DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

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September 28, 2020

TO: Supervisor Kathryn Barger, Chair
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Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Janice Hahn

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director

SUBJECT: **MENTAL HEALTH LEGISLATIVE UPDATE**

The Department of Mental Health (DMH) has been advocating aggressively for changes in law to support reform with a specific focus on growing and diversifying our programs for additional impact through the Peer Support Specialist bill (SB 803), optimizing our supportive housing capacity through the Board and Care data collection bill (AB 1766), and covering more services for people who are commercially insured through the Mental Health parity bill (SB 855) over this past year.

We are pleased to inform you that with support from this Board of Supervisors, and close ongoing partnership with CEO Legislative Affairs, all three mental health legislative bills were signed by Governor Newsom this past Friday.

SB 803 (Beall): Mental Health Services: Peer Support Specialist Certification

SB 803 establishes a peer support specialist (peer) certification program and adds peer support specialist services as a Medi-Cal covered benefit for counties that opt in. SB 803 requires the Department of Health Care Services (DHCS) to establish statewide standards for certifying peers and to seek federal waivers necessary to establish peer services as a Medi-Cal provider type.

Peers, working in conjunction with other mental health providers as a multidisciplinary team, have proven to increase participation in treatment, reduce hospitalizations and homelessness, and improve outcomes. Peer support specialists are self-identified consumers who use their lived experience formal training to assist others in recovering from mental illness. Peers are key for programs to address racial and socioeconomic disparities and are

uniquely capable of establishing trusting relationships to help individuals engage, access resources, and continue in treatment. Peers will become not only a bigger and more core workforce in service but also help define and forge the future of the entire behavioral health field.

AB 1766 (Bloom) Licensed Adult Residential Facilities and Residential Care Facilities for the Elderly: Data Collection: Residents with a Serious Mental Disorder

Adult Residential Care Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs), also known as Board and Cares, play a vital role in the public health system by offering a home and structured and supportive environment to clients who are at risk of homelessness, incarceration, and institutionalization.

AB 1766 will ensure that data is provided to DMH and partners to stabilize, better use, improve, and expand the Board and Care network. AB 1766 requires that much needed data be collected to identify those facilities that "house and support" low-income residents with serious mental illness and also notifies counties to upcoming closures.

SB 855 (Wiener) Health Coverage Mental Health or Substance Abuse Disorders

SB 855 expands the ability of Californians who buy insurance or get it from their employers to obtain treatment for a wide array of mental health and substance use disorders. SB 855 replaces the California Mental Health Parity Act with a broader requirement that holds health plans as well as disability insurers accountable to: cover medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions, establish requirements for medical necessity determinations (utilization review), and ban discretionary clauses in health plan contracts.

It also requires commercial health insurers to pay for medically necessary treatment of any behavioral health or substance use disorder listed in the DSM-5, the manual that defines mental health conditions. By replacing current mental health parity law, SB 855 will increase access to treatment, reduce numerous negative outcomes including incarceration and hospitalization, and reduce the large number of individuals who fall back on public insurance (Medi-Cal) because private insurers deny coverage for behavioral health services.

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Enclosed:
1. SB 803 (Beall) - Mental Health Services: Peer Support Specialist Certification
2. AB 1766 (Bloom) - Licensed Adult Residential Facilities and Residential Care Facilities for the Elderly: Data Collection: Residents with a Serious Mental Disorder
3. SB 855 (Wiener) - Health Coverage Mental Health or Substance Abuse Disorders

Senate Bill No. 803

Passed the Senate August 31, 2020

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Secretary of the Senate

Passed the Assembly August 31, 2020

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2020, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to add Article 1.4 (commencing with Section 14045.10) to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 803, Beall. Mental health services: peer support specialist certification.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program and provides for various services, including behavioral and mental health services that are rendered by Medi-Cal enrolled providers.

This bill would require the department, by July 1, 2022, subject to any necessary federal waivers or approvals, to establish statewide requirements for counties or their representatives to use in developing certification programs for the certification of peer support specialists, who are individuals who self-identify as having lived experience with the process of recovery from mental illness, substance use disorder, or both. The bill would authorize a county, or an agency that represents a county, to develop a peer support specialist certification program and certification fee schedule, both of which would be subject to department approval. The bill would require the department to seek any federal waivers it deems necessary to establish a demonstration or pilot project for the provision of peer support services in a county that agrees to participate in and fund the project, as specified.

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

SECTION 1. This act shall be known, and may be cited, as the Peer Support Specialist Certification Program Act of 2020.

