SENATE BILL No. 1337

Introduced by Senator McGuire

February 18, 2022

An act to add Section 1368.3 to the Health and Safety Code, and to add Section 10125.3 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1337, as introduced, McGuire. Coordinated specialty care for first-episode psychosis.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies that provide hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, of a person of any age.

This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on and after January 1, 2023, to provide coverage for coordinated specialty care (CSC) services for the treatment of first-episode psychosis, which is described by the bill as a team-based service delivery method composed of specified treatment modalities and affiliated activities including, but not limited to, case management, pharmacotherapy and medication management, psychotherapy, and outreach and recruitment activities. The bill would require the CSC services provided to be consistent with the Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation, developed by the National Institute of Mental Health. The bill would

specify the membership of the CSC team and applicable training and supervision requirements. The bill would require the health care service plan or health insurer to use specified billing procedures for the services provided by the CSC team.

The bill would require the Department of Managed Health Care and the Department of Insurance, as appropriate, in collaboration with the State Department of Health Care Services, to create a working group to establish guidelines, including, but not limited to, inclusion and exclusion criteria for individuals eligible to receive CSC services, and caseload and geographic boundary parameters for the treatment team. The bill would provide that its requirements would not apply to a nongrandfathered individual health care service plan contract or health insurance policy, or group health care service plan contract or health insurance policy covering 50 or fewer employees, if the appropriate department determines that compliance with any or all of those requirements would require the state to assume the cost and provide payments to enrollees or insureds to defray the cost of providing services described in the bill, pursuant to specified federal law.

Because a violation of the bill's requirements 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. State-mandated local program: yes.

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

SECTION 1. Section 1368.3 is added to the Health and Safety Code, to read:

1368.3. (a) The following definitions apply for purposes of this section:

(1) "CSC" means coordinated specialty care.

(2) "CSC manual" or "manual" means the Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation (CSC manual) developed by the National Institute of Mental Health.

(3) "Department" means the Department of Managed Health Care.

(4) "FEP" means first-episode psychosis.

(5) "HCPCS" means the Healthcare Common Procedure Coding System.

(6) "SEE" means supported education and employment.

(b) A health care service plan contract issued, amended, or renewed on and after January 1, 2023, shall provide coverage for coordinated specialty care services for the treatment of first-episode psychosis, which is a team-based service delivery method composed of the following treatment modalities and affiliated activities:

(1) Case management. Case management assists individuals with problem solving, offering solutions to address practical problems, and coordinating social services across multiple areas of need. Case management involves frequent in-person contact between the clinician and the individual and their family, with sessions occurring in clinic, community, and home settings.

(2) Family support and education. Family education and support teaches relatives or others providing support about psychosis and its treatment and strengthens their capacity to aid in the individual's recovery. To the greatest extent possible, and consistent with decisionmaking. For individuals less than 18 years of age, participation of a family member or guardian is strongly recommended.

(3) Pharmacotherapy and medication management. Pharmacotherapy and medication management approaches that are evidence-based guide medication selection and dosing for individuals with FEP. Pharmacotherapy typically begins with a low dose of a single antipsychotic medication and involves monitoring for psychopathology, side effects, and attitudes towards medication at every visit. Special emphasis should be given to cardiometabolic risk factors such as smoking, weight gain, hypertension, dyslipidemia, and prediabetes.

(4) Individual and group psychotherapy. Psychotherapy for FEP is based upon cognitive and behavioral treatment principles and emphasizes resilience training, illness and wellness management, and general coping skills. Treatment consists of core and supplemental modules and is tailored to each individual's needs. Individuals and psychotherapists work one-on-one, and in groups,

meeting weekly or biweekly, with the duration and frequency of sessions personalized for each individual.

(5) Supported education and employment. Supported education and employment services facilitate the individual's return to work or school, as well as attainment of expected vocational and educational milestones. SEE emphasizes rapid placement in the individual's desired work or school setting and provides active and sustained coaching and support to ensure the individual's success. An SEE specialist strives to integrate vocational and mental health services, is the CSC team liaison with outside educators and employers, and frequently works with the individual in the community to enhance school or job performance.

(6) Coordination with primary care. Coordination with primary care means that team members maintain close contact with primary care providers to ensure optimal medical treatment for risk factors related to comorbid medical conditions.

