April 15, 2021

The Honorable Jim Wood
Chair, California Assembly Committee on Health
State Capitol, Room 6005
10th and L Streets
Sacramento, CA 95814

The Honorable Richard Pan
Chair, California Senate Committee on Health
State Capitol, Room 2191
10th and L Streets
Sacramento, CA 95814

Via E-mail only

Dear Assembly Member Wood and Senator Pan:

The California Health Benefits Review Program (CHBRP) was asked by Assembly Health Committee staff on March 26, 2021 to provide a letter regarding Assembly Bill 935 (Maienschein) *Telehealth: Mental Health*. CHBRP analyzed similar legislation in 2019. This letter details differences between the two bills and provides some updates to the information provided within CHBRP's prior analysis of AB 1676.

The February 17, 2021 version of AB 935 would require health plans regulated by the California Department of Managed Care (DMHC) and health insurers regulated by the California Department of Insurance (CDI) to provide access to a mental health consultation program for providers who treat children and pregnant and certain postpartum persons. This requirement is similar to what was proposed in a 2019 bill CHBRP analyzed, AB 1676 (Maienschein) *Health care: mental health*. As with AB 935, AB 1676 would have required plans and insurers to make such a program available. There are some differences between the two bills, however, as noted below:

- AB 935 would require access to a mental health consultation program with mental health clinicians including but not limited to psychiatrists, whereas AB 1676 would have required access to a psychiatrist;
- AB 935 would require the consultation to be by phone or video, whereas AB 1676 would not have made such a requirement; and
- AB 935 would require the consultation program to include a triage service and guidance on a range of evidence-based treatment options, screening tools, and referrals, whereas AB 1676 would not have made either of these requirements.

Below are findings from CHBRP's analysis of AB 1676, as well as updated information, that may be useful for consideration of AB 935.

Policy Context: In 2019, CHBRP was not aware of benefit mandates in other states requiring *plans or insurers* to establish a telepsychiatry consultation program for providers. However, Massachusetts had passed laws providing state funding for a psychiatric phone consultation program for providers who treat children[1] and separately for providers who treat pregnant and postpartum persons.[2] The Massachusetts Child Psychiatry Access Project (MCPAP) is for providers

who treat children, and MCPAP for Moms is for providers who treat pregnant and postpartum persons.

CHBRP is aware of two recent (2020-2021) state legislative initiatives related to mental health consultation programs for providers.

- A 2020 law[3] requires the Washington State Health Care Authority (HCA), in collaboration with the University of Washington, to continue implementing a psychiatry consultation line that provides emergency department providers, primary care providers, and county and municipal correctional facility providers with on-demand access to psychiatric and substance use disorder clinical consultation for adult patients. The program is funded by the state Medicaid program and the HCA, which must collect a proportional share of program costs from health carriers, self-funded multiple employer welfare arrangements, and employers or other entities that provide health care in the state.
- A 2021 bill[4] has been proposed that would require the New York State Office of Mental Hygiene to establish regional child psychiatry access projects across the state to provide primary care providers with timely access to child psychiatry consultations. The program would be funded by gifts on state personal income tax forms.

Several other initiatives related to pediatric and maternal mental health consultation programs for providers are described below.