SEC. 2. Article 1.4 (commencing with Section 14045.10) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 1.4. Peer Support Specialist Certification Program

14045.10. The Legislature finds and declares all of the following:

(a) Peer providers in California provide individualized support, coaching, facilitation, and education to clients with mental health care needs and substance use disorders in a variety of settings. Yet, no statewide scope of practice, standardized curriculum, training standards, supervision standards, or certification protocol is available.

(b) The United States Department of Veterans Affairs and at least 48 states utilize standardized curricula and certification protocols for peer support services.

(c) The federal Centers for Medicare and Medicaid Services (CMS) recognizes that the experiences of peer support specialists, as part of an evidence-based model of care, can be an important component in a state's delivery of effective mental health and substance use disorder treatment. The CMS encourages states to offer comprehensive programs.

(d) A substantial number of research studies demonstrate that peer supports improve client functioning, increase client satisfaction, reduce family burden, alleviate depression and other symptoms, reduce homelessness, reduce hospitalizations and hospital days, increase client activation, and enhance client self-advocacy.

(e) Certification can increase the diversity and effectiveness of the behavioral health workforce through the use of peers with lived experience.

14045.11. It is the intent of the Legislature that the peer support specialist certification program, established under this article, achieve all of the following:

(a) Support the ongoing provision of services for individuals experiencing mental health care needs, substance use disorder needs, or both, by certified peer support specialists.

(b) Support coaching, linkage, and skill building of individuals with mental health needs, substance use disorder needs, or both, and to families or significant support persons.

(c) Increase family support by building on the strengths of families and helping them achieve a better understanding of mental illness in order to help individuals achieve desired outcomes.

(d) Support collaboration with others providing care or support to the individual or family.

(e) Assist parents, families, and individuals in developing coping mechanisms and problem-solving skills in order to help individuals achieve desired outcomes.

(f) Promote skill building for individuals in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

(g) Encourage employment under the peer support specialist certification to reflect the culture, ethnicity, sexual orientation, gender identity, mental health service experiences, and substance use disorder experiences of the individuals the peer support specialists serve.

14045.12. For purposes of this article, the following definitions apply:

(a) "Certification" means the activities related to the verification that an individual has met all of the requirements under this article and that the individual may provide peer support specialist services pursuant to this article.

(b) "Certified" means all federal and state requirements have been satisfied by an individual who is seeking designation under this article, including completion of curriculum and training requirements, testing, and agreement to uphold and abide by the code of ethics.

(c) "Code of ethics" means the standards to which a peer support specialist is required to adhere.

(d) "Core competencies" means the foundational and essential knowledge, skills, and abilities required for peer specialists.

(e) "Cultural competence" means a set of congruent behaviors, attitudes, and policies that come together in a system or agency that enables that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates, at all levels, the importance of

language and culture, intersecting identities, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs to provide services in a culturally competent manner.

(f) "Department" means the State Department of Health Care Services.

(g) "Peer support specialist" means an individual who is 18 years of age or older, who has self-identified as having lived experience with the process of recovery from mental illness, substance use disorder, or both, either as a consumer of these services or as the parent or family member of the consumer, and who has been granted certification under a county peer support specialist certification program.

(h) "Peer support specialist services" means culturally competent services that promote engagement, socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. Peer support specialist services include, but are not limited to, prevention services, support, coaching, facilitation, or education that is individualized and is conducted by a certified peer support specialist.

(i) "Recovery" means a process of change through which an individual improves their health and wellness, lives a self-directed life, and strives to reach their full potential. This process of change recognizes cultural diversity and inclusion, and honors the different routes to resilience and recovery based on the individual and their cultural community.

14045.13. By July 1, 2022, subject to Section 14045.19, the department shall do all of the following:

(a) Establish statewide requirements for counties, or an agency representing counties, to use in developing certification programs for the certification of peer support specialists.

(b) Define the qualifications, range of responsibilities, practice guidelines, and supervision standards for peer support specialists. The department may utilize best practice materials published by the federal Substance Abuse and Mental Health Services Administration, the United States Department of Veterans Affairs, and related notable experts in the field as a basis for development of these definitions.

(c) Determine curriculum and core competencies required for certification of an individual as a peer support specialist, including curriculum that may be offered in areas of specialization, including, but not limited to, transition-age youth, veterans, gender identity, sexual orientation, and any other areas of specialization identified by the department. Core-competencies-based curriculum shall include, at a minimum, training related to all of the following elements:

(1) The concepts of hope, recovery, and wellness.

(2) The role of advocacy.

(3) The role of consumers and family members.

(4) Psychiatric rehabilitation skills and service delivery, and addiction recovery principles, including defined practices.

(5) Cultural competence training.

(6) Trauma-informed care.

(7) Group facilitation skills.

