Abbreviated Analysis

California Senate Bill 1338: CARE Court Program

Summary to the 2021–2022 California State Legislature
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SUMMARY

On April 20, 2022, the California Senate Committee on Health requested that the California Health Benefits Review Program (CHBRP)[1] conduct an abbreviated assessment of specific aspects of California Senate Bill 1338.

The bill establishes the Community Assistance, Recovery, and Empowerment (CARE) Act, which would implement a *new statewide procedure for treating persons over the age of 18 with schizophrenia spectrum or other psychotic disorder through a court-ordered CARE plan* for 12 to 24 months.

1. As requested, CHBRP's analysis focuses on the portion of SB 1338 that would be applicable to health insurance. SB 1338 is silent regarding (and so would not affect) CDI-regulated insurers. SB 1338 would explicitly exempt from its requirements the DMHC-regulated plans enrolling Medi-Cal beneficiaries. For other DMHC-regulated plans, as of January 1, 2023, the Care Act would: Require insurance coverage for an evaluation for the enrollee's eligibility for CARE Court and the provision of all health care services for an enrollee when required or recommended for the enrollee pursuant to a CARE plan approved by a court, as specified.
2. Prohibit requiring prior authorization for services provided pursuant to a CARE plan. However, SB 1338 would permit a health plan to conduct a post claim review to determine appropriate payment of a claim, and permits denial under specified circumstances.
3. Prohibit copayments, coinsurance, deductibles, or any other form of cost sharing to services provided to an enrollee pursuant to a CARE plan.

Additionally, SB 1338 would prohibit providers from billing the enrollee, or seeking reimbursement from the enrollee, for services provided pursuant to a CARE plan.
SB 1338 permits an array of caregivers, health professionals, family members, first-responders, co-habitants, and public agency staff to file a petition to initiate CARE proceedings.

Background. Schizophrenia (or, Schizophrenia Spectrum Disorder) is a severe mental disorder characterized by fundamental disturbances in thinking, perception and emotions. Schizophrenia is a mental illness that currently has no cure; however, with the use of pharmaceutical and psychosocial treatments, symptoms can be managed. Schizophrenia has a lifetime prevalence of about 1% and accounts for a major health care burden, with annual associated costs in the United States estimated to be more than $150 billion. States have attempted, through a variety of mechanisms and approaches, to achieve a balance between providing for the safety and well-being of those with severe mental illness while recognizing their inherent due process and civil rights. Comorbidity is highly prevalent between substance use disorders (SUDs) and schizophrenia.

Prevalence in California. Nearly 1 in 24 adults in California have a serious mental illness that makes it difficult to carry out major life activities, including schizophrenic spectrum disorders. CHBRP estimates that there are 5,657 enrollees utilizing care for schizophrenic spectrum and other psychotic disorders in the population subject to this bill (i.e., people enrolled in commercial health plans or health insurance policies subject to the Knox-Keene Act over the age of 18). This is a narrower subset than the population as a whole.

Population affected. If enacted, SB 1338 would apply to the health insurance of approximately 14,081,000 enrollees (36% of all Californians).

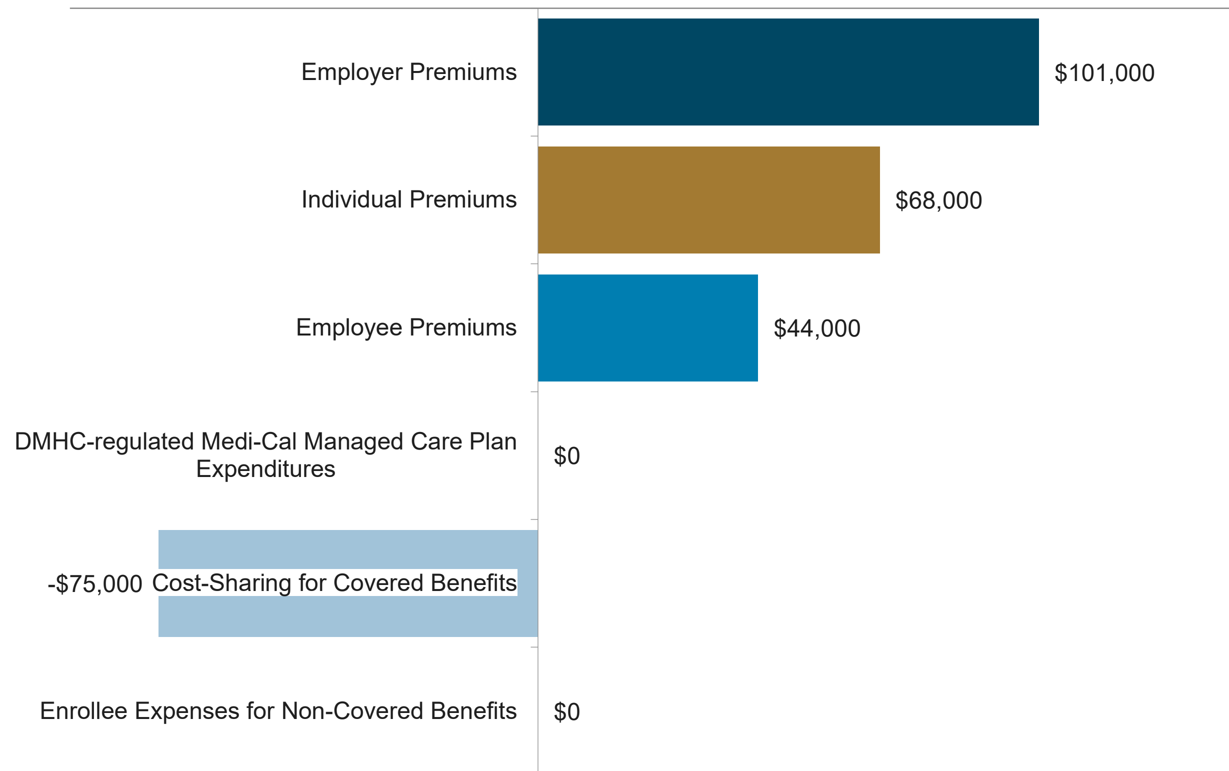
Treatments. Treatment options include anti-psychotic medications, outpatient office visits, and inpatient care.

[1] Refer to CHBRP's full report for full citations and references.

Benefit coverage. CHBRP estimates no change in benefit coverage due to SB 1338, with 100% of enrollees estimated to have coverage at baseline and postmandate.

Expenditures: CHBRP estimates SB 1338 would increase the total net annual expenditures by $138,000 for DMHC-regulated plans and their enrollees. However, coverage does not guarantee access to care for mental health disorders, because access is dependent on the supply of providers.

Figure A. Estimated Expenditure Impacts of SB 1338 in First Year



Source: California Health Benefits Review Program, 2022.

Medical effectiveness. Due to the abbreviated timeline for completing this analysis, a full scope new literature search was not possible. Findings from previous related legislation (SB 859 of 2019, AB 2242 of 2020 and AB 1859 of 2022) were selected by CHBRP because they addressed coverage for behavioral health services, respectively. These recent analyses of mental health services legislation reached the following conclusions that are applicable to SB 1338:

1. There is a preponderance of evidence that antipsychotic medications are more effective than placebos at improving symptoms of schizophrenia, depression, quality of life and social function and that some antipsychotic medications are associated with lower rates of discontinuation and adverse effects.
2. There is a preponderance of evidence that multiple psychosocial interventions used to treat schizophrenia improve functional outcomes, quality of life, and core illness symptoms relative to usual care.
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 *limited evidence* that reducing cost sharing for follow-up outpatient mental health services increases use of these services.

CHBRP notes that *lack of evidence* does not mean *lack of affect*; limited research in the subject area can lead to insufficient or limited evidence on the effect of the services. Additional relevant findings can be found in the Medical Effectiveness section.

