRP's conclusion is based. Definitions of CHBRP's grading scale terms is included in the box below, and more information is included in Appendix B.

The following terms are used to characterize the body of evidence regarding an outcome:

Clear and convincing evidence indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

Preponderance of evidence indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.

Limited evidence indicates that the studies have limited generalizability to the population of interest and/or the studies have a fatal flaw in research design or implementation.

Inconclusive evidence indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

Insufficient evidence indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

More information is available in Appendix B.

The Impact of Timely Mental Health Outpatient Visits on Use of Mental Health Services

Impact on Hospital Readmissions

CHBRP did not find any new studies on the impact of receipt of mental health outpatient follow-up services after discharge from an inpatient psychiatric hospitalization on hospital readmission. The CHBRP report on AB 2242 found one systematic review (Sfetcu et al., 2017) and four studies that examined the impact of receipt of mental health outpatient follow-up services after discharge from an inpatient psychiatric hospitalization on readmission (Beadles et al., 2015; Busch et al., 2015; Marcus et al., 2017; Trask et al., 2016). All of these studies examined the use of follow-up outpatient visits by persons discharged from an inpatient psychiatric hospitalization regardless of whether the hospitalization was voluntary or involuntary. In the systematic review, five studies examining readmission were inconsistent. Four additional studies of the impact of outpatient care following discharge from inpatient psychiatric care published after the studies included in Sfetcu et al.'s (2017) systematic review (Beadles et al., 2015; Busch et al., 2015; Marcus et al, 2017; Trask et al., 2016) found inconclusive evidence that receipt of mental health outpatient follow-up services after discharge from an inpatient psychiatric hospitalization reduced hospital readmission.

Summary of findings regarding the impact of timely mental health outpatient visits on hospital readmissions: There is *inconclusive evidence* that timely mental health outpatient visits reduce hospital readmissions based on nine studies. The study that examined the population that is most similar to the population whose coverage would be affected by AB 1859 found that receipt of follow-up outpatient care within 30 days of discharge was associated with a reduction in the odds of readmission for psychiatric care but that there was no statistically significant difference in odds of readmission between people who received follow-up outpatient care within seven days of discharge and people who did not receive follow-up care within seven days of discharge (Beadles et al.,2015).

Figure 1. Impact of Timely Mental Health Outpatient Visits on Hospital Readmissions

Impact on Emergency Department Visits

CHBRP's literature search for AB 2242 concluded that there is insufficient evidence regarding the impact of follow-up care with a mental health provider after a psychiatric hospitalization on ED visits. The only study identified on this topic (Beadles et al., 2015). found no statistically significant difference in the number of ED visits among people receiving follow-up care with a mental health provider within 7 days versus within 8 to 30 days versus people who did not receive follow-up care within 30 days of discharge.

CHBRP's literature search for AB 1859 did not identify any additional studies of the impact of follow-up mental health care after a psychiatric hospitalization on ED visits.

Summary of findings regarding the impact of timely mental health outpatient visits on emergency department visits: There is *insufficient evidence* that timely follow-up care with a mental health provider

reduces ED visits based on one study. The absence of evidence is not an indication that follow-up outpatient visits do not affect ED visits; it is an indication that the impact is unknown.

Figure 2. Impact of Timely Mental Health Outpatient Visits on Emergency Department Visits

Impact on Medication Adherence

CHBRP literature search for AB 2242 concluded that there is insufficient evidence regarding the impact of follow-up outpatient visits after a psychiatric hospitalization on adherence to medications used to treat mental illness. The only study identified (Beadles et al., 2015) concluded that people with depression or schizophrenia who received follow-up outpatient care within 0 to 7 days of discharge or 8 to 30 days of discharge were more likely to fill any prescription for an antidepressant or antipsychotic medication than people who received no follow-up outpatient care within 30 days of discharge. However, there were no statistically significant differences in the percentage of days of medication covered by an insurance claim during the 6 months following discharge.