(8) Self-awareness and self-care.

(9) Cooccurring disorders of mental health and substance use.

(10) Conflict resolution.

(11) Professional boundaries and ethics.

(12) Preparation for employment opportunities, including study and test-taking skills, application and résumé preparation, interviewing, and other potential requirements for employment.

(13) Safety and crisis planning.

(14) Navigation of, and referral to, other services.

(15) Documentation skills and standards.

(16) Confidentiality.

(d) Specify peer support specialist employment training requirements, including core-competencies-based training and specialized training necessary to become certified under this article, and require training to include people with lived experience as consumers and family members.

(e) Establish a code of ethics.

(f) Determine continuing education requirements for biennial certification renewal.

(g) Determine the process for initial certification issuance and biennial certification renewal.

(h) Determine a process for investigation of complaints and corrective action, including suspension and revocation of certification and appeals.

(i) Determine a process for an individual employed as a peer support specialist on January 1, 2022, to obtain certification under this article.

(j) Determine requirements for peer support specialist certification reciprocity between counties, and for peer support specialists from out of state.

(k) Seek any federal approvals, related to the statewide certification standards, that it deems necessary to implement this article. For any federal approvals that the department deems necessary related to the statewide certification standards, this article shall be implemented only if and to the extent that the department obtains those federal approvals.

14045.14. (a) Subject to department approval, a county, or an agency representing the county, may develop a peer support specialist certification program in accordance with this article and any standards established by the department. That county, or an agency representing that county, shall oversee and enforce the certification requirements developed pursuant to this article. To request department approval of the county peer support specialist program, a county, or an agency representing the county, shall do all of the following:

(1) Submit to the department a peer support specialist program plan describing how the peer support specialist program will meet all of the federal and state requirements for the certification and oversight of peer support specialists.

(2) Submit to periodic reviews conducted by the department to ensure adherence to all federal and state requirements.

(3) Submit annual peer support specialist program reports to the department.

(b) If a county chooses not to develop peer support specialist certification programs in accordance with this article, the county may fund peer programs to the extent those programs meet all requirements of the applicable funding source.

(c) The Legislature finds that peer support specialist certification is conducted at the state level in other states, but this section passes this responsibility to counties. Subject to an appropriation by the Legislature, the state shall fund the startup costs to implement this section.

14045.15. (a) To receive a certification under this article, an applicant shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Possess a high school diploma or equivalent degree.

(3) Be self-identified as having experience with the process of recovery from mental illness or substance use disorder either as a consumer of these services or as the parent or family member of the consumer.

(4) Be willing to share their experience.

(5) Have a strong dedication to recovery.

(6) Agree, in writing, to adhere to a code of ethics.

(7) Successfully complete the curriculum and training requirements for a peer support specialist.

(8) Pass a certification examination approved by the department for a peer support specialist.

(b) To maintain certification under this article, a certified peer support specialist shall meet both of the following requirements:

(1) Adhere to the code of ethics and biennially sign an affirmation.

(2) Complete any required continuing education, training, and recertification requirements.

14045.16. This article does not authorize an individual who is certified pursuant to this article to diagnose an illness, prescribe medication, or provide clinical services.

14045.17. The department shall solicit stakeholder input that may include input from the Office of Statewide Health Planning and Development, peer support and family organizations, mental health services and substance use disorder treatment providers and organizations, the County Behavioral Health Directors Association of California, and the California Behavioral Health Planning Council in implementing this article. Consultation shall include regular stakeholder meetings. The department may additionally conduct technical workgroups upon the request of stakeholders.

14045.18. A participating county, or an agency representing a participating county, is authorized to establish a certification fee schedule for the purpose of supporting the activities associated with the ongoing administration of the peer support specialist certification program. Before the fee schedule may be implemented, the department shall review and either approve or disapprove the fee schedule of the participating county or an agency representing the participating county.

14045.19. (a) The department shall seek any federal waivers it deems necessary to establish a demonstration or pilot project for the provision of peer support services in counties that agree to participate and provide the necessary nonfederal share funding for the demonstration or pilot project. The demonstration or pilot project shall do all of the following:

(1) Include a peer support specialist certified pursuant to this article as a Medi-Cal provider type for purposes of the demonstration or pilot project.

(2) Include peer support specialist services as a distinct service type in counties that opt in to the demonstration or pilot project.

(3) Develop and implement one or more billing codes, reimbursement rates, and claiming requirements for peer support specialist services.

(b) (1) This section does not require a county to participate in a demonstration or pilot project pursuant to this section. A county that opts to participate in a demonstration or pilot project and provide the necessary nonfederal share funding shall be considered to do so voluntarily for purposes of all state and federal laws.