Table 1. SB 1338 Impacts on Benefit Coverage, Utilization, and Cost, 2023

	Baseline (2023)	Postmandate Year 1 (2023)	Increase/ Decrease	Change Postmandate
Benefit coverage				
Total enrollees with health insurance subject to state-level benefit mandates (a)	22,810,000	22,810,000	0	0.00%
Total enrollees with health insurance subject to SB 1338	14,081,000	14,081,000	0	0.00%
Total percentage of enrollees with coverage fully compliant with SB 1338	0%	100%	100%	0.00%
Utilization and cost				
Number of enrollees utilizing care for schizophrenic spectrum and other psychotic disorder	5,657	5,657	-	0.00%
Number of services per enrollee utilizing care				
Court-ordered Psychiatric Evaluation	-	113	113	N/A
Emergency Department Cases	379	381	2	0.43%
Inpatient Psychiatric Admits	1,159	1,159	-	0.00%
Outpatient Psychiatric Visits	9,101	9,156	55	0.59%
Office Visits	86,342	86,403	61	0.07%
Anti-psychotic prescriptions	28,244	28,264	20	0.07%
Per-unit cost of service				
Court-ordered Psychiatric Evaluation	$306	$306	-	0.00%
Emergency Department Cases	$5,308	$5,308	-	0.00%
Inpatient Psychiatric Admits	$24,418	$24,418	-	0.00%
Outpatient Psychiatric Admits	$765	$765	-	0.00%
Office Visits (PCP, Specialty Outpatient Visits)	$144	$144	-	0.00%
Anti-psychotic prescriptions	$334	$334	-	0.00%
Total annual costs of services	$59,121,000	$59,221,000	$100,000	0.17%
Expenditures				
Premium (expenditures) by payer				
Private employers for group insurance	$52,967,575,000	$52,967,668,000	$93,000	0.00%
CalPERS HMO employer expenditures (b) (c)	$5,895,476,000	$5,895,484,000	$8,000	0.00%
Medi-Cal Managed Care Plan expenditures (d)	$25,989,411,000	$25,989,411,000	$0	0.00%
Enrollee premiums (expenditures)				
Enrollees for individually purchased insurance	$24,029,788,000	$24,029,856,000	$68,000	0.00%
Individually Purchased – Outside Exchange	$6,324,312,000	$6,324,331,000	$19,000	0.00%
Individually Purchased – Covered California	$17,705,476,000	$17,705,525,000	$49,000	0.00%

	Baseline (2023)	Postmandate Year 1 (2023)	Increase/ Decrease	Change Postmandate
Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (c)	$24,504,936,000	$24,504,980,000	$44,000	0.00%
Enrollee out-of-pocket expenses				
Cost sharing for covered benefits (deductibles, copayments, etc.)	$15,807,011,000	$15,806,936,000	-$75,000	0.00%
Expenses for noncovered benefits (d) (e)	$0	$0	$0	0.00%
Total Expenditures	$149,194,197,000	$149,194,335,000	$138,000	0.00%

Source: California Health Benefits Review Program, 2022.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(b) Of the increase in CalPERS employer expenditures, about 51.7% or $4,000 would be state expenditures for CalPERS members who are state employees or their dependents.

About one in four (24.8%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

(c) Enrollee premium expenditures include contributions by employees to employer-sponsored health insurance, health insurance purchased through Covered California, and contributions to Medi-Cal Managed Care.

(d) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.

(e) Although enrollees with newly compliant benefit coverage may have paid for some tests before SB 1338, CHBRP cannot estimate the frequency with which such situations may have occurred, and therefore cannot estimate the related expense. Postmandate, such expenses would be eliminated, though enrollees with newly compliant benefit coverage might, postmandate, pay for some tests for which coverage is denied (through utilization management review), as some enrollees who always had compliant benefit coverage may have done and may continue to do, postmandate.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Management Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; COHS = County Operated Health System; OPD = Outpatient Prescription Drug.

BACKGROUND ON PSYCHOTIC DISORDERS, SCHIZOPHRENIA DISORDERS & 5150 HOLDS IN CALIFORNIA

Mental health disorders are among the most common health conditions faced by Californians: nearly 1 in 24 have a serious mental illness that makes it difficult to carry out major life activities (Holt, 2018). Schizophrenia spectrum disorders are one of the serious mental illnesses. The prevalence of serious mental illness varies by income, with much higher rates of mental illness at lower income levels for both children and adults (Holt, 2018).

The psychotic disorders in the current edition of the diagnostic manual, DSM-5[2], are defined by clinical syndromes (rather than diseases). The disorders are distinguished mainly by duration and symptom profile (Lieberman and First, 2018). This report will focus on schizophrenia. "Schizophrenia spectrum disorders" are one group of psychotic disorders and the focus of this proposed legislation.

Schizophrenia Disorders

Schizophrenia has a lifetime prevalence of about 1% and accounts for a significant health care burden, with annual associated costs in the United States estimated to be more than $150 billion (Cloutier et al, 2021). The cumulative lifetime risk for men and women is similar, although it is higher for men in the age group younger than 40 years (Rössler et al., 2005). Yet, despite its relatively low prevalence, its health, social, and economic burden is substantial for patients as well for families, caregivers, and communities (Chong et al., 2016). Schizophrenia Spectrum Disorder[3] (SSD) currently has no cure. However, with the use of pharmaceutical and psychosocial treatments, symptoms can be managed.

Schizophrenia is a severe mental disorder characterized by fundamental disturbances in thinking, perception and emotions. Schizophrenia is one of the top 25 leading causes of disability worldwide and has a complex presentation with a multifactorial cause (McCutcheon et al., 2019). A 1990-2017 systematic review and meta-analysis of the prevalence of comorbid substance use in schizophrenia spectrum disorders in community and clinical settings, showed that 42% prevalence of any substance abuse disorders among patients with schizophrenia (Hunt et al., 2018). People with schizophrenia and substance abuse are therefore more likely to have higher rates of hospitalization, homelessness, aggression, violence, incarceration and suicidality than those with a singular diagnosis of schizophrenia (Green et al., 2007).

Some persons with schizophrenia will at some point, or repeatedly, be gravely disabled or a danger to themselves or others. They may require medical evaluation and potentially medical treatment but be unable to agree to it voluntarily. This is where the 72-hour involuntary holds are another avenue for treatment. The next section provides an overview of these 72-hour involuntary psychiatric holds which are commonly known as "5150s" in reference to the California code number that governs their use.

The Involuntary Hold (5150) Process

In California, Laura's Law targets a subset of the population of people with mental illness who are falling through the cracks. (Castro J, 2015). "Laura's Law"[4] is California's state law that provides community-

[2] The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association (APA). It is an official archive of all conditions that are formally recognized as mental health disorders.
[3] People with schizophrenia spectrum disorders may exhibit different combinations of metacognitive deficits related to various types of difficulties and symptoms.
[4] Signed into law in 2002, Laura's Law was adopted by the state Legislature after a volunteer at a Nevada County mental health clinic was killed. The legislation allows each county in the state to decide whether to adopt the provision.

based, assisted outpatient treatment (AOT) to a small population of individuals who meet strict legal criteria and who – as a result of their mental illness – are unable to voluntarily access community mental health services (California Association of Local Behavioral Health Boards & Commissions, 2021). 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 above the age of 14 — who, for reasons related to mental health, are at increased risk to harm themselves or others (or are "gravely disabled")[5]. 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 what is called a 1799 hold,[6] 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).[7,8] For further information, CHBRP produced a recent analysis on the subject, as it relates to AB 1859.[9]

If an individual no longer meets the criteria, as may often happen when someone comes in as a danger to themselves or others and has the opportunity to "calm down," or start to receive some of the effects of medication for her illness, the individual has to be released. This process of decompensation and re-admission constitutes a "revolving door" in which the individual uses emergency services and does not receive long-term stabilization or treatment (Hoffman, H., 1994).

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[5] WIC §5000, et seq.

[6] A 1799 hold is an emergency psychiatric hold ordered by licensed professional staff (physicians) who provide emergency medical services in a. licensed general acute care hospital (once an individual is otherwise.

[7] Welfare and Institutions Code 5325.2.

[8] 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.

[9] Available at: http://analyses.chbrp.com/document/view.php?id=1669.

POLICY CONTEXT

SB 1338 offers a new mechanism of helping connect a person in crisis with a court-ordered CARE plan for up to 12 months, with the possibility to extend for an additional 12 months. The California Health & Human Services Agency (CHHSA) states that the newly established CARE Court would provide an upstream diversion to prevent more restrictive conservatorships or incarceration.[10]

To date, states have attempted through a variety of mechanisms and approaches (Bernstein and Seltzer, 2003) to achieve a balance between providing for the safety and well-being of those with severe mental illness, those who are seen as gravely disabled or at risk of harming themselves or others, and recognizing their inherent due process and civil rights (Wyder et al., 2016). California's existing mechanisms to treat persons with serious mental illness includes treatment for persons who are a danger to themselves or others or who are currently "gravely disabled" under the Lanterman-Petris-Short (LPS) Act; assisted outpatient treatment (AOT) under Laura's Law; and housing conservatorships being implemented in San Francisco on a pilot basis and in the implementation of Laura's Law (which a number of counties have adopted).[11]

This bill establishes the Community Assistance, Recovery, and Empowerment (CARE) Act, which would implement a new statewide procedure for treating persons with specified mental illnesses through the courts. A person is eligible for CARE court jurisdiction if they are 18 years of age or older; diagnosed with schizophrenia or another psychotic disorder; are not currently stabilized and in treatment with a county behavioral health agency; and currently lack medical decision-making capacity. An individual may be referred to the CARE court through a petition from specified medical and county professionals, specified peace officers, and specified persons in the individual's life, such as a family member or roommate[12]; an individual can also be referred from misdemeanor trial proceedings if they have been found incompetent to stand trial, or from conservatorship or AOT proceedings. Once a petition is filed, counsel and a "support person" are appointed to assist the individual with the evaluation process.

The Legislature requested that CHBRP analyze a specific component of SB 1338, as the legislation interacts with DMHC-regulated health insurance plans.