(7) Outreach and recruitment activities. Outreach and recruitment activities are designed to facilitate the outreach and referral process and are responsible for initial assessments of an enrollee's potential eligibility for the program. This process should identify potential referring entities, including, but not limited to, mental health facilities, health systems, emergency departments, primary care practitioners, educational institutions, professional organizations, family organizations, consumer organizations, social service programs, substance use disorder programs, criminal justice systems, and places of worship. The outreach and referral process should implement and maintain systems to track all the outreach activities and referrals.

(c) The treatment modalities and affiliated activities described in subdivision (b) shall be performed by a team that consists of the following members, provided that there may be flexibility in the actual composition of the team members, as the team structure is described in the CSC manual:

(1) A team leader who is a licensed clinician.

(2) An individualized placement and support specialist.

(3) A skills trainer who is a licensed clinician.

(4) A psychiatrist.

(5) A certified peer support specialist with lived experience with a mental illness.

(6) An outreach and referral specialist.

(7) Other team members, as appropriate, based on the team structure of existing CSC programs throughout the country that adhere to appropriate fidelity measures and have demonstrated sustained positive outcomes using an alternative or supplemented team structure.

(d) The treatment modalities and affiliated activities described in subdivision (b), as performed by the team members described in subdivision (c), shall be consistent with the performance and fidelity measures identified in Appendix 12: Resources for Fidelity, described in the CSC manual, provided that there shall be flexibility in determining adherence to Appendix 12.

(e) The team members described in subdivision (c) shall undergo training consistent with the recommendations of Section III and Appendices 4 to 9, inclusive, of the of the CSC manual, provided that the team may incorporate supplemental training methods identified by the scientific and research communities developed subsequent to the release of the manual.

(f) The team members described in subdivision (c) shall undergo supervision consistent with the recommendations of Section IV and Appendices 10 and 11 of the of the CSC manual, provided that the team may incorporate supplemental supervision methods identified by the scientific and research communities developed subsequent to the release of the manual.

(g) (1) The department, in collaboration with the Department of Insurance and the State Department of Health Care Services, shall create a working group to establish guidelines regarding the all of the following:

(A) The inclusion and exclusion criteria for individuals to be eligible for the treatment modalities and affiliated activities identified and described in subdivision (b), as performed by the team described in subdivision (c), provided that the working group shall take into consideration the criteria identified in Appendix 2 of the CSC manual but disregard the stipulation of Appendix 2 that requires an individual receiving CSC to have the ability to understand and speak English.

(B) The caseload and geographic boundary parameters for the team described in subdivision (c), which shall take into account the ideal recommended caseload and geographic boundaries identified in the CSC manual along with population density and

other factors that may make the recommended caseloads and geographic boundaries impractical.

(C) The benchmarks, including time parameters, for individuals receiving CSC services, that will determine when it is appropriate for those individuals to transition to alternative treatment regimens.

(D) The possibility of utilizing telehealth beyond what is currently required or permitted by statute or regulation, solely for use in delivering CSC services.

(2) The working group described in paragraph (1) shall have the following membership:

(A) A staff representative of the department.

(B) A staff representative of the State Department of Health Care Services.

(C) A psychiatrist with knowledge of FEP and CSC, provided that a psychiatrist with experience in participating in CSC shall be given precedence over psychiatrists without experience in participating in CSC.

(D) A mental health clinician with knowledge of FEP and CSC, provided that a mental health clinician with experience in participating in CSC shall be given precedence over clinicians without experience in participating in CSC.

(E) A professional with experience in providing supportive services, particularly supported education and supported employment.

(F) A representative appointed by a state, regional, or local mental health advocacy group or appointed by a collection of state, regional, or local mental health advocacy groups.

(G) An individual who has lived experience with psychosis, or a family member of an individual who has lived experience with psychosis.

(H) Three representatives appointed by health care service plans that issue individual or group health care service plan contracts in this state.

(3) The working group described in paragraph (1) and (2) shall convene no later than March 1, 2023, and shall convene at least once per month until the guidelines identified in paragraph (1) are finalized; however, the guidelines shall be completed within one year the workgroup first convenes.

(4) Within 60 days after the guidelines identified in paragraph (1) are finalized pursuant to paragraph (3), the department shall adopt implementing regulations.