(2) A county that opts to participate in a demonstration or pilot project pursuant to this section agrees to fund the nonfederal share of any applicable expenditures through certified public expenditures or intergovernmental transfers in accordance with Section 433.51 of Title 42 of the Code of Federal Regulations. Each participating county shall certify that the local funds it uses to fund the nonfederal share of expenditures pursuant to this section qualify for federal financial participation pursuant to applicable federal Medicaid laws and any terms of federal approval, in the form and manner as required by the department.

(3) Demonstration or pilot projects developed and implemented pursuant to this section shall not constitute a mandate of a new program or higher level of service that has an overall effect of increasing the costs mandated by the 2011 realignment legislation for the counties that opt in to a demonstration or pilot project.

(4) General Fund moneys shall not be used to fund the nonfederal share of any expenditures made pursuant to a demonstration or pilot project under this section.

(c) This section shall be implemented only if and to the extent that the department obtains any necessary federal approvals, and

federal financial participation is available and is not otherwise jeopardized.

14045.20. For the purpose of implementing this article, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including contracts for the purpose of obtaining subject matter expertise or other technical assistance. Contracts entered into or amended pursuant to this section 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 or the Department of Technology.

14045.21. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article, in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions, without taking any further regulatory action.

Approved _____, 2020

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Governor

Assembly Bill No. 1766

Passed the Assembly August 30, 2020

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Chief Clerk of the Assembly

Passed the Senate August 28, 2020

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Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2020, at _____ o'clock ____M.

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Private Secretary of the Governor

CHAPTER _____

An act to add Sections 1507.4, 1509.6, and 1569.4 to the Health and Safety Code, relating to adult residential facilities.

LEGISLATIVE COUNSEL'S DIGEST

AB 1766, Bloom. Licensed adult residential facilities and residential care facilities for the elderly: data collection: residents with a serious mental disorder.

The California Community Care Facilities Act provides for the licensure and regulation of community care facilities by the State Department of Social Services, including various adult residential facilities, as described. The act includes legislative findings and declarations that there is an urgent need to establish a coordinated and comprehensive statewide service of quality community care for the mentally ill, the developmentally and physically disabled, and children and adults who require care or services. A person who violates the California Community Care Facilities Act is guilty of a misdemeanor. Existing law, the California Residential Care Facilities for the Elderly Act, provides for the licensure and regulation of residential care facilities for the elderly, as defined, by the department and expresses the intent of the Legislature to require that those facilities be licensed as a separate category within the existing licensing structure of the department.

This bill would require the department to collect information and send a report to each county's department of mental health or behavioral health, beginning May 1, 2021, and annually thereafter, of all licensed adult residential facilities and residential care facilities for the elderly, as described, that accept a specified federal rate and accept residents with a serious mental disorder, as defined, and the number of licensed beds at each facility. The bill would require the department, beginning May 1, 2021, and quarterly thereafter, to send to those county departments a report of licensed adult residential facilities and residential care facilities for the elderly that closed permanently in the prior quarter, as specified. The bill would require the department to notify the county mental or behavioral health department within 3 business days upon

receiving notice that a licensed adult residential facility or residential care facility for the elderly intends to close permanently.

The bill would also revise the California Community Care Facilities Act by requiring an applicant or licensee of an adult community care facility to maintain an email address of record with the department and to provide written notification to the department of the email address and of any change to the email address within 10 business days of the change. Because a person who violates the California Community Care Facilities Act is guilty of a misdemeanor, the bill would create new crimes, thereby imposing a state-mandated local program.

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

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

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

SECTION 1. Section 1507.4 is added to the Health and Safety Code, to read:

1507.4. (a) Beginning May 1, 2021, and annually thereafter, the department shall collect information and send a report to each county's department of mental health or behavioral health of all licensed adult residential facilities in the county that accept the federal supplemental security rate and accept residents with a serious mental disorder, as defined in Section 5600.3 of the Welfare and Institutions Code, and the number of licensed beds at each facility.

(b) Beginning May 1, 2021, and quarterly thereafter, the department shall send to each county's department of mental health or behavioral health the report of licensed adult residential facilities that closed permanently in the prior quarter, by county, and shall include the number of licensed beds of each facility and the reason for closing. The report shall include cumulative data and closure trends for each county and be based on facilities identified in subdivision (a).

(c) Upon receiving notice that a licensed adult residential facility intends to close permanently, the department shall notify the county mental or behavioral health department within three business days.

SEC. 2. Section 1509.6 is added to the Health and Safety Code, to read:

1509.6. An applicant or licensee of an adult community care facility shall maintain an email address of record with the department. The applicant or licensee shall provide written notification to the department of the email address and of any change to the email address within 10 business days of the change.