Benefit Mandate

SB 1338 would require a health plan contract issued, amended, renewed, or delivered on or after July 1, 2023, that covers hospital, medical, or surgical expenses, to provide coverage for the development of an evaluation for the enrollee's eligibility for CARE Court. SB 1338 would also require the plan to cover the provision of all health care services for an enrollee when required or recommended for the enrollee pursuant to a CARE plan approved by a court. SB 1338 would also prohibit a health plan from requiring prior authorization for services provided pursuant to a CARE plan approved by a court under the CARE Court program and permits a health plan to conduct a post claim review to determine appropriate payment of a claim, and permits denial under specified circumstances. It prohibits services provided to an

[10] Available at: https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARECourt_FAQ.pdf.

[11] Roughly half of California's counties have chosen not to implement Laura's Law (most are primarily rural counties). The California Association of Local Behavioral Health Boards and Commissions maintains a list of counties that have implemented the law. Available at: https://www.calbhbc.org/lauras-law.html.

[12] SB 1338 permits the following persons to file a petition to initiate CARE proceedings: a) A person 18 years of age or older with whom the respondent resides; b) A spouse, parent, sibling, or adult child of the respondent; c) The director of a hospital, or their designee, in which the respondent is hospitalized; d) The director of a public or charitable organization, agency, or home, or their designee, currently or previously providing behavioral health services to the respondent or in whose institution the respondent resides; e) A qualified behavioral health professional, or their designee, who is, or has been, either supervising the treatment of, or treating the respondent for a mental illness; f) A first responder, including a peace officer, firefighter, paramedic, emergency medical technician, mobile crisis response worker, or homeless outreach worker; g) The public guardian or public conservator, or their designee, of the county in which the respondent is present or reasonably believed to be present; and, h) The director of a county behavioral health agency, or their designee, of the county in which the respondent is present or reasonably believed to be present.

enrollee pursuant to a CARE plan from being subject to copayment, coinsurance, deductible, or any other form of cost sharing. It also prohibits providers from billing the enrollee or subscriber, or seeking reimbursement from the enrollee or subscriber, for services provided pursuant to a CARE plan. Finally, it specifies that these provisions do not apply to Medi-Cal managed care contracts.

The full text of SB 1338 can be found in Appendix A.

Interaction with Existing Benefit Mandate Requirements

Health benefit mandates may interact and align with multiple state and federal mandates or provisions (see summary below). Given the complexity of this topic with other jurisdictions and requirements under the Welfare & Institutions Code, CHBRP suggests readers interested in further discussion of those provisions consult with the Senate Judiciary Committee Analysis, which can be accessed online[13] (California Senate Judiciary, 2022).

California Policy Landscape

California law and regulations

California's mental health parity law[14] 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.

Senate Bill 855 (Wiener, Mental Health Parity) passed in 2020 amended 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.[15]

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*.[16] 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[17] 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.[18]

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[13] Available at: https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202120220SB1338#.
[14] Health and Safety Code 1374.72; Insurance Code (IC) 10144.5.
[15] SB 855 required: 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.
[16] 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.
[17] 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.
[18] IC 10112.27(a)(2)(A)(i); 28 CCR 1300.67.

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.[19] 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 non-urgent care is 10 business days for mental health treatment with a nonphysician provider.[20] In addition, CDI requires access to mental health professionals within 30 minutes or 15 miles of a covered person's residence or workplace,[21] 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 included the requirement that health plans/insurers 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. CHBRP included this for reference given the provider supply constraints in mental health.

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

CHBRP is unaware of similar requirements or similar proposed legislation in other states related to the other SB 1338 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.[22] 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,[23] 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

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[19] 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.
[20] DMHC. *Timely Access to Care*. Available at: https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccesstoCare.aspx. Accessed April 1, 2022.
[21] CDI. *Provider Network Adequacy*. Available at: http://www.insurance.ca.gov/01-consumers/110-health/10-basics/pna.cfm. Accessed April 1, 2022.
[22] Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the ACA.
[23] H&SC Section 1374.72; IC Section 10144.5 and 10123.15.

exists in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).[24,25]

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.

Essential Health Benefits

Mental health services are one of the 10 Essential Health Benefits (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, SB 1338 would not require coverage for a new state benefit mandate that appears to exceed the definition of EHBs in California.

Analytic Considerations

If enacted, SB 1338 would apply to the health insurance of approximately 14,081,000 enrollees (36% of all Californians). This represents 62% 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, however, the bill exempts DMHC-regulated Medi-Cal managed care plans.

CHBRP assumes 100% baseline coverage of services. The bill would impact cost sharing and, to an extent, utilization of a small subset of enrollees in DMHC-regulated plans. For further information on analytic approach, see Appendix C

Prevalence of Schizophrenia Disorders in California

CHBRP estimates the number of enrollees utilizing care for schizophrenic spectrum and other psychotic disorders to be 5,657 in the state-regulated health insurance markets subject to SB 1338, over the age of 18. This model reflects claims from the 2019 Milliman Consolidated Health Cost Guidelines Sources Database (CHSD) with utilization and cost trended to 2023. Medical claims were identified by a primary diagnosis for schizophrenia and prescription drug claims are for the anti-psychotic therapeutic class.[26] SB 1338's coverage provisions do not interact with Medi-Cal Managed Care Plans, which may have a higher prevalence of schizophrenia disorders among enrollees in commercial market insurance plans.

Mental Health Workforce

Coverage does not guarantee access to care for mental health and substance use disorders. Access is also determined by the supply of providers. Among people with mental health/SUD who seek care, lack of provider access is 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

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[24] 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.

[25] 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.

[26] The unit charge for psychiatric evaluations is for CPT code 90792.

(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.

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).

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

Baseline and Postmandate Benefit Coverage and Utilization

Coverage

CHBRP estimates no change in benefit coverage due to SB 1338, with 100% of enrollees estimated to have coverage at baseline and postmandate. CHBRP used the incidence rate identified in the claims data for schizophrenia disorders to estimate the target population by market segment. This approach may underestimate undiagnosed cases.

Utilization

Of the 5,657 enrollees with state-regulated insurance who are diagnosed with schizophrenia or other psychotic disorders, CHBRP projects 113 would receive court-ordered psychiatric evaluations in year 1, and 57 enrollees would enter the CARE Court 12-24 month program.

This would yield an increase of 2 emergency department visits, 55 outpatient psychiatric visits, 61 office visits, and 20 new anti-psychotic medication prescriptions. Utilization of services associated with treatment of schizophrenia spectrum and psychotic disorders among persons already engaging in services through their insurance are assumed to increase for CARE program participants post-mandate, as the proposed legislation prohibits cost-sharing requirements for these enrollees.

Baseline and Postmandate Expenditures

SB 1338 would increase total net annual expenditures by $138,000 for enrollees with health insurance subject to state-level benefit mandates. This is due to a $213,000 increase in total health insurance premiums and a $75,000 reduction in enrollee cost sharing.

Of the 5,657 enrollees over the age of 18 having one or more medical claims for schizophrenia, CHBRP assumed 2% would receive the psychiatric evaluation for the CARE program and 1% (or half of those receiving the evaluation) would enter the program. CHBRP developed these estimates as a reasonable projection accounting for the administrative and cultural barriers to establishing these Courts and for referrals being made. CHBRP using expert opinion in developing its estimates. CHBRP’s analysis is limited to the health care service components of this bill and does not include other elements, including housing supports.

MEDICAL EFFECTIVENESS

The medical effectiveness review synthesizes findings from systematic reviews of evidence regarding the effectiveness of treatment of schizophrenia spectrum and other psychotic disorders, and evidence from studies regarding the impact of receipt of follow-up outpatient mental health services after discharge from inpatient mental health treatment and the impact of cost sharing on use of mental health services. The review draws on findings from CHBRP's reports on AB 2242, AB 1859 and SB 855, three bills that address coverage for behavioral health services.

Conceptual Framework

The impact of SB 1338 on outcomes for people with schizophrenia spectrum and other psychotic disorders who are enrolled in DMHC-regulated health insurance plans depends on several factors.

- The existence of effective treatments for schizophrenia spectrum and other another psychotic disorders.
- Evidence that providing timely follow-up outpatient treatment after discharge from treatment for an acute episode of one of these disorders improves outcomes.
- Evidence that eliminating cost sharing for behavioral health services increases use of services among people with these.

The Medical Effectiveness review summarizes evidence regarding each of these factors.

Key Questions

The medical effectiveness review addresses the following key questions related to SB 1338.

1. Are there effective treatments for schizophrenia spectrum and other psychotic disorders?
2. Is there evidence that receipt of timely follow-up outpatient mental health treatment after treatment for an acute episode of mental illness?
3. Does cost sharing affect the use of mental health services?

Outcomes Assessed

The review of evidence-based treatment guidelines and the literature reviews conducted (for AB 1859, AB 2242, and SB 855) addressed a variety of outcomes relevant to the impact of SB 1338 on people enrolled in DMHC-regulated health insurance plans: readmissions for psychiatric inpatient care, ED visits for psychiatric care, use of outpatient mental health services, medication adherence, and mental health outcomes (e.g., delusions, hallucinations).