CHBRP's literature search for AB 1859 did not identify any additional studies of the impact of follow-up mental health care after a psychiatric hospitalization on medication adherence.

Summary of findings regarding the impact of timely mental health outpatient visits on medication adherence: There is *insufficient evidence* that timely follow-up care with a mental health provider improves medication adherence based on one study. The absence of evidence is not an indication that follow-up outpatient visits do not improve medication adherence; it is an indication that the impact is unknown.

Figure 3. Impact of Timely Mental Health Outpatient Visits on Medication Adherence

The Impact of Timely Mental Health Outpatient Visits on Mental Health Outcomes

Impact on Suicides

CHBRP's literature search for AB 1859 identified **one recent study** that examined timely follow-up visits after inpatient psychiatric discharge on suicide risk in children and adolescents (Fontanella et al., 2020). In this study of 139,694 youths admitted to a psychiatric hospital, the authors reported that having an outpatient visit within 7 days of a psychiatric discharge was associated with a significantly reduced risk of suicide during the 8 to 180 days following discharge. No studies of the impact of follow-up visits on suicide risk among adults were identified.

Summary of findings regarding the impact of timely mental health outpatient visits on mental health outcomes: There is *insufficient evidence,* based on one study (Fontanella et al., 2020), that timely follow-up care with a mental health provider improves mental health outcomes. The absence of evidence

is not an indication that follow-up outpatient visits do not affect mental health outcomes; it is an indication that the impact is unknown.

Figure 4. Impact of Timely Mental Health Outpatient Visits on Mental Health Outcomes

The Impact of Scheduling Follow-up Outpatient Visits on Use of Mental Health Services

Impact on Follow-up Outpatient Visits

CHBRP's literature search for AB 1859 identified **one recent study** (Smith et al., 2020) that examined 15,520 patients with inpatient psychiatric discharges to determine associations between scheduling an outpatient mental health appointment as part of the discharge plan and attending an outpatient visit within 7 and 30 days following discharge. The proportions of patients attending outpatient visits within 7 and 30 days were 43% and 65%, respectively, for patients who had appointments scheduled prior to discharge compared to 23% and 39%, respectively, for patients who did not have appointments scheduled as part of their discharge plans. Additionally, when the authors created propensity scores to control for factors affecting the likelihood of attending a follow-up appointment (e.g., being homeless, having a substance use disorder), they found patients who had an outpatient appointment scheduled as part of their discharge plan were still significantly more likely to attend an outpatient visit within 7 days (OR = 1.69; 95% CI, 1.48-1.94; P < .0001) and 30 days (OR = 1.65; 95% CI, 1.42-1.93; P < .0001) of hospital discharge compared to those who did not have an appointment scheduled as part of their discharge plan.

Summary of findings regarding the impact of scheduling timely mental health outpatient visits on the use of follow-up outpatient services: There is *insufficient evidence,* based on one study (Smith et al., 2020), that timely follow-up care with a mental health provider increases the use of outpatient services. The absence of evidence is not an indication that scheduling follow-up outpatient visits does not affect the use of outpatient services; it is an indication that the impact is unknown.

Figure 5. The Impact of Scheduling Timely Mental Health Outpatient Visits on the Use of Follow-Up Outpatient Services

Impact on Hospital Readmissions

In a systematic review of 13 studies, Vigod et al. (2013) examined the impact of interventions aimed at easing the transition from inpatient to outpatient mental health care on hospital readmission rates among adults with mental illness. Two studies included in the systematic review found that a telephone follow up asking about mental health status and visits with outpatient mental health providers significantly reduced hospital readmission rates and two studies in the systematic review found that efforts to ensure timely follow-up appointments significantly reduced hospital readmission rates. A study published after Vigod et al.'s systematic review (Habit et al., 2018) that analyzed readmission data, found that appointment follow-up reminder letters mailed to patients discharged from one inpatient psychiatric hospital resulted in a 1% decrease in 30-day readmission rates (10% versus 9%). However, this study did not have a comparison group and, thus, does not control for other factors that may have affected the readmission rate.