SEC. 3. Section 1569.4 is added to the Health and Safety Code, to read:

1569.4. (a) Beginning May 1, 2021, and annually thereafter, the department shall collect information and send a report to each county's department of mental health or behavioral health of all licensed residential care facilities for the elderly in the county that accept the federal supplemental security rate and accept residents with a serious mental disorder, as defined in Section 5600.3 of the Welfare and Institutions Code, and the number of licensed beds at each facility.

(b) Beginning May 1, 2021, and quarterly thereafter, the department shall send to each county's department of mental health or behavioral health the report of licensed residential care facilities for the elderly that closed permanently in the prior quarter, by county, and shall include the number of licensed beds of each facility and the reason for closing. The report shall include cumulative data and closure trends for each county and be based on facilities identified in subdivision (a).

(c) Upon receiving notice that a licensed residential care facility for the elderly intends to close permanently, the department shall notify the county mental or behavioral health department within three business days.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within

the meaning of Section 6 of Article XIII B of the California Constitution.

Approved _____, 2020

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Governor

Senate Bill No. 855

Passed the Senate August 30, 2020

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Secretary of the Senate

Passed the Assembly August 26, 2020

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2020, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to add Sections 1367.045 and 1374.721 to, and to repeal and add Section 1374.72 of, the Health and Safety Code, and to add Section 10144.52 to, and to repeal and add Section 10144.5 of, the Insurance Code, relating to health coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 855, Wiener. Health coverage: mental health or substance use disorders.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of disability insurers by the Department of Insurance.

Existing law, known as the California Mental Health Parity Act, requires every health care service plan contract or disability insurance policy issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions, as specified. Existing law requires those benefits to include, among other things, outpatient services, inpatient hospital services, partial hospital services, and prescription drugs, if the plan contract or policy includes coverage for prescription drugs.

This bill would revise and recast those provisions, and would instead require a health care service plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. The bill would prohibit a health care service plan or disability insurer from limiting benefits or coverage for mental health and substance use disorders to short-term or acute treatment. The bill

would revise the covered benefits to include basic health care services, as defined, intermediate services, and prescription drugs.

This bill would require a health care service plan or disability insurer that provides hospital, medical, or surgical coverage to base medical necessity determinations and the utilization review criteria the plan or insurer, and any entity acting on the plan's or insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders, on current generally accepted standards of mental health and substance use disorder care. The bill would require the health care service plan or insurer to apply specified clinical criteria and guidelines in conducting utilization review of the covered health care services and benefits and would prohibit the plan or insurer from applying different, additional, or conflicting criteria than the criteria and guidelines in the specified sources. The bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, to assess administrative or civil penalties, as specified, for violation of the requirements relating to utilization review. The bill would make any provision in a health care service plan issued, delivered, amended, or renewed on or after January 1, 2021, that reserves discretionary authority to the plan, or an agent of the plan, to determine eligibility for benefits or coverage, interprets the terms of the contract, or provides standards of interpretation or review that are inconsistent with California law, void and unenforceable, as specified. The bill would declare that its provisions are severable.

Because a willful violation of these requirements with respect to health care service plans would be a crime, this bill would impose a state-mandated local program.

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

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

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

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

(a) The California Mental Health Parity Act (Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code) was enacted in 1999 to require coverage of all diagnosis and medically necessary treatment of nine listed severe mental illnesses, as well as serious emotional disturbances of a child. However, this list of nine severe mental illnesses is not only incomplete and out-of-date, but also fails to encompass the range of mental health and substance use disorders whose complex interactions are contributing to overdose deaths from opioids and methamphetamines, the increase in suicides, and other so-called deaths of despair.

(b) Following the California Mental Health Parity Act, the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 put in place even more robust mental health parity protections, which also applied to substance use disorders, making the most important provision of the California Mental Health Parity Act its coverage requirement for medically necessary treatment for severe mental illnesses and serious emotional disturbances of a child.

(c) The federal Affordable Care Act (ACA) includes mental health and addiction coverage as one of the 10 essential health benefits, but it does not contain a definition for medical necessity, and despite the ACA, needed mental health and addiction coverage can be denied through overly restrictive medical necessity determinations.

(d) With one in five adults in the United States experiencing a mental health disorder and 1 in 13 individuals 12 years of age or older experiencing a substance use disorder, it is critical for the California Mental Health Parity Act to be expanded to apply to all mental health and substance use disorders, as defined by preeminent national and international bodies.

(e) The conditions currently listed in the California Mental Health Parity Act, including autism, are all included in the broader definition of mental health and substance use disorders.