Study Findings

This following section summarizes CHBRP's findings regarding literature regarding the potential impact of SB 1338 on people enrolled in DMHC-regulated health insurance plans. 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.

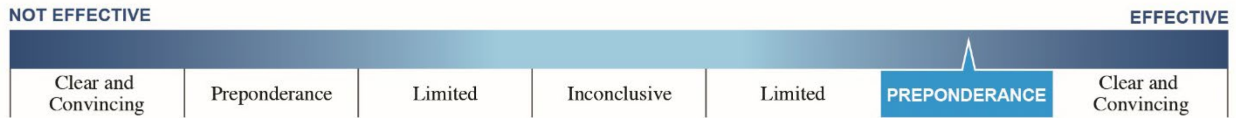
Treatments for Schizophrenia Spectrum Disorders

CHBRP reviewed findings from a systematic review of literature regarding the effectiveness of treatments for schizophrenia spectrum disorders that was prepared to inform the third edition of the American Psychiatric Association's (APA) clinical practice guideline for treatment of schizophrenia (APA, 2021). This systematic review synthesized findings from individual studies as well as those of several systematic reviews.

Pharmacotherapy

The systematic review for the APA clinical practice guideline synthesized findings from the AHRQ systematic review and several meta-analyses of randomized clinical trials that compared antipsychotic medications to placebos and to one another. The authors of the systematic review concluded that antipsychotic medications have moderate effects on symptoms of schizophrenia, depression, quality of life and social functioning and that these effects are larger than effects associated with placebos. They also found few statistically significant differences between different antipsychotic medications with regard to effects on mental health outcomes but that some medications were associated with lower rates of discontinuation and adverse events, such as cardiovascular events (e.g., acute coronary syndrome, stroke), neurological conditions (e.g., parkinsonism), and weight gain (APA, 2021).

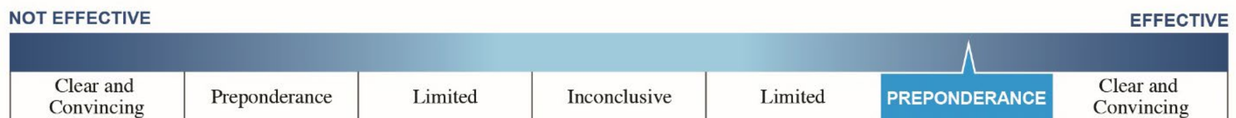
Summary of findings regarding the impact of pharmacotherapy for schizophrenia: There is a preponderance of evidence that antipsychotic medications are more effective than placebos at improving symptoms of schizophrenia, depression, quality of life and social functioning and that some antipsychotic medications are associated with lower rates of discontinuation and adverse events.



Psychosocial Interventions

The systematic review for the APA clinical practice guideline concluded that the following psychosocial interventions improve functional outcomes, quality of life, and core symptoms of schizophrenia relative to usual care: cognitive behavioral therapy, psychoeducation, family intervention (if in contact with family members), self-management skills training, cognitive remediation, social skills training, and supported employment (APA, 2021). The APA guideline also found evidence that coordinated specialty care is more effective than usual care for treatment of early psychosis and that assertive community treatment is more effective than usual care for people with schizophrenia who experience frequent relapse, homelessness, or legal difficulties.

Summary of findings regarding the impact of psychosocial interventions for schizophrenia: There is a preponderance of evidence that multiple psychosocial interventions used to treat schizophrenia improve functional outcomes, quality of life, and core illness symptoms relative to usual care.



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

In light of CHBRP's finding that there is a preponderance of evidence that effective treatments for schizophrenia exist, CHBRP proceeded to review evidence regarding the impact of timely receipt of treatment following an acute episode of illness. The literature on this topic focuses on people who were discharged from an inpatient psychiatric hospitalization.

Impact on Hospital Readmissions

CHBRP's 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, findings from the five studies that examined effects on readmission were inconsistent. Four additional studies 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) also 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 mental health outpatient visits reduce hospital readmissions based on nine studies.

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 with schizophrenia who received follow-up care with a mental health provider within 30 days of discharge versus people who did not receive follow-up care within 30 days of discharge.

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 Outpatient Visits for Mental Health Services

CHBRP's literature search for AB 2242 identified one study of the impact of follow-up care with a mental health provider after a psychiatric hospitalization on outpatient visits for mental health services. The only study identified on this topic (Beadles et al., 2015) found that people with schizophrenia who received follow-up care with a mental health provider within 30 days of discharge versus people who did not receive follow-up care within 30 days of discharge had more outpatient visits for mental health services during the 6 months following discharge than people who did not receive follow-up care within 30 days of discharge.

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 3. 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 schizophrenia who received follow-up outpatient care within 30 days of discharge were more likely to fill any prescription for an antipsychotic medication than people who received no follow-up outpatient care within 30 days of discharge. Receipt of follow-up outpatient care within 8 to 30 days of discharge was associated with a higher percentage of days of medication covered by an insurance claim during the 6 months following discharge. These findings suggest that timely outpatient care increases the likelihood that people will fill an initial prescription for an antipsychotic medication but does not change medication adherence over time.

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 4. 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 searches for AB 2242 and AB 1859 did not identify any studies of the impact of follow-up visits on suicide risk among adults were identified. CHBRP identified one study of effects on suicide risk among adolescents (Fontanella et al., 2020) but the findings may not be generalizable to SB 1338, which would only apply to adults.

Summary of findings regarding the impact of timely mental health outpatient visits on mental health outcomes: There is *insufficient evidence* 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 5. Impact of Timely Mental Health Outpatient Visits on Mental Health Outcomes

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

Most studies of the impact of cost sharing on use of mental health services among people with commercial health insurance have examined the impact of reductions in cost sharing for mental health that are associated with the establishment of laws or policies mandating parity in coverage for mental health and physical health services. The most sweeping of these laws, the Mental Health Parity and

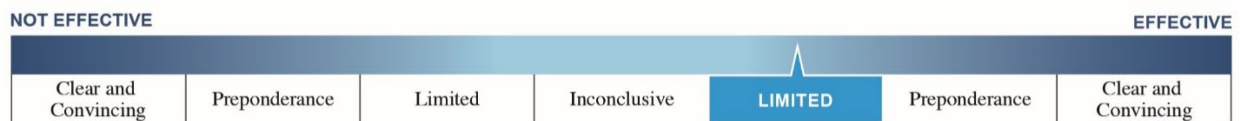
Addiction Equity Act (MHPAEA), lifted quantitative limits on coverage (e.g., the number of outpatient visits covered) and nonquantitative limits on coverage (e.g., prior authorization, medical necessity review), in addition to mandating parity in cost sharing for mental health and physical health services. CHBRP's review of literature on mental health parity laws for its report on SB 855 (Wiener, Mental Health Parity),[27] drew two main conclusions. First, these studies yielded inconclusive findings regarding the impact of parity on the likelihood that enrollees would use any mental health services. Second, there was a preponderance of evidence that parity laws are associated with an increase in numbers of visits for mental health services among people who use these services.

Findings from the studies of mental health parity laws suggest that the cost sharing provisions of SB 1338 alone may not be sufficient to lead people with schizophrenia spectrum or other psychotic disorders to use mental health services but that those who use services would use more services. However, the generalizability of these findings may be limited because these studies enrolled people with a wide range of mental health conditions, including many with disorders such as anxiety and depression, who would not be eligible for referral to CARE court. These studies also examined use of outpatient mental health services among people regardless of whether their condition is stabilized, whereas SB 1338 focuses on people whose conditions are not stabilized.

CHBRP's literature review for AB 2242 identified one study of the impact of copayments on the use of follow-up outpatient mental health services following psychiatric hospitalization (Ndumele et al., 2011; Trivedi et al., 2008). Their findings may be more relevant to SB 1338 than findings from studies of mental health parity because they focus on use of services by people who have recently had an acute episode of mental illness. 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 that had higher cost sharing for mental health services than primary are services.

Summary of findings regarding the impact of cost sharing on the use of mental health services: There is *limited evidence* that reducing cost sharing increases the rate at which people utilize mental health services. 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 with schizophrenia spectrum or other psychotic disorders whose conditions are not stabilized. 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.

Figure 6. The Impact of Cost Sharing on the Use of Behavioral 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

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

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 7. The Impact of Cost Sharing on Mental Health Outcomes

NOT EFFECTIVE | INSUFFICIENT EVIDENCE | EFFECTIVE

Clear and Convincing	Preponderance	Limited	Inconclusive	Limited	Preponderance	Clear and Convincing

APPENDIX A TEXT OF BILL ANALYZED

On April 20, 2022, the California Assembly Committee on Health requested that CHBRP analyze SB 1338.