CHBRP's literature review for AB 1859 identified **one more recent study** (Adams et al., 2020) that compared eight patients in an intervention group who were called within 72 hours of discharge to reinforce discharge instructions and administer a health questionnaire to 16 control group patients discharged during the same timeframe with no follow-up telephone call. Although the findings were not statistically significant, four patients in the control group were readmitted or visited the ED within 30 days of discharge compared to zero in the intervention group.

Summary of findings regarding the impact of scheduling follow-up mental health outpatient visits on hospital readmissions: CHBRP found *inconclusive evidence* that scheduling mental health outpatient visits reduces hospital readmissions based on 13 studies included in the systematic review (Vigod et al., 2013) and two additional studies published after the studies included in the systematic review. The generalizability of findings from these studies to AB 1859 is uncertain because most of the interventions studied involved more than scheduling an outpatient visit.

Figure 6. The Impact of Scheduling Follow-Up Mental Health Outpatient Visits on Hospital Readmissions

The Impact of Distance from Providers on the Use of Mental Health Services

CHBRP's report on AB 2242 concluded that there is insufficient evidence regarding the impact of distance from a provider on use of mental health services. One study (Zulian et al. 2011) found that people who live closer to outpatient mental health facilities are more likely to use them. It is important to note that the population studied includes all people with mental health conditions, not just those who recently completed involuntary treatment and, thus, the findings may not fully generalize to health plan enrollees in California who were on a 5150 hold.

Summary of findings regarding the impact of distance from providers on the use of mental health services: There is *insufficient evidence* on the impact of distance on the use of mental health services based on one study. The absence of evidence is not an indication that proximity of providers does not affect use of mental health services; it is an indication that the impact is unknown.

Figure 7. The Impact of Distance from Providers on the Use of Mental Health Services

The Impact of Distance from Providers on Mental Health Outcomes

CHBRP did not identify any studies that address the effect of access to follow-up outpatient mental health services in close proximity to a patient's business or residence on mental health outcomes.

Summary of findings regarding the impact of distance from providers on mental health outcomes: There is *insufficient evidence* on the impact of proximity of follow-up outpatient mental health services to a patient's business or residence on mental health outcomes. The absence of evidence is not an

indication that proximity of mental health services does not affect mental health outcomes; it is an indication that the impact is unknown.

Figure 8. The Impact of Distance from Providers on Mental Health Outcomes

The Impact of Cost Sharing on the Use of Mental Health Services

CHBRP's literature review for AB 2242 identified two studies that examined the impact of copayments on the use of mental health services (Ndumele et al., 2011; Trivedi et al., 2008). Although these studies did not specifically examine cost sharing for out-of-network outpatient mental health services, their findings are relevant to AB 1859 because the bill would reduce cost sharing for covered mental health services from out-of-network mental health providers to the same level as cost sharing for in-network providers.

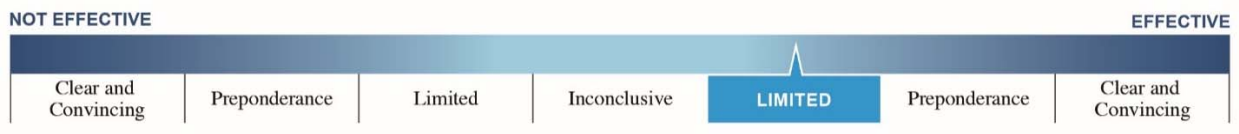
Trivedi et al. (2008) found that the percentage of Medicare beneficiaries who had an outpatient follow-up visit within 7 days or 30 days after a psychiatric hospitalization was greater among beneficiaries enrolled in plans with full parity compared with plans with no parity. This study also found a significant relationship between copayment costs and follow-up visits. Though less generalizable, Ndumele et al. (2011) by contrast, found little change in the use of mental health services after Medicare managed care plans implemented changes in copayments regardless of whether patients had recently been released from involuntary psychiatric treatment.