(f) When medically necessary mental health and substance use disorder care is not covered, individuals with mental health and

substance use disorders often have their conditions worsen, ending up on Medicaid, in the criminal justice system, or on the streets, resulting in harm to individuals and communities, and higher costs to taxpayers.

(g) In 2016, approximately 6,000,000 veterans in the United States had private health care coverage, making it critical to ensure that the veterans' private health plans cover all medically necessary treatment for the invisible wounds of war.

(h) Expansion of the California Mental Health Parity Act will help address the following manifestations of the ongoing mental health and addiction crises in California:

(1) Between 2012 and 2017, California's rate of fatal overdoses for all opioids increased 22 percent, while fatal overdose rates increased 85 percent for heroin and 425 percent for fentanyl.

(2) Suicide rates in California increased by 14.8 percent between 1999 and 2016, with the suicide rate from 1991 to 2017, inclusive, for children 10 to 14 years of age, inclusive, increasing by 225 percent.

(3) Thirty-seven percent of students with a mental health condition 14 years of age and older drop out of school, and mental illness has the highest dropout rate of any disability group.

(4) The correlation between untreated mental illness, substance use disorders, and incarceration is substantial, as three in four individuals in jail have been diagnosed with both a mental illness and a substance use disorder.

(5) Untreated mental health and substance use disorders are an enormous problem with incarcerated youth, with 70 percent of youth arrested each year having a mental health disorder.

(6) As many as one-third of the 130,000 individuals who are homeless living on the streets in California have a mental health condition.

(i) In two court decisions, Harlick v. Blue Shield of California, 686 F.3d 699 (9th Cir. 2011), cert. denied, 133 S.Ct. 1492 (2013), and Rea v. Blue Shield of California, 226 Cal.App.4th 1209, 1227 (2014), the California Mental Health Parity Act was interpreted to require coverage of medically necessary residential treatment.

(j) Coverage of intermediate levels of care such as residential treatment, which are essential components of the level of care continuum called for by nonprofit, and clinical specialty associations such as the American Society of Addiction Medicine

(ASAM), are often denied through overly restrictive medical necessity determinations.

(k) In March 2019, the United States District Court of the Northern District of California ruled in Wit v. United Behavioral Health, 2019 WL 1033730 (Wit; N.D.CA Mar. 5, 2019), that United Behavioral Health created flawed level of care placement criteria that were inconsistent with generally accepted standards of mental health and substance use disorder care in order to "mitigate" the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008.

(*l*) As described by the federal court in Wit, the eight generally accepted standards of mental health and substance use disorder care require all of the following:

(1) Effective treatment of underlying conditions, rather than mere amelioration of current symptoms, such as suicidality or psychosis.

(2) Treatment of co-occurring behavioral health disorders or medical conditions in a coordinated manner.

(3) Treatment at the least intensive and restrictive level of care that is safe and effective and meets the needs of the patient's condition; a lower level or less intensive care is appropriate only if it safe and just as effective as treatment at a higher level or service intensity.

(4) Erring on the side of caution, by placing patients in higher levels of care when there is ambiguity as to the appropriate level of care, or when the recommended level of care is not available.

(5) Treatment to maintain functioning or prevent deterioration.

(6) Treatment of mental health and substance use disorders for an appropriate duration based on individual patient needs rather than on specific time limits.

(7) Accounting for the unique needs of children and adolescents when making level of care decisions.

(8) Applying multidimensional assessments of patient needs when making determinations regarding the appropriate level of care.

(m) The court in Wit found that all parties' expert witnesses regarded the ASAM criteria for substance use disorders and Level of Care Utilization System, Child and Adolescent Level of Care Utilization System, Child and Adolescent Service Intensity Instrument, and Early Childhood Service Intensity Instrument

(LOCUS/CALOCUS and CASII/ECSII) criteria for mental health disorders as prime examples of level of care criteria that are fully consistent with generally accepted standards of mental health and substance use care.

SEC. 2. Section 1367.045 is added to the Health and Safety Code, to read:

1367.045. (a) If a health care service plan contract offered, issued, delivered, amended, or renewed on or after January 1, 2021, contains a provision that reserves discretionary authority to the plan, or an agent of the plan, to determine eligibility for benefits or coverage, to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state, that provision is void and unenforceable.

(b) For purposes of this section, the term "discretionary authority" means a contract provision that has the effect of conferring discretion on a health care service plan or other claims administrator to determine entitlement to benefits or interpret contract language that, in turn, could lead to a deferential standard of review by a reviewing court.

(c) This section does not prohibit a health care service plan from including a provision in a contract that informs an enrollee that, as part of its routine operations, the plan applies the terms of its contracts for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining policies, procedures, and processes, so long as the provision could not give rise to a deferential standard of review by a reviewing court.