- At the federal level, the Health Resources & Services Administration (HRSA), with funding from the 21st Century Cures Act, has provided five-year grants to states to create or expand programs focused on maternal mental health (7 states) and pediatric mental health (21 states).[5]
- MCPAP leadership created a program called Lifeline4Moms, which helps organizations develop, implement, evaluate, and sustain approaches for addressing perinatal mental health conditions.[6] Lifeline4Moms also works with organizations to secure further funding so more states can create programs similar to MCPAP for Moms and so current federally-funded programs can continue beyond their five-year funding. A 2020 report from Lifeline4Moms showed that 12 states (including the 7 funded by HRSA as described above) have implemented a perinatal psychiatry access program based on the MCPAP for Moms model and another 9 are developing such programs.[7] As examples, published articles describe provider-to-provider telepsychiatry consultation programs in Wisconsin[8] and Michigan.[9]
- Health care providers have access to a *perinatal* psychiatric consult line provided by Postpartum Support International (PSI).[10] This service is available to medical providers who have questions about mental health care related to pregnant and postpartum patients and pre-conception planning. It is staffed by reproductive psychiatrists who are members of PSI and specialists in the treatment of perinatal mental health disorders.
- An example of a local resource for *pediatric* providers is the UCSF Child & Adolescent Psychiatry Portal (CAPP), a child psychiatry access program designed to meet the needs of pediatric primary care practices serving as front-line care providers for mental health.[11] The goal of CAPP is to increase access to necessary mental health care by improving primary care provider knowledge, skills, and confidence to manage mild-moderate, commonly occurring behavioral health conditions.

Medical Effectiveness: In 2019, because AB 1676 did not specify which telehealth modalities would be included as part of the consultation program, CHBRP assumed the telehealth consultation program was similar to eConsults. Defined in the 2019 CHBRP report on AB 1676 as provider-to-provider telehealth consultations, eConsults included both synchronous (e.g., phone,

videoconference) and asynchronous (e.g., email, electronic health record/EHR) modalities. CHBRP found *limited evidence* that psychiatric eConsults are effective at improving appropriate treatment of mental health conditions as measured by improvement in the receipt of more appropriate care and mental health outcomes in patients, provider knowledge and skill development for mental health treatment, provider satisfaction, and timeliness of services.

Specific to phone telehealth consultations, only one study (Hilty et al., 2004) specifically reported on a program with a "warm-line" providing primarily phone access to a variety of specialists, including psychiatrists, to assist primary care providers in the treatment of patients (adults and children) with developmental disabilities in rural California.[12] This was a case series study with no comparison group and reported data from 30 consultations provided through the program.

Specific to the population listed in AB 1676, CHBRP identified one case study (Straus and Sarvet, 2014) of MCPAP that examined pediatric primary care providers' ability to meet the psychiatric needs of their clients.[13] This study showed an increase in provider knowledge as perceived by the consultants, referrals to behavioral health services, and ability to provide appropriate care. Based on this single case study of one program with no comparison group, CHBRP found *insufficient evidence* on the effectiveness of psychiatric eConsults specifically for children and pregnant and postpartum persons. Please note: insufficient evidence is not evidence of no effect; it means the effect is unknown.

An updated literature search may identify studies published since early 2019 that could change the above conclusions.

Benefit Coverage, Utilization, and Cost Impacts: In 2019, CHBRP estimated that 74% of commercial/CalPERS enrollees in plans and policies regulated by DMHC or CDI and 38% of Medi-Cal beneficiaries enrolled in DMHC-regulated plans were already enrolled in health plans or policies with a psychiatric eConsult program. For those health plans and insurers with psychiatric eConsult programs, psychiatrists are usually available via phone, video-conference, and email consultation to all outpatient providers regardless of specialty. Note that these eConsult programs are *not specific to* the types of providers or the patient populations specified in AB 1676, but *any contracted provider* treating these populations would have access to a psychiatrist for an eConsult.

CHBRP did not model utilization changes because the bill relates to a program for providers, not a benefit for enrollees. CHBRP assumed there would be increased administrative costs associated with the implementation of AB 1676, as well as an increase in overall utilization of psychiatric services, but the expenditure impact could not be estimated.

These findings are still relevant when considering the potential impacts of AB 935. Two provisions of AB 935 may mean the proportion of enrollees or beneficiaries in health plans or policies with a psychiatric eConsult program would be different than shown in the AB 1676 analysis: 1) the types of mental health clinicians included in AB 935 are broader than those included in AB 1676, and 2) AB 935 would require that the consultation program be accessible by phone and video, whereas AB 1676 did not.