SENATE BILL **NO. 1338**

Introduced by Senators Umberg and Eggman

February 18, 2022

An act to add ~~Part 1.3 (commencing with Section 5565) to Division 5 of~~ *Section 1374.723 to the Health and Safety Code, to amend Section 1370.01 of the Penal Code, and to add Part 8 (commencing with Section 5970) to Division 5 of* the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1338, as amended, Umberg. Community Assistance, Recovery, and Empowerment (CARE) Court Program.

~~Existing~~

(1) Existing law, the Assisted Outpatient Treatment Demonstration Project Act of 2002, known as Laura's Law, requires each county to offer specified mental health programs, unless a county or group of counties opts out by a resolution passed by the governing body, as specified. Existing ~~law defines "assisted outpatient treatment" to mean categories of outpatient services that have been ordered by a court, as prescribed.~~ *law, the Lanterman-Petris-Short Act, provides for short-term and longer-term involuntary treatment and conservatorships for people who are determined to be gravely disabled.*

~~This bill would establish the Community Assistance, Recovery, and Empowerment (CARE) Court Program to connect a person struggling with untreated mental illness and substance use disorders with a court-ordered CARE plan. The bill would authorize a court to order an adult person who is suffering from a mental illness and a substance use disorder and who lacks medical decisionmaking capacity to obtain treatment and services under a CARE plan that is managed by a CARE team, as specified. The bill would require each county to participate in providing services under the program. By imposing new duties on counties, 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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.~~

This bill would enact the Community Assistance, Recovery, and Empowerment (CARE) Act, which would authorize specified people to petition a civil court to create a CARE plan and implement services, to be provided by county behavioral health agencies, to provide behavioral health care, stabilization medication, and housing support to adults who are suffering from schizophrenia spectrum and psychotic disorders and who lack medical decisionmaking capacity. The bill would specify the process by which the petition is filed and reviewed, including requiring the petition to be signed under penalty of perjury, and to contain specified information, including the acts that support the petitioner's belief that the respondent meets the CARE criterion. The bill would also specify the schedule of review hearings required if the respondent is ordered to comply with a one-year CARE plan by the court. The bill would authorize the CARE plan to be extended for up to one year and prescribes the requirement for the graduation plan that is required upon leaving the CARE program. By expanding the crime of perjury and imposing additional duties on the county behavioral health agencies, this bill would impose a state-mandated local program.

This bill would include in the CARE program the respondent's right to have a supporter and counsel at all proceedings. The bill would require the California Health and Human Services Agency, subject to appropriation, to administer the CARE Supporter program, which would make available a trained supporter to each respondent.

This bill would authorize the court, at any time during the proceedings if it finds the county not complying with court orders, to fine the county up to $1,000 per day and, if the court finds persistent noncompliance, to appoint a receiver to secure court-ordered care for the respondent at the county's cost.

(2) 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. Existing law requires health care service plans to provide coverage for medically necessary treatment of mental health and substance use disorders. Violation of the Knox-Keene Act is a crime.

This bill would require health care service plans to cover the cost of developing an evaluation for CARE services and the provision of all health care services for an enrollee when required or recommended for the enrollee pursuant to a CARE plan, as specified, without cost sharing. By creating a new crime, this bill would impose a state-mandated local program.

(3) Existing law prohibits a person from being tried or adjudged to punishment while that person is mentally incompetent. Existing law establishes a process by which a defendant's mental competency is evaluated and by which the defendant receives treatment, with the goal of returning

the defendant to competency. Existing law suspends a criminal action pending restoration to competency.

This bill, for misdemeanor defendants who have been determined to be incompetent to stand trial, would authorize the court to refer the defendant to the CARE program.

(4) 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 with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

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. *The Legislature finds and declares all of the following:*

(a) Thousands of Californians are suffering from untreated schizophrenia spectrum and psychotic disorders, leading to risks to their health and safety and increased homelessness, incarceration, hospitalization, conservatorship, and premature death. These individuals, families, and communities deserve a path to care and wellness.

(b) With advancements in behavioral health treatments, many people with untreated schizophrenia spectrum and psychotic disorders can stabilize, begin healing, and thrive in community-based settings, with the support of behavioral health services, stabilizing medications, and housing. But too often this comprehensive care is only provided after arrest, conservatorship, or institutionalization.

(c) A new approach is needed to act earlier and to provide support and accountability, both to individuals with these untreated severe mental illnesses and to local governments with the responsibility to provide behavioral health services. California's civil courts will provide a new process for earlier action, support, and accountability, through a new Community Assistance, Recovery, and Empowerment (CARE) Court Program.

(d) Self-determination and civil liberties are important California values that can be advanced and protected for individuals with these untreated severe mental illnesses and without current capacity for medical decisionmaking, with the establishment of a new CARE Supporter role, in addition to legal counsel, for CARE proceedings.

(e) California continues to act with urgency to expand behavioral health services and to increase housing choices and end homelessness for all Californians. CARE provides a vital solution for some of the most ill and most vulnerable Californians.

SEC. 2. *Section 1374.723 is added to the Health and Safety Code, to read:*

1374.723. *(a) A health care service plan contract issued, amended, renewed, or delivered on or after July 1, 2023, that covers hospital, medical, or surgical expenses shall cover the cost of developing an evaluation pursuant to Section 5977 of the Welfare and Institutions Code and the provision of all health care services for an enrollee when required or recommended for the enrollee pursuant to a care plan approved by a court in accordance with the court's authority under Sections 5977 and 5982 of the Welfare and Institutions Code.*

(b) (1) A health care service plan shall not require prior authorization for services provided pursuant to a care plan approved by a court under the CARE program.

(2) A health care service plan may conduct a postclaim review to determine appropriate payment of a claim. Payment for services subject to this section may be denied only if the health care service plan reasonably determines the enrollee was not enrolled with the plan at the time the services were rendered, the services were never performed, or the services were not provided by a health care provider appropriately licensed or authorized to provide the services.

(3) Notwithstanding paragraph (1), a health care service plan may require prior authorization for services as permitted by the department pursuant to subdivision (e).

(c) (1) A health care service plan shall provide for reimbursement of services provided to an enrollee pursuant to this section at the greater of either of the following amounts:

(A) The health plan's contracted rate with the provider.

(B) The fee-for-service or case reimbursement rate paid in the Medi-Cal program for the same or similar services, including prescription drugs, as identified by the State Department of Health Care Services.

(2) A health care service plan shall provide reimbursement for services provided pursuant to this section in compliance with the requirements for timely payment of claims, as required by this chapter.

(d) Services provided to an enrollee pursuant to a CARE plan shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. An individual or entity shall not bill the enrollee or subscriber, nor seek reimbursement from the enrollee or subscriber, for services provided pursuant to a CARE plan.

(e) No later than July 1, 2023, the director of the Department of Managed Health Care may issue guidance to health care service plans regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340)

of Part 1 of Division 3 of Title 2 of the Government Code). Guidance issued pursuant to this subdivision shall be effective only until the director adopts regulations pursuant to the Administrative Procedure Act.

(f) This section does not apply to Medi-Cal managed care contracts entered pursuant to 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, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(g) This section shall become operative on July 1, 2023.

***SEC. 3**. Section 1370.01 of the Penal Code is amended to read:*

1370.01. (a) If the defendant is found mentally competent, the criminal process shall resume, and the trial on the offense charged or hearing on the alleged violation shall proceed.

(b) If the defendant is found mentally incompetent, the trial, judgment, or hearing on the alleged violation shall be suspended and the court may do either of the following:

(1) (A) Conduct a hearing, pursuant to Chapter 2.8A (commencing with Section 1001.35) of Title 6, and, if the court deems the defendant eligible, grant diversion pursuant to Section 1001.36 for a period not to exceed one year from the date the individual is accepted into diversion or the maximum term of imprisonment provided by law for the most serious offense charged in the misdemeanor complaint, whichever is shorter.

(B) If the court opts to conduct a hearing pursuant to this paragraph, the hearing shall be held no later than 30 days after the finding of incompetence. If the hearing is delayed beyond 30 days, the court shall order the defendant to be released on their own recognizance pending the hearing.

(C) If the defendant performs satisfactorily on diversion pursuant to this section, at the end of the period of diversion, the court shall dismiss the criminal charges that were the subject of the criminal proceedings at the time of the initial diversion.

(D) If the court finds the defendant ineligible for diversion based on the circumstances set forth in subdivision (b) or (d) of Section 1001.36, the court may, after notice to the defendant, defense counsel, and the prosecution, hold a hearing to determine whether to do any of the following:

(i) Order modification of the treatment plan in accordance with a recommendation from the treatment provider.

(ii) Refer the defendant to assisted outpatient treatment pursuant to Section 5346 of the Welfare and Institutions Code. A referral to assisted outpatient treatment may only occur in a county where services are available pursuant to Section 5348 of the Welfare and Institutions Code, and the agency agrees to accept responsibility for treatment of the defendant. A hearing to determine eligibility for assisted outpatient treatment shall be held within 45 days after the date of the referral.

If the hearing is delayed beyond 45 days, the court shall order the defendant, if confined in county jail, to be released on their own recognizance pending that hearing. If the defendant is accepted into assisted outpatient treatment, the charges shall be dismissed pursuant to Section 1385.