(d) This section applies to both group and individual health care service plan contracts.

SEC. 3. Section 1374.72 of the Health and Safety Code is repealed.

SEC. 4. Section 1374.72 is added to the Health and Safety Code, to read:

1374.72. (a) (1) Every health care service plan contract issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(2) For purposes of this section, "mental health and substance use disorders" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

(3) (A) For purposes of this section, "medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

(B) This paragraph does not limit in any way the independent medical review rights of an enrollee or subscriber under this chapter.

(4) For purposes of this section, "health care provider" means any of the following:

(A) A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.

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

(D) An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.

(E) An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.

(F) A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.

(G) A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.

(H) A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

(5) For purposes of this section, "generally accepted standards of mental health and substance use disorder care" has the same meaning as defined in paragraph (1) of subdivision (f) of Section 1374.721.

(6) A health care service plan shall not limit benefits or coverage for mental health and substance use disorders to short-term or acute treatment.

(7) All medical necessity determinations by the health care service plan concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with mental health and substance use disorders shall be conducted in accordance with the requirements of Section 1374.721. This paragraph does not deprive an enrollee of the other protections of this chapter, including, but not limited to, grievances, appeals, independent medical review, discharge, transfer, and continuity of care.

(8) A health care service plan that authorizes a specific type of treatment by a provider pursuant to this section shall not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to this authorization for any reason, including, but not limited to, the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract, or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility. This section shall not be construed to

expand or alter the benefits available to the enrollee or subscriber under a plan.

(b) The benefits that shall be covered pursuant to this section shall include, but not be limited to, the following:

(1) Basic health care services, as defined in subdivision (b) of Section 1345.

(2) Intermediate services, including the full range of levels of care, including, but not limited to, residential treatment, partial hospitalization, and intensive outpatient treatment.

(3) Prescription drugs, if the plan contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, all of the following patient financial responsibilities:

(1) Maximum annual and lifetime benefits, if not prohibited by applicable law.

(2) Copayments and coinsurance.

(3) Individual and family deductibles.

(4) Out-of-pocket maximums.

(d) If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary followup services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.

(e) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) 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.

(f) (1) For the purpose of compliance with this section, a health care service plan may provide coverage for all or part of the mental health and substance use disorder services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A health care service plan shall provide the mental health and substance use disorder coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans, provided that all appropriate mental health or substance use disorder services are actually available within those geographic service areas within timeliness standards.

(3) Notwithstanding any other law, in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing, provided that these practices are consistent with Section 1374.76 of this code, and Section 2052 of the Business and Professions Code.

(g) This section shall not be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter.

(h) A health care service plan shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(i) A health care service plan shall not adopt, impose, or enforce terms in its plan contracts or provider agreements, in writing or in

operation, that undermine, alter, or conflict with the requirements of this section.

SEC. 5. Section 1374.721 is added to the Health and Safety Code, to read:

1374.721. (a) A health care service plan that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the plan, and any entity acting on the plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

(b) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, a health care service plan shall apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(c) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a health care service plan shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a health care service plan from applying utilization review criteria to health care services and benefits for mental health and substance use disorders that meet either of the following criteria:

(1) Are outside the scope of the criteria and guidelines set forth in the sources specified in subdivision (b), provided the utilization review criteria were developed in accordance with subdivision (a).

(2) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subdivision (b), provided that the utilization review criteria were developed in accordance with subdivision (a).

(d) If a health care service plan purchases or licenses utilization review criteria pursuant to paragraph (1) or (2) of subdivision (c), the plan shall verify and document before use that the criteria were developed in accordance with subdivision (a).

(e) To ensure the proper use of the criteria described in subdivision (b), every health care service plan shall do all of the following:

(1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the health care service plan's staff, including any third parties contracted with the health care service plan to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.

(2) Make the education program available to other stakeholders, including the health care service plan's participating providers and covered lives. Participating providers shall not be required to participate in the education program.

(3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and health care service plan enrollees.

(4) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(5) Conduct interrater reliability testing to ensure consistency in utilization review decisionmaking covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in paragraph (3) of subdivision (f).

(6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

(7) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(f) The following definitions apply for purposes of this section:

(1) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 1374.73. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical

practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) "Mental health and substance use disorders" has the same meaning as defined in paragraph (2) of subdivision (a) of Section 1374.72.

(3) "Utilization review" means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, enrollees, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to enrollees.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a health care service plan contract is covered as medically necessary for an enrollee.

(4) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a health care service plan to conduct utilization review.