Public Health Impacts: CHBRP's 2019 analysis found that the impacts of AB 1676 on public health and disparities in health outcomes are unknown due to insufficient evidence regarding the effectiveness of psychiatric eConsults for mental health treatment for children and pregnant and postpartum persons. As noted above, there is limited evidence suggesting that psychiatric eConsults for the population overall are effective. It stands to reason that the populations specified in AB 1676 would experience the same effectiveness of psychiatric eConsults as the general population.

Making telepsychiatry consultations available for providers who treat children and pregnant and postpartum persons could potentially increase access and timeliness to appropriate mental health care. It is estimated that this change in access would be greatest for rural beneficiaries who may, directly or through their primary care provider, otherwise not have had their mental health concerns addressed by a psychiatrist due to shortages of licensed psychiatrists in rural areas.

These findings are also applicable to AB 935.

Essential Health Benefits: In 2019, because AB 1676 would have required plans and insurers to establish a telepsychiatry consultation program for providers and is not a benefit for enrollees, CHBRP noted that it would not exceed essential health benefits (EHBs). This is the same for AB 935.

CHBRP believes the above points from the 2019 analysis are relevant to a 2021 consideration of AB 935. CHBRP's full 2019 analysis of AB 1676 can be accessed at www.chbrp.org.[14]

Conclusion: Overall, much of CHBRP's 2019 analysis of AB 1676 remains relevant. CHBRP has highlighted key findings in this letter that may be particularly useful when considering the potential impacts of AB 935.

CHBRP's faculty and staff appreciate the opportunity to provide these analyses and we will be happy to respond to any of your questions. On behalf of the CHBRP Team, we hope that both of you, your families, and staff remain safe and healthy during this difficult time. And as always, please feel free to contact me at your convenience with any feedback or suggestions.

Thank you.

Sincerely,

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REFERENCES

[1] Commonwealth of Massachusetts Chapter 149 in the Acts of 2004. Available online at https://malegislature.gov/Laws/SessionLaws/Acts/2004/Chapter149.
[2] Commonwealth of Massachusetts Chapter 313 in the Acts of 2010. Available at: https://malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter313.
[3] Washington State Legislature, House Bill 2728. Available at: https://app.leg.wa.gov/billsummary?BillNumber=2728&Year=2020.
[4] New York State Senate Bill 3033. Available at: https://www.nysenate.gov/legislation/bills/2021/S3033.
[5] Health Resources and Services Administration. HRSA awards over $12M for maternal & child mental health programs, September 25, 2018. Available at: https://www.hrsa.gov/about/news/press-releases/hrsa-awards-12-million-maternal-child-mental-health-programs
[6] Lifeline4Moms website, University of Massachusetts Medical School. Available at: https://www.umassmed.edu/lifeline4moms/
[7] Byatt, N et al. 2020. Promoting the Health of Parents & Children: Addressing Perinatal Mental Health by Building Medical Provider Capacity Through Perinatal Psychiatry Access Programs, University of Massachusetts Medical School.
[8] Wichman, CL et al. 2019. Feasibility of model adaptations and implementation of a perinatal psychiatric teleconsultation program. *General Hospital Psychiatry*, 59: 51-57.
[9] Marcus, S et al. 2019. The Michigan Child Collaborative Care Program: Building a Telepsychiatry Consultation Service. *Psychiatric Services*, 70(9): 849-52.
[10] Postpartum Support International: Perinatal Psychiatric Consult Line website. Available at: https://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/. Accessed April 14, 2021.
[11] UCSF Benioff Children's Hospitals Child and Adolescent Psychiatry Portal website. Available at: https://capp.ucsf.edu/. Accessed April 14, 2021.
[12] Hilty DM et al. 2004. Multispecialty telephone and e-mail consultation for patients with developmental disabilities in rural California. *Telemedicine Journal & e-Health*, 10(4):413-421.
[13] Straus JH and Sarvet B. 2014. Behavioral health care for children: The Massachusetts child psychiatry access project. *Health Affairs,* 33(12):2153-2161.
[14] CHBRP Analysis of AB 1676. 2019. Available at: http://analyses.chbrp.com/document/view.php?id=1421.