(iii) Refer the defendant to the county conservatorship investigator in the county of commitment for possible conservatorship proceedings for the defendant pursuant to Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code. A defendant shall only be referred to the conservatorship investigator if, based on the opinion of a qualified mental health expert, the defendant appears to be gravely disabled, as defined in subparagraph (A) of paragraph (1) of subdivision (h) of Section 5008 of the Welfare and Institution Code. Any hearings required in the conservatorship proceedings shall be held in the superior court in the county of commitment. The court shall transmit a copy of the order directing initiation of conservatorship proceedings to the county mental health director or the director’s designee and shall notify the county mental health director or their designee of the outcome of the proceedings. Before establishing a conservatorship, the public guardian shall investigate all available alternatives to conservatorship pursuant to Section 5354 of the Welfare and Institutions Code. If a petition is not filed within 60 days of the referral, the court shall order the defendant, if confined in county jail, to be released on their own recognizance pending conservatorship proceedings. If the outcome of the conservatorship proceedings results in the establishment of conservatorship, the charges shall be dismissed pursuant to Section 1385.

(iv) Refer the defendant to the CARE program pursuant to Section 5978 of the Welfare and Institutions Code. A hearing to determine eligibility for CARE shall be held within 14 days after the date of the referral. If the hearing is delayed beyond 14 days, the court shall order the defendant, if confined in county jail, to be released on their own recognizance pending that hearing. If the defendant successfully completes CARE, the charges shall be dismissed pursuant to Section 1385.

(2) Dismiss the charges pursuant to Section 1385. If the criminal action is dismissed, the court shall transmit a copy of the order of dismissal to the county mental health director or the director’s designee.

(c) If the defendant is found mentally incompetent and is on a grant of probation for a misdemeanor offense, the court shall dismiss the pending revocation matter and may return the defendant to supervision. If the revocation matter is dismissed pursuant to this subdivision, the court may modify the terms and conditions of supervision to include appropriate mental health treatment.

(d) It is the intent of the Legislature that a defendant subject to the terms of this section receive mental health treatment in a treatment facility and not a jail. A term of four days will be deemed to have been served for every two days spent in actual custody against the maximum term of diversion. A defendant not in actual custody shall otherwise receive day for day credit against the term of diversion from the date the defendant is accepted into diversion. “Actual custody” has the same meaning as in Section 4019.

(e) This section shall apply only as provided in subdivision (b) of Section 1367.

SEC. 4. *Part 8 (commencing with Section 5970) is added to Division 5 of the Welfare and Institutions Code, to read:*

PART 8. The Community Assistance, Recovery, and Empowerment Act
CHAPTER 1. General Provisions

5970. *This part shall be known, and may be cited, as Community Assistance, Recovery, and Empowerment (CARE) Act.*

5971. *Unless the context otherwise requires, the following definitions shall govern the construction of this part.*

(a) "Court-ordered evaluation" means an evaluation ordered by a superior court pursuant to Section 5977.

(b) "CARE plan" means an individualized, clinically appropriate range of behavioral health related services and supports provided by a county behavioral health agency, including, but not limited to, clinical care, stabilization medications, and a housing plan, pursuant to Section 5982.

(c) "Graduation plan" means a plan that is developed by the person who is the subject of the petition, with assistance from a supporter, as needed, and the person's treatment team. The graduation plan shall include a strategy to support a successful transition out of court jurisdiction and may include a psychiatric advance directive. The graduation plan may also include, but is not limited to, on-going behavioral health services, including medication management, peer support services, housing and related support services, vocational or educational services, and psychoeducation.

(d) "Psychiatric advance directive" means a legal document that allows a person with mental illness to protect their autonomy and ability to self-direct care by documenting their preferences for treatment in advance of a mental health crisis.

(e) "Respondent" means the person who is subject to the petition for CARE court proceedings.

(f) "Supporter" means an adult, trained pursuant to Chapter 4 (commencing with Section 5980), who assists the person who is the subject of the petition, which may include supporting the person to understand, make, communicate, implement, or act on their own life decisions.

CHAPTER 2. Process

5972. *A court may order a respondent to participate in CARE proceedings if the court finds, by clear and convincing evidence, that the facts stated in the petition are true and establish that the requisite criteria set forth in this section are met, including all of the following:*

(a) The person is 18 years of age or older.

(b) The person has a diagnosis of schizophrenia spectrum or other psychotic disorder, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

(c) The person is not clinically stabilized in on-going treatment with the county behavioral health agency.

(d) The person currently lacks medical decisionmaking capacity.

***5973**. Proceedings under this part may be commenced in any of the following:*

(a) The county in which the respondent resides.

(b) The county where the respondent is found.

(c) The county where the respondent is facing criminal or civil proceedings.

***5974**. The following persons may file a petition to initiate CARE proceedings:*

(a) A person 18 years of age or older with whom the respondent resides.

(b) A spouse, parent, sibling, or adult child of the respondent.

(c) The director of a hospital, or their designee, in which the respondent is hospitalized, including hospitalization pursuant to Section 5150 or 5250.

(d) The director of a public or charitable organization, agency, or home, or their designee, currently or previously providing behavioral health services to the respondent or in whose institution the respondent resides.

(e) A qualified behavioral health professional, or their designee, who is, or has been, either supervising the treatment of, or treating the respondent for a mental illness.

(f) A first responder, including a peace officer, firefighter, paramedic, emergency medical technician, mobile crisis response worker, or homeless outreach worker.

(g) The public guardian or public conservator, or their designee, of the county in which the respondent is present or reasonably believed to be present.

(h) The director of a county behavioral health agency, or their designee, of the county in which the respondent is present or reasonably believed to be present.

***5975**. The petition shall be signed under the penalty of perjury and contain all of the following:*

(a) The name of the court to which it is addressed.

(b) The title of the proceeding.

(c) The name, age, and address, if any, of the respondent.

(d) The code section and the subdivision under which the proceedings are instituted.

(e) The petitioner's relationship with the respondent.

(f) Facts that support the petitioner's belief that the respondent meets the CARE criterion, including identification of the county behavioral health agency with responsibility for providing care to the respondent, if known.

(g) Either of the following:

(1) An affirmation or affidavit of a qualified behavioral health professional, stating that the qualified behavioral health professional or their designee has examined the respondent within three months of the submission of the petition, or has made appropriate attempts, but has not been successful, in eliciting the cooperation of the respondent to submit to an examination, and that the qualified behavioral health professional had determined that, based on an examination or a review of records and collateral interviews, the respondent meets, or is likely to meet, the diagnostic criteria for CARE proceedings.

(2) Evidence that the respondent was detained for intensive treatment pursuant to Article 4 (commencing with Section 5250) of Chapter 2 of Part 1 within the previous 90 days.

***5976**. The respondent shall have all of the following rights:*

(a) To receive notice of the hearings.

(b) To receive a copy of the court-ordered evaluation.

(c) To be represented by counsel at all stages of a proceeding commenced under this chapter.

(d) To a supporter, as described in Section 5982.

(e) To be present at the hearing unless the respondent waives the right to be present or the court makes a finding described in Section 5977 or appears remotely.

(f) To present evidence.

(g) To call witnesses.

(h) To cross-examine witnesses.

(i) To appeal decisions, and to be informed of the right to appeal.

5977. *(a) (1) Upon receipt by the court of a petition, the court shall set an initial hearing not later than 14 days from the date the petition is filed with the court.*

(2) The court shall appoint counsel and a supporter within five calendar days of filing.

(3) The petitioner shall be responsible for providing notice of the hearing to the respondent, the respondent's counsel and supporter, and the county behavioral health agency in the county where the respondent resides.

(b) (1) At the initial hearing, which shall occur 14 days after the petition is filed with the court, the court shall determine if the respondent meets the CARE criteria.

(2) All of the following shall be required for the hearing:

(A) The petitioner shall be present. If the petitioner is not present, the matter shall be dismissed.

(B) The respondent may waive their appearance and appear through their counsel. If the respondent does not waive their appearance and does not appear at the hearing, and appropriate attempts to elicit the attendance of the respondent have failed, the court may conduct the hearing in the respondent's absence. If the hearing is conducted without the respondent present, the court shall set forth the factual basis for doing so.

(C) A representative from the county behavioral health agency shall be present.

(D) The supporter shall be allowed to be present.

(3) (A) The court shall determine if the petitioner has presented prima facie evidence that respondent meets the CARE criteria.

(B) If the court finds that the petitioner has not presented sufficient prima facie evidence, the court shall dismiss the case without prejudice, unless the court makes a finding on the record that the petitioner's filing was not in good faith.

(C) If the court finds that the petitioner has submitted prima facie evidence that the respondent meets the CARE criteria, the court shall order the county behavioral health agency to work with the respondent and the respondent's counsel and supporter to determine if the respondent shall engage in a treatment plan. A case management conference shall be set for no later than 14 days after the court makes its finding.