(h) The department, by regulation, may update the treatment modalities and affiliated activities identified and described in subdivision (a) and (b), the team structure described in subdivision (c), the outcome and fidelity measures described in subdivision (d), the training requirements described in subdivision (e), and the supervision requirements described in subdivision (f) in a manner consistent with the objectives of this part.

(i) A health care service plan shall use a single, monthly case rate paid as a monthly per-member-per-month rate that reimburses the team described in subdivision (c) for the full range of CSC services described in subdivision (a) and (b) for any individual meeting the target criteria who is receiving services for the full CSC model that month.

(1) The health care service plan shall bill services under this subdivision using the Healthcare Common Procedure Coding System (HCPCS) T1024 billing code for team management, with the HK modifier code for specialized mental health programs for high-risk populations, provided that the minimum monthly services shall include all of the following:

(A) At least two face-to-face visits or telehealth contacts from a team member.

(B) One collateral contact via an electronic modality, including, but not limited to, telephone, email, a phone-based application, or telehealth.

(C) One team staff meeting discussion with the full team, including the licensed professionals on the team;

(D) Provision of additional services during early stages of treatment as well as any time an individual experiences periods of destabilization, as medically necessary.

(E) The team shall continue providing medically necessary services beyond the minimum monthly service requirements, as needed.

(2) A daily encounter rate, which shall be billed under the HCPCS T1024 billing code for team management, for each encounter that the patient receives the treatment modalities and affiliated activities described in subdivisions (a) and (b) through the team described in subdivision (c) for less intensive service

delivery, provided that the health care service plan may require that the team described in subdivision (c) provide documentation that the billable activity occurred and that no other additional services were medically necessary due to the individual being hospitalized or being stabilized and not requiring the minimum service provision, or there was another reason, as documented in the medical record, so long as the request for the documentation and the review of the documentation complies with this section and the nonquantitative treatment limitation requirements for the federal Mental Health Parity and Addiction Equity Act, in 45 C.F.R. 146.136(c)(4).

(3) The department shall adopt regulations that update the billing and reimbursement methodology described in this subdivision, as necessary.

(j) (1) An individual or group health care service plan contract issued renewed, or amended on or after January 1, 2023, shall provide coverage of the supported education and employment services identified in paragraph (5) of subdivision (a) and described in paragraph (5) of subdivision (b) for individuals who have transitioned to an alternate treatment regimen that no longer meets the specifications of CSC, and those services shall be billed and reimbursed separately and distinctly from the payment structures identified in subdivision (i).

(2) The department, in collaboration with the State Department of Health Care Services, shall adopt regulations that establish a billing and reimbursement methodology for coverage of the supported education and employment services described in paragraph (1).

(k) This section does not apply to a nongrandfathered individual health care service plan contract or a nongrandfathered group health care service plan contract covering 50 or fewer employees, if the department determines that compliance with the section, in whole or part, will require the state to assume the cost and provide payments to enrollees to defray the cost of the services, pursuant to 42 U.S.C. SEC. 18031(d)(3)(B)(ii).

SEC. 2. Section 10125.3 is added to the Insurance Code, to read:

10125.3. (a) The following definitions apply for purposes of this section:

(1) “CSC” means coordinated specialty care.

(2) "CSC manual" or "manual" means the Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation (CSC manual) developed by the National Institute of Mental Health.

(3) "Department" means the Department of Insurance.

(4) "FEP" means first-episode psychosis.

(5) "HCPCS" means the Healthcare Common Procedure Coding System.

(6) "SEE" means supported education and employment.

(b) A health insurance policy issued, amended, or renewed on and after January 1, 2023, shall provide coverage for coordinated specialty care services for the treatment of first-episode psychosis, which is a team-based service delivery method composed of the following treatment modalities and affiliated activities:

(1) Case management. Case management assists individuals with problem solving, offering solutions to address practical problems, and coordinating social services across multiple areas of need. Case management involves frequent in-person contact between the clinician and the individual and their family, with sessions occurring in clinic, community, and home settings.

(2) Family support and education. Family education and support teaches relatives or others providing support about psychosis and its treatment and strengthens their capacity to aid in the individual's recovery. To the greatest extent possible, and consistent with the individual's preferences, supportive persons are included in all phases of treatment planning and decisionmaking. For individuals less than 18 years of age, participation of a family member or guardian is strongly recommended.