Multiple studies have examined the impact of reductions in cost sharing for mental health services among people with commercial health insurance that are associated with the establishment of laws or policies mandating parity in coverage for mental health and physical health services. These studies, which are discussed in greater detail in CHBRP's report on SB 855 (Wiener, Mental Health Parity),[34] have inconclusive findings regarding the impact of parity on the probability that enrollees will use any mental health services and a preponderance of evidence that numbers of visits increase among people who use mental health services. In addition, the most sweeping mental health parity mandate, the Mental Health Parity and Addiction Equity Act (MHPAEA), lifted quantitative limits on coverage (e.g., the number of outpatient visits covered) and nonquantitative limits on coverage (e.g., prior authorization, medical necessity review), in addition to mandating parity in cost sharing for mental health and physical health services. AB 1859 will have less impact than those two pieces of legislation because it only addresses cost sharing for out-of-network services for people discharged following a 5150 hold.

Summary of findings regarding the impact of cost sharing on the use of mental health services: There is *limited evidence* that reducing cost sharing for follow-up outpatient visits increases the rate at which people recently discharged from an involuntary psychiatric hold will utilize outpatient visits. Most studies of the impact of reductions in cost sharing for outpatient mental health services that have examined effects on people with commercial health insurance have not focused exclusively on people who were recently discharged from an involuntary psychiatric hold and are not able to isolate the effects of reductions in cost sharing from other changes in mental health benefits. CHBRP identified one study showing that lower cost sharing was associated with higher rates of use of outpatient mental health services following discharge from a psychiatric hospitalization, but the study was conducted among Medicare beneficiaries.

[34] See CHBRP's website: https://chbrp.org/completed_analyses/index.php?billno=855&year=&author=&keywords=

Figure 9. The Impact of Cost Sharing on the Use of Mental Health Services



The Impact of Cost Sharing on Mental Health Outcomes

CHBRP did not identify any studies that address the relationship between cost sharing for follow-up outpatient mental health services and mental health outcomes.

Summary of findings regarding the impact of cost sharing on mental health outcomes: There is *insufficient evidence* regarding the impact of cost sharing for mental health services on mental health outcomes. The absence of evidence is not an indication that cost sharing for mental health services does not affect mental health outcomes; it is an indication that the impact is unknown.

Figure 10. The Impact of Cost Sharing on Mental Health Outcomes

Summary of Findings

CHBRP's report on AB 2242 reached the following conclusions that are applicable to AB 1859.

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

- There is *insufficient evidence* to determine if reducing cost sharing for follow-up outpatient mental health services improves mental health outcomes.

CHBRP's review of more recent studies relevant to AB 1859 published after the report on AB 2242 yielded the following additional findings:

- There is *insufficient evidence* of effects of timely follow-up care with a mental health provider on suicide rates, a mental health outcome.
- There is *insufficient evidence* that scheduling timely follow-up care with a mental health provider increases the use of outpatient services.

APPENDIX A TEXT OF BILL ANALYZED

On February 16, 2022, the California Assembly Committee on Health requested that CHBRP analyze AB 1859.

ASSEMBLY BILL **NO. 1859**

Introduced by Assembly Member Levine

February 08, 2022

An act to add Section 1367.014 to the Health and Safety Code, and to add Section 10112.34 to the Insurance Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1859, as introduced, Levine. Mental health services.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include coverage for essential health benefits, which include mental health services.

Existing law, the Lanterman-Petris-Short Act, sets forth procedures for the involuntary detention, for up to 72 hours for evaluation and treatment, of a person who, as a result of a mental health disorder, is a danger to others or to themselves or is gravely disabled.