(c) (1) At the case management conference hearing, the court shall determine if a settlement agreement may be entered into by the parties.

(2) The case management conference may be continued for up to 14 days upon stipulation of the respondent and the county behavioral health agency.

(3) The court's findings that a settlement agreement may be entered into by the parties shall require a recitation of all terms and conditions on the record.

(4) If the court finds that parties have agreed to a settlement agreement, and the court agrees with the terms of the agreement, the court shall stay the matter and set a progress hearing for 60 days.

(5) (A) If the court finds that the parties are not likely to reach a settlement agreement, the court shall order a clinical evaluation of the respondent unless the parties stipulate otherwise.

(B) The court shall order the county behavioral health agency to conduct the evaluation unless the parties stipulate otherwise.

(C) The court shall set a hearing to review the evaluation within 14 days.

(D) The evaluation shall be confidential pursuant to Section 5200.

(d) (1) At the evaluation review hearing, the court shall review the evaluation and any other evidence from all interested individuals, including, but not limited to, evidence from the petitioner, the county behavioral health agency, the respondent, and the supporter.

(2) The hearing may be continued a maximum of 14 days upon stipulation of the respondent and the county behavioral health agency.

(3) (A) If the court finds that the evaluation and other evidence demonstrate by clear and convincing evidence that the respondent meets the CARE criteria, the court shall order the county behavioral health agency, the respondent, and the respondent's counsel and supporter to jointly develop a CARE plan.

(B) The respondent and the county behavioral health agency may request appellate writ review of the order to develop a CARE plan.

(C) A hearing to approve the CARE plan shall be set not more than 14 days from the date of the order to develop a CARE plan.

(4) If the court finds that the evidence does not, by clear and convincing evidence, support that the respondent meets the CARE criteria, the court shall dismiss the petition without prejudice.

(e) (1) The plan approval and implementation hearing to approve the CARE plan shall occur within 14 days after date of the order to develop a CARE plan.

(2) The CARE plan may be presented by both or either of the parties. After presentation, the court may do any of the following:

(A) Approve the plan as presented and make any orders necessary for the implementation of the plan.

(B) Order the plan modified to better meet the needs of the parties, approve the plan as modified, within the scope of the county behavioral health agency's services, and make any orders necessary for the implementation of the plan.

(C) Reject the plan and order the parties to continue to work on the plan. The court shall set a subsequent hearing for no more than 14 days after rejecting the proposed plan.

(3) (A) If the court rejects the plan or if there is no CARE plan because the parties have not had sufficient time to complete it, the court may grant a continuance for no more than 14 days.

(B) At the subsequent CARE plan approval and implementation hearing, the court shall review the CARE plan, at which time the court may do either of the following:

(i) Approve the plan as presented and make any orders necessary to implement the plan.

(ii) Order the plan modified, within the scope of the county behavioral health agency's services, to better meet the needs of the parties, approve the plan as modified, and make any orders necessary to implement the plan.

(4) Court approval of the CARE plan begins the one-year CARE program timeline.

(f) The court shall schedule a status conference for 60 days after the approval of the CARE plan to review the progress of the CARE plan's implementation.

(g) (1) The 60-day status conference shall be followed by regular status conferences set by the court, at least every 180 days.

(2) Intermittent lapses or setbacks experienced by the respondent shall be reviewed by the court.

(h) (1) In the 11th month of the program timeline, the court shall hold a one-year status hearing. At that hearing, the court shall determine whether to graduate the respondent from the program with a graduation plan or reappoint the respondent to the program for another term, not to exceed one year.

(2) The one-year status hearing shall be an evidentiary hearing. All parties shall be permitted to speak, present evidence, and the court shall hear recommendations from the county behavioral health agency.

(3) If the respondent has successfully completed participation in the one-year CARE program, the respondent shall not be reappointed to the program.

(4) At the one-year status hearing, the respondent may request graduation or reappointment to the CARE program. If the respondent elects to accept voluntary reappointment to the program, the respondent may request any amount of time, up to and including one additional year, to be reappointed to the CARE program.

(5) If the respondent requests to be graduated from, or times out of, the program, the court shall officially graduate the respondent and terminate its jurisdiction with a graduation plan.

(6) Upon completion, for a respondent who was transferred from another court, the referring court shall be given notice of completion and the underlying matter shall be terminated.

(i) The hearings described in this section shall occur in-person unless the court, in its discretion, determines that a party may appear remotely through the use of remote technology.

(j) Consistent with its constitutional rulemaking authority, the Judicial Council shall adopt rules to implement the policies and provisions in this section to promote statewide consistency, including, but not limited to, what is included in the petition form packet, the clerk's review of the petition, and the process by which counsel and supporter will be appointed.

***5978**. (a) A court may refer an individual from assisted outpatient treatment and conservatorship proceedings to CARE proceedings.*

(b) A court may refer an individual from misdemeanor proceedings pursuant to Section 1370.01 of the Penal Code.

CHAPTER 3. Accountability

***5979**. (a) If, at any time during the proceedings, the court determines by a preponderance of evidence that the respondent is not participating in CARE proceedings, after the respondent receives notice, or is failing to comply with their CARE plan, the court may terminate the respondent's participation in the CARE program. The court may utilize existing legal authority pursuant to Article 4 (commencing with Section 5200) of Chapter 2 of Part 1, to ensure the respondent's safety. The subsequent proceedings may use the CARE proceedings as a factual presumption that no suitable community alternatives are available to treat the individual.*

(b) If, at any time during the proceedings, the court finds that the county is not complying with court orders, the court may fine the county up to one thousand dollars ($1,000) per day for noncompliance. If a county is found to be persistently noncompliant, the court may appoint a receiver to secure court-ordered care for the respondent at the county's cost.

(c) Either the respondent or the county behavioral health agency may appeal an adverse court determination to the appellate division of the superior court.

CHAPTER 4. The Supporter

***5980**. (a) Subject to appropriation, the California Department of Aging shall administer the CARE Supporter program, which shall make available a trained supporter to the respondent. The department shall train the supporter on supported decisionmaking with individuals who have behavioral health conditions and on the use of psychiatric advance directives, with support and input from peers, family members, disability groups, providers, and other relevant stakeholders. The department may enter into a technical assistance and training agreement to provide trainings*

either directly to supporters or to the contracted entities who will be responsible for hiring and matching supporters to respondents. The CARE Supporter program contracts shall include labor standards.

(b) The CARE Supporter program shall be designed to do all of the following:

(1) Offer the respondent a flexible and culturally responsive way to maintain autonomy and decisionmaking authority over their own life by developing and maintaining voluntary supports to assist them in understanding, making, communicating, and implementing their own informed choices.

(2) Strengthen the respondent's capacity and prevent or remove the need to use more restrictive protective mechanisms, such as conservatorship.

(3) Assist the respondent with understanding, making, and communicating decisions and expressing preferences throughout the CARE court process.

(c) If the respondent chooses to have a supporter who was not trained pursuant to this section, that person may serve as a supporter without compensation.

***5981**. (a) Notwithstanding any other provision of this part, the respondent may have their supporter present, if available, in any meeting, judicial proceeding, or communication related to any of the following:*

(1) An evaluation.

(2) Creation of a CARE plan.

(3) Establishing a psychiatric advance directive.

(4) Development of a graduation plan.

(b) A supporter shall do all the following, to the best of their ability and to the extent reasonably possible:

(1) Support the will and preferences of the respondent.

(2) Respect the values, beliefs, and preferences of the respondent.

(3) Act honestly, diligently, and in good faith.

(4) Avoid, to the greatest extent possible, and disclose, minimize, and manage, conflicts of interest.

(c) Unless explicitly authorized, a supporter shall not do any of the following:

(1) Make decisions for, or on behalf of, the respondent, except when necessary to prevent imminent bodily harm or injury.

(2) Sign documents on behalf of the respondent.

(3) Substitute their own judgment for the decision or preference of the respondent.
(d) In addition to the obligations in this section, a supporter shall be bound by all existing obligations and prohibitions otherwise applicable by law that protect people with disabilities and the elderly from fraud, abuse, neglect, coercion, or mistreatment. This section does not limit a supporter's civil or criminal liability for prohibited conduct against the respondent, including liability for fraud, abuse, neglect, coercion, or mistreatment, including liability under the Elder Abuse and Dependent Adult Civil Protection Act (Chapter 11 (commencing with Section 15600) of Part 3 of Division 9), including, but not limited to, Sections 15656 and 15657.

CHAPTER 5. CARE Plan

***5982**. The CARE plan shall be created by the respondent, their supporter and counsel, and the county behavioral health agency. The plan shall include all of the following components:*

(a) (1) Behavioral health treatment, which includes medically necessary mental health or substance use disorder treatment, or both.

(2) If the respondent is enrolled in the Medi-Cal program, the county shall provide all medically necessary specialty mental health and substance use disorder treatment services, as those services are defined in the Medi-Cal program and consistent with their responsibilities thereunder, to a respondent when included in their court ordered CARE plan. Specialty mental health services and substance use disorder treatment services may be included in the CARE plan if they are determined to be medically necessary by the clinical evaluation. If the respondent is an enrollee in a health care service plan, other than a Medi-Cal managed care plan, the services shall be provided and reimbursed pursuant to Section 1374.723 of the Health and Safety Code.