(3) Pharmacotherapy and medication management. Pharmacotherapy and medication management approaches that are evidence-based guide medication selection and dosing for individuals with FEP. Pharmacotherapy typically begins with a low dose of a single antipsychotic medication and involves monitoring for psychopathology, side effects, and attitudes towards medication at every visit. Special emphasis should be given to cardiometabolic risk factors such as smoking, weight gain, hypertension, dyslipidemia, and prediabetes.

(4) Individual and group psychotherapy. Psychotherapy for FEP is based upon cognitive and behavioral treatment principles and emphasizes resilience training, illness and wellness management, and general coping skills. Treatment consists of core and

supplemental modules and is tailored to each individual's needs. Individuals and psychotherapists work one-on-one, and in groups, meeting weekly or biweekly, with the duration and frequency of sessions personalized for each individual.

(5) Supported education and employment. Supported education and employment services facilitate the individual's return to work or school, as well as attainment of expected vocational and educational milestones. SEE emphasizes rapid placement in the individual's desired work or school setting and provides active and sustained coaching and support to ensure the individual's success. An SEE specialist strives to integrate vocational and mental health services, is the CSC team liaison with outside educators and employers, and frequently works with the individual in the community to enhance school or job performance.

(6) Coordination with primary care. Coordination with primary care means that team members maintain close contact with primary care providers to ensure optimal medical treatment for risk factors related to comorbid medical conditions.

(7) Outreach and recruitment activities. Outreach and recruitment activities are designed to facilitate the outreach and referral process and are responsible for initial assessments of an insured's potential eligibility for the program. This process should identify potential referring entities, including, but not limited to, mental health facilities, health systems, emergency departments, primary care practitioners, educational institutions, professional organizations, family organizations, consumer organizations, social service programs, substance use disorder programs, criminal justice systems, and places of worship. The outreach and referral process should implement and maintain systems to track all the outreach activities and referrals.

(c) The treatment modalities and affiliated activities described in subdivision (a) shall be performed by a team that consists of the following members, provided that there may be flexibility in the actual composition of the team members, as the team structure is described in the CSC manual:

(1) A team leader who is a licensed clinician.

(2) An individualized placement and support specialist.

(3) A skills trainer who is a licensed clinician.

(4) A psychiatrist.

(5) A certified peer support specialist with lived experience with a mental illness.

(6) An outreach and referral specialist.

(7) Other team members, as appropriate, based on the team structure of existing CSC programs throughout the country that adhere to appropriate fidelity measures and have demonstrated sustained positive outcomes using an alternative or supplemented team structure.

(d) The treatment modalities and affiliated activities described in subdivision (b), as performed by the team members described in subdivision (c), shall be consistent with the performance and fidelity measures identified in Appendix 12: Resources for Fidelity, described in the CSC manual, provided that there shall be flexibility in determining adherence to Appendix 12.

(e) The team members described in subdivision (c) shall undergo training consistent with the recommendations of Section III and Appendices 4 to 9, inclusive, of the of the CSC manual, provided that the team may incorporate supplemental training methods identified by the scientific and research communities developed subsequent to the release of the manual.

(f) The team members described in subdivision (c) shall undergo supervision consistent with the recommendations of Section IV and Appendices 10 and 11 of the of the CSC manual, provided that the team may incorporate supplemental supervision methods identified by the scientific and research communities developed subsequent to the release of the manual.

(g) (1) The department, in collaboration with the Department of Managed Health Care and the State Department of Health Care Services, shall create a working group to establish guidelines regarding the all of the following:

(A) The inclusion and exclusion criteria for individuals to be eligible for the treatment modalities and affiliated activities identified and described in subdivision (a) and (b), as performed by the team described in subdivision (c), provided that the working group shall take into consideration the criteria identified in Appendix 2 of the CSC manual but disregard the stipulation of Appendix 2 that requires an individual receiving CSC to have the ability to understand and speak English.

(B) The caseload and geographic boundary parameters for the team described in subdivision (c), which shall take into account

the ideal recommended caseload and geographic boundaries identified in the CSC manual along with population density and other factors that may make the recommended caseloads and geographic boundaries impractical.

(C) The benchmarks, including time parameters, for individuals receiving CSC services, that will determine when it is appropriate for those individuals to transition to alternative treatment regimens.

(D) The possibility of utilizing telehealth beyond what is currently required or permitted by statute or regulation, solely for use in delivering CSC services.