This bill would require a health care service plan or a health insurance policy issued, amended, or renewed on or after January 1, 2023, that includes coverage for mental health services to, among other things, approve the provision of mental health services for persons who are detained for 72-hour treatment and evaluation under the Lanterman-Petris-Short Act and to schedule an initial outpatient appointment for that person with a licensed mental health professional on a date that is within 48 hours of the person’s release from detention. The bill would prohibit a noncontracting provider of covered mental health services from billing the previously described enrollee or insured more than the cost-sharing amount the enrollee or insured would pay to a contracting provider for those services. Because a willful violation of the bill’s requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1367.014 is added to the Health and Safety Code, to read:

1367.014. (a) A health care service plan contract issued, amended, or renewed on or after January 1, 2023, that includes coverage for mental health services shall do all of the following:

(1) Approve the provision of mental health services for enrollees under the plan who are detained for 72-hour treatment and evaluation pursuant to Article 1 (commencing with Section 5150) of Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code.

(2) Schedule an initial outpatient appointment for the enrollee described in paragraph (1) with a licensed mental health professional. The appointment shall be scheduled for a date that is within 48 hours of the enrollee's release from detention.

(3) Ensure that the location of facilities providing the covered mental health services for the enrollee described in paragraph (1) be within reasonable proximity of the business or personal residences of the enrollee, and so located as to not result in unreasonable barriers to accessibility.

(4) (A) Provide that if an enrollee described in paragraph (1) receives covered mental health services from a noncontracting provider, the enrollee shall pay no more than the same cost-sharing amount that the enrollee would pay for the same covered services received from a contracting provider. This amount shall be referred to as the "in-network cost-sharing amount."

(B) An enrollee shall not owe the noncontracting provider more than the in-network cost-sharing amount for covered mental health services. At the time of payment by the plan to the noncontracting provider, the plan shall inform the enrollee and the noncontracting provider of the in-network cost-sharing amount owed by the enrollee.

(C) A noncontracting provider shall not bill or collect any amount from the enrollee for covered mental health services, except for the in-network cost-sharing amount.

(D) For purposes of this paragraph, covered mental health services are mental health services that are urgently needed to prevent serious deterioration of the enrollee's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee can receive services from a contracting provider.

(b) This section does not apply to Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 2. Section 10112.34 is added to the Insurance Code, to read:

10112.34. (a) A health insurance policy issued, amended, or renewed on or after January 1, 2023, that includes coverage for mental health services shall do all of the following:

(1) Approve the provision of mental health services for insureds under the policy who are detained for 72-hour treatment and evaluation pursuant to Article 1 (commencing with Section 5150) of Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code.

(2) Schedule an initial outpatient appointment for the insured described in subdivision (a) with a licensed mental health professional. The appointment shall be scheduled for a date that is within 48 hours of the insured's release from detention.

(3) Ensure that the location of facilities providing the covered mental health services for the insured described in paragraph (1) be within reasonable proximity of the business or personal residences of insureds, and so located as to not result in unreasonable barriers to accessibility.

(4) (A) Provide that if an insured described in paragraph (1) receives covered mental health services from a noncontracting provider, the insured shall pay no more than the same cost-sharing amount that the insured would pay for the same covered services received from a contracting provider. This amount shall be referred to as the "in-network cost-sharing amount."

(B) An insured shall not owe the noncontracting provider more than the in-network cost-sharing amount for covered mental health services. At the time of payment by the insurer to the noncontracting provider, the insurer shall inform the insured and the noncontracting provider of the in-network cost-sharing amount owed by the insured.

(C) A noncontracting provider shall not bill or collect any amount from the insured for covered mental health services, except for the in-network cost-sharing amount.

(D) For purposes of this paragraph, covered mental health services are mental health services that are urgently needed to prevent serious deterioration of the insured's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the insured can receive services from a contracting provider.