(3) Counties are encouraged to employ medically necessary, evidence-based practices and promising practices supported with community-defined evidence, which may include assertive community treatment, peer support services, and psychoeducation.

(b) (1) As part of the provision of behavioral health care, the care plan may include medically necessary stabilization medications, including antipsychotic medications. If medically necessary, medications may be provided as long-acting injections.

(2) Court ordered stabilization medications shall not be forcibly administered, absent a separate order by the court pursuant to Sections 5332 to 5336, inclusive.

(3) Medically necessary stabilization medications may be prescribed by the treating licensed behavioral health care provider and medication support services shall be offered. The respondent, in the development and on-going maintenance of the plan, shall work with their behavioral health

care provider and their supporter to address medication concerns and make changes to the treatment plan.

(c) A housing plan that describes the housing needs of the respondent and the housing resources that will be considered in support of an appropriate housing placement. The respondent shall have diverse housing options, including, but not limited to, housing in clinically enhanced interim or bridge housing, licensed adult and senior care settings, and supportive housing. Counties may offer appropriate housing placements in the region as early as feasible in the engagement process. This section does not allow the court to order housing or to require the county to provide housing.

CHAPTER 6. Technical Assistance and Administration

***5983**. (a) Subject to appropriation, the State Department of Health Care Services shall provide technical assistance to county behavioral health agencies to support the implementation of this part, including trainings regarding the CARE model and statute and data collection.*

(b) Subject to appropriation, the State Department of Health Care Services shall administer the Behavioral Health Bridge Housing program to provide funding for clinically enhanced bridge housing settings to serve individuals who are experiencing homelessness and have behavioral health conditions. Individuals who are CARE program participants shall be prioritized for any appropriate bridge housing funded by the Behavioral Health Bridge Housing program.

(c) Subject to appropriation, the Judicial Council shall provide technical assistance to judges to support the implementation of this part, including trainings regarding the CARE model and statutes, working with the supporter, best practices, and evidence-based models of care for people with severe behavioral health conditions.

***5984**. (a) For purposes of implementing this part, the California Health and Human Services Agency, the State Department of Health Care Services, and the California Department of Aging may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this part shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.*

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the California Health and Human Services Agency, the State Department of Health Care Services, and the California Department of Aging may implement, interpret, or make specific this part, in whole or in part, by means of plan letters, information notices, provider bulletins, or other similar instructions, without taking any further regulatory action.

SEC. 5*. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, 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.*

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

~~SECTION 1.Part 1.3 (commencing with Section 5565) is added to Division 5 of the Welfare and Institutions Code, to read:~~

~~1.3.Community Assistance, Recovery, and Empowerment (CARE) Court Program~~

~~5565.(a)The Community Assistance, Recovery, and Empowerment (CARE) Court Program is hereby established to connect a person struggling with untreated mental illness and substance use disorders with a court-ordered CARE plan.~~

~~(b)(1)A court may order a person who is the subject of a petition filed pursuant to this section to obtain treatment and services under a CARE plan if the court finds that the facts stated in the verified petition are true and established and the criteria set in this section are met, including, but not limited to, each of the following:~~

~~(A)The person is 18 years of age or older.~~

~~(B)The person is suffering from a mental illness and a substance use disorder.~~

~~(C)The person lacks medical decisionmaking capacity.~~

~~(2)A court may order the person to have a CARE plan for up to 12 months, and may renew the plan for up to another 12 months. The court shall conduct periodic review hearings.~~

~~(3)A person who is ordered under a CARE plan who does not complete the plan may be referred to conservatorship pursuant to Chapter 3 (commencing with Section 5350) of Part 1, and it shall be presumed that there are no suitable alternatives to conservatorship available to the person~~

~~(c)A petition for an order authorizing a CARE plan may be filed by a family member, county representative, community-based social services provider, behavioral health provider, or first responder in the superior court in the county in which the person who is the subject of the petition is present or reasonably believed to be present.~~

~~**(d)(1)A CARE plan shall be managed by a CARE team in the community, and may include clinically prescribed and individualized interventions with several supportive services, including, but not limited to, medication and housing.**~~

~~**(2)The CARE team shall consist of clinical team members, a public defender, and a support person to help make self-directed care decisions.**~~

~~**(e)(1)Each county shall participate in providing services under the program.**~~

~~**(2)The court may order sanctions or appoint an agent to ensure the county provides services under the program.**~~

~~**SEC. 2.If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.**~~

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 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*.[28] 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;*
- *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.

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

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.

APPENDIX C

Methodology and Assumptions for Baseline Benefit Coverage

- The population subject to the mandated offering includes individuals aged 18 years and over, covered by DMHC-regulated commercial insurance plans, and CalPERS plans subject to the requirements of the Knox-Keene Health Care Service Plan Act HMOs. Medi-Cal Managed Care Plans are not included in this mandate.
- CHBRP assumed 100% of the population in plans and policies subject to mandated offerings currently receive some form of coverage for physical and mental health care related to schizophrenic spectrum and other psychotic disorders.

Methodology and Assumptions for Baseline Utilization and Cost

- The average cost and utilization rates for medical services and prescription drugs are based on the 2019 Consolidated Health Cost Guidelines Sources Database (CHSD). The data was limited to adult (age 18+) California commercial enrollees.
- Medical claims to be included in this analysis were identified by a schizophrenia-related diagnosis code in the primary diagnosis position. The procedure codes used to identify schizophrenic spectrum claims are shown in Table C-1. CHBRP included claims for inpatient and outpatient psychiatric services (facility and professional), emergency department visits, and office visits.

Table C-1. Schizophrenia Spectrum and Psychotic Disorder Diagnosis Codes (ICD-10)

Diagnosis Code	Description
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F2081	Schizophreniform disorder
F2089	Other schizophrenia
F209	Schizophrenia, unspecified
F21	Schizotypal disorder
F250	Schizoaffective disorder, bipolar type
F251	Schizoaffective disorder, depressive type
F258	Other schizoaffective disorders
F259	Schizoaffective disorder, unspecified
F601	Schizoid personality disorder

Source: California Health Benefits Review Program, 2022.

- CHBRP included prescription drug claims for members identified as having at least one medical claim with a schizophrenia-related primary diagnosis and for which the Medi-Span database of pharmaceuticals identified the major therapeutic class of the drug as "antipsychotic/antimanic."
- Medical and prescription drug claims were trended from 2019 to 2023 using the trends shown in Table C-2 below, per the Milliman Health Cost Guidelines.

Table C-2. Trended Prescription Drug Claims, 2019-2023

	Annual Trend	
Category of Service	**Utilization**	**Allowed Charge**
Inpatient - Psychiatric	0.00%	4.00%
Emergency Department	1.25%	4.50%
Outpatient - Psychiatric	1.25%	4.50%
Office Visit - Psychiatric	0.25%	3.50%
Rx - Antipsychotics	1.50%	3.00%

Source: California Health Benefits Review Program, 2022.

Methodology and Assumptions for Baseline Cost Sharing

- The paid-to-allowed ratios for medical services and prescription drugs were calculated using the CHSD database.
- The CHSD commercial claims database is representative of the large group market. We relied upon the Milliman Health Cost Guidelines 2022 utilization adjustment factors to adjust the utilization rates from the data to estimate utilization in the absence of cost sharing.
- To adjust for average plan benefit differentials by line of business, we calculated utilization adjustment factors for each line of business and multiplied the zero-cost sharing utilization by these factors.

Methodology and Assumptions for Postmandate Utilization

- CHBRP used the incidence rate identified in the claims data to estimate the target population by market segment.
- CHBRP assumed that court petitions would be filed on behalf of 2% of the identified population, and that one half of these (1% of the total enrollees with a schizophrenia spectrum diagnosis) would be approved for the CARE program.
- CHBRP assumed that each enrollee for whom a court petition is filed will receive an initial psychiatric evaluation. Utilization of services associated with treatment of schizophrenia spectrum and psychotic disorders are assumed to increase for CARE program participants post-mandate, as the proposed legislation prohibits cost-sharing requirements for these enrollees. The utilization impact for these members was estimated from the copay utilization factors previously cited, current cost sharing requirements and zero-cost sharing utilization levels.
- This analysis is limited to the healthcare services described by this document. Additional requirements described by the bill were excluded from the analysis.

Methodology and Assumptions for Postmandate Cost

- CHBRP assumed there would be no change in per unit cost postmandate.
- CHBRP estimated the cost of the initial psychiatric evaluation for the enrollees for whom petitions are filed as the average allowed reimbursement for CPT code 90792 ("Psych diag eval w/med srvcs") using the 2019 CHSD database trended to 2023.

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Methodology and Assumptions for Postmandate Cost Sharing

- The bill prohibits cost sharing for the services provided through this program.

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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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