(g) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders covered by a health care service plan contract, including prescription drugs.

(h) This section applies to a health care service plan that conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on behalf of a health care service plan.

(i) The director may assess administrative penalties for violations of this section as provided for in Section 1368.04, in addition to any other remedies permitted by law.

(j) A health care service plan shall not adopt, impose, or enforce terms in its plan contracts or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(k) This section does not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) 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.

SEC. 6. Section 10144.5 of the Insurance Code is repealed.

SEC. 7. Section 10144.5 is added to the Insurance Code, to read:

10144.5. (a) (1) Every disability insurance policy issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(2) For purposes of this section, "mental health and substance use disorders" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

(3) (A) For purposes of this section, "medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care provider.

(B) This paragraph does not limit in any way the independent medical review rights of an insured or policyholder under this chapter.

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

(A) A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.

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

(D) An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.

(E) An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.

(F) A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.

(G) A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.

(H) A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

(5) For purposes of this section, "generally accepted standards of mental health and substance use disorder care" has the same meaning as defined in paragraph (1) of subdivision (f) of Section 10144.52.

(6) A disability insurer shall not limit benefits or coverage for mental health and substance use disorders to short-term or acute treatment.

(7) All medical necessity determinations made by the disability insurer concerning service intensity, level of care placement, continued stay, and transfer or discharge of insureds diagnosed with mental health and substance use disorders shall be conducted in accordance with the requirements of Section 10144.52.

(8) A disability insurer that authorizes a specific type of treatment by a provider pursuant to this section shall not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to this authorization for any reason, including, but not limited to, the insurer's subsequent rescission, cancellation, or modification of the insured's or policyholder's contract, or the insurer's subsequent determination that it did not make an accurate determination of the insured's or policyholder's eligibility. This section shall not be construed to expand or alter the benefits available to the insured or policyholder under an insurance policy.

(b) The benefits that shall be covered pursuant to this section shall include, but not be limited to, the following:

(1) Basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code.

(2) Intermediate services, including the full range of levels of care, including, but not limited to, residential treatment, partial hospitalization, and intensive outpatient treatment.

(3) Prescription drugs, if the policy includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the disability insurance policy shall include, but not be limited to, all of the following patient financial responsibilities:

(1) Maximum and annual lifetime benefits, if not prohibited by applicable law.

(2) Copayments and coinsurance.

(3) Individual and family deductibles.

(4) Out-of-pocket maximums.

(d) If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the disability insurer shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary followup services that, to the maximum extent possible,

meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the insured within geographic and timely access standards. The insured shall pay no more than the same cost sharing that the insured would pay for the same covered services received from an in-network provider.

(e) This section shall not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies.

(f) (1) For the purpose of compliance with this section, a disability insurer may provide coverage for all or part of the mental health and substance use disorder services required by this section through a separate specialized health insurance policy or mental health policy. This paragraph shall not apply to policies that are subject to Section 10112.27.

(2) A disability insurer shall provide the mental health and substance use disorder coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, disability insurance policies that provide benefits to insureds through preferred provider contracting arrangements are not precluded from requiring insureds who reside or work in geographic areas served by specialized health insurance policies or mental health insurance policies to secure all or part of their mental health services within those geographic areas served by specialized health insurance policies or mental health insurance policies, provided that all appropriate mental health or substance use disorder services are actually available within those geographic service areas within timeliness standards.

(3) Notwithstanding any other law, in the provision of benefits required by this section, a disability insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing, provided that these practices are consistent with Section 10144.4 of this code, and Section 2052 of the Business and Professions Code.

(g) This section shall not be construed to deny or restrict in any way the department's authority to ensure a disability insurer's compliance with this code.

(h) A disability insurer shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(i) A disability insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(j) If the commissioner determines that a disability insurer has violated this section, the commissioner may, after appropriate notice and opportunity for hearing in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), by order, assess a civil penalty not to exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each violation.

SEC. 8. Section 10144.52 is added to the Insurance Code, to read:

10144.52. (a) A disability insurer that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

(b) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, a disability insurer shall apply the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(c) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a disability insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a disability insurer from applying utilization review criteria to health care services and benefits for mental health and substance use disorders that meet either of the following criteria:

(1) Are outside the scope of the criteria and guidelines set forth in the sources specified in subdivision (b), provided the utilization review criteria were developed in accordance with subdivision (a).

(2) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subdivision (b), provided that the utilization review criteria were developed in accordance with subdivision (a).

(d) If a disability insurer purchases or licenses utilization review criteria pursuant to paragraph (1) or (2) of subdivision (c), the insurer shall verify and document before use that the criteria were developed in accordance with subdivision (a