(b) This section does not apply to an insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code).

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

APPENDIX B LITERATURE REVIEW SPECIFICATIONS

This appendix describes methods used in the literature review conducted for this report. A discussion of CHBRP's system for medical effectiveness grading evidence, as well as lists of MeSH Terms, publication types, and keywords, follows.

Studies of follow-up outpatient mental health services were identified through searches of PubMed, the Cochrane Library, Web of Science, Embase, Scopus, the Cumulative Index of Nursing and Allied Health Literature, and PsycINFO. Websites maintained by the following organizations that produce and/or index meta-analyses and systematic reviews were also searched: the Agency for Healthcare Research and Quality (AHRQ), the International Network of Agencies for Health Technology Assessment (INAHTA), the National Health Service (NHS) Centre for Reviews and Dissemination, the National Institute for Health and Clinical Excellence (NICE), and the Scottish Intercollegiate Guideline Network.

The search was limited to abstracts of studies published in English from 2020 to present. For studies published prior to 2020, CHBRP relied on the literature search conducted in 2020 for the report on AB 2242, a previous bill regarding coverage for outpatient care following an involuntary psychiatric hold.

Reviewers screened the title and abstract of each citation retrieved by the literature search to determine eligibility for inclusion. The reviewers acquired the full text of articles that were deemed eligible for inclusion in the review and reapplied the initial eligibility criteria.

Medical Effectiveness Review

The medical effectiveness literature review returned abstracts for 44 articles, of which 8 were reviewed for inclusion in this report. A total of 10 studies were included in the medical effectiveness review for AB 2242: A total of 3 new studies since 2020 were included in the medical effectiveness review for AB 1859.

Medical Effectiveness Evidence Grading System

In making a "call" for each outcome measure, the medical effectiveness lead and the content expert consider the number of studies as well the strength of the evidence. Further information about the criteria CHBRP uses to evaluate evidence of medical effectiveness can be found in CHBRP's *Medical Effectiveness Analysis and Research Approach*.[35] To grade the evidence for each outcome measured, the team uses a grading system that has the following categories:

- Research design;
- Statistical significance;
- Direction of effect;
- Size of effect; and
- Generalizability of findings.

The grading system also contains an overall conclusion that encompasses findings in these five domains. The conclusion is a statement that captures the strength and consistency of the evidence of an intervention's effect on an outcome. The following terms are used to characterize the body of evidence regarding an outcome:

- *Clear and convincing evidence;*
- *Preponderance of evidence;*
- *Limited evidence;*

[35] Available at: http://chbrp.com/analysis_methodology/medical_effectiveness_analysis.php.

- *Inconclusive evidence;* and
- *Insufficient evidence.*

A grade of *clear and convincing evidence* indicates that there are multiple studies of a treatment and that the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective.

A grade of *preponderance of evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.

A grade of *limited evidence* indicates that the studies had limited generalizability to the population of interest and/or the studies had a fatal flaw in research design or implementation.

A grade of *inconclusive evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

A grade of *insufficient evidence* indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

Search Terms (* indicates truncation of word stem)

After Care

After Treatment

Appointment*

Appointments and Schedules

Community Mental Health Services

Continuity of Patient Care

Discharg*

Discharge Planning

Emergency Services, Psychiatric

Follow-up

Hospital Readmission

Hospital Discharge

Insurance

Mental Health

Mental Health Services

Mental Hospital

Mental Disorders

Mental Illness

Outcome Assessment, Health Care

Patient Discharge

Patient Handoff

Patient Readmission

Postdischarge

Post-discharge

Psychiatric Illness

Psychiatric Hospital Discharge

Readmission

Rehospitalization

Schedule*

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ABOUT CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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Please direct any questions concerning this document to: California Health Benefits Review Program; MC 3116; Berkeley, CA 94720-3116, info@chbrp.org, or www.chbrp.org