(2) The working group described in paragraph (1) shall have the following membership:

(A) A staff representative of the department.

(B) A staff representative of the State Department of Health Care Services.

(C) A psychiatrist with knowledge of FEP and CSC, provided that a psychiatrist with experience in participating in CSC shall be given precedence over psychiatrists without experience in participating in CSC.

(D) A mental health clinician with knowledge of FEP and CSC, provided that a mental health clinician with experience in participating in CSC shall be given precedence over clinicians without experience in participating in CSC.

(E) A professional with experience in providing supportive services, particularly supported education and supported employment.

(F) A representative appointed by a state, regional, or local mental health advocacy group or appointed by a collection of state, regional, or local mental health advocacy groups.

(G) An individual who has lived experience with psychosis, or a family member of an individual who has lived experience with psychosis.

(H) Three representatives appointed by health insurers that issue individual or group health insurance policies in this state.

(3) The working group described in paragraph (1) paragraph (2) shall convene no later than March 1, 2023, and shall convene at least once per month until the guidelines identified in paragraph (1) are finalized; however, the guidelines shall be completed within one year the workgroup first convenes.

(4) Within 60 days after the guidelines identified in paragraph (1) are finalized pursuant to paragraph (3), the department shall adopt implementing regulations.

(h) The department, by regulation, may update the treatment modalities and affiliated activities identified and described in subdivision (a) and (b), the team structure described in subdivision (c), the outcome and fidelity measures described in subdivision (d), the training requirements described in subdivision (e), and the supervision requirements described in subdivision (f) in a manner consistent with the objectives of this part.

(i) A health insurer shall use a single, monthly case rate paid as a monthly per-member-per-month rate that reimburses the team described in subdivision (c) for the full range of CSC services described in subdivision (a) and (b) for any individual meeting the target criteria who is receiving services for the full CSC model that month.

(1) The health insurer shall bill services under this subdivision using the Healthcare Common Procedure Coding System (HCPCS) T1024 billing code for team management, with the HK modifier code for specialized mental health programs for high-risk populations, provided that the minimum monthly services shall include all of the following:

(A) At least two face-to-face visits or telehealth contacts from a team member.

(B) One collateral contact via an electronic modality, including, but not limited to, telephone, email, a phone-based application, or telehealth.

(C) One team staff meeting discussion with the full team, including the licensed professionals on the team;

(D) Provision of additional services during early stages of treatment as well as any time an individual experiences periods of destabilization, as medically necessary.

(E) The team shall continue providing medically necessary services beyond the minimum monthly service requirements, as needed.

(2) A daily encounter rate, which shall be billed under the HCPCS T1024 billing code for team management, for each encounter that the patient receives the treatment modalities and affiliated activities described in subdivisions (a) and (b) through the team described in subdivision (c) for less intensive service

delivery, provided that the insurer may require that the team described in subdivision (c) provide documentation that the billable activity occurred and that no other additional services were medically necessary due to the individual being hospitalized or being stabilized and not requiring the minimum service provision, or there was another reason, as documented in the medical record, so long as the request for the documentation and the review of the documentation complies with this section and the nonquantitative treatment limitation requirements for the federal Mental Health Parity and Addiction Equity Act, in 45 C.F.R. 146.136(c)(4).

(3) The department shall adopt regulations that update the billing and reimbursement methodology described in this subdivision, as necessary.

(j) (1) An individual or group health insurance policy issued renewed, or amended on or after January 1, 2023, shall provide coverage of the supported education and employment services identified in paragraph (2) of subdivision (a) and described in paragraph (5) of subdivision (b) for individuals who have transitioned to an alternate treatment regimen that no longer meets the specifications of CSC, and those services shall be billed and reimbursed separately and distinctly from the payment structures identified in subdivision (i).

(2) The department, in collaboration with the State Department of Health Care Services, shall adopt regulations that establish a billing and reimbursement methodology for coverage of the supported education and employment services described in paragraph (1).

(k) This section does not apply to a nongrandfathered individual health insurance policy or a nongrandfathered group health insurance policy covering 50 or fewer employees, if the department determines that compliance with the section, in whole or part, will require the state to assume the cost and provide payments to insureds to defray the cost of the services, pursuant to 42 U.S.C. Sec. 18031(d)(3)(B)(ii).

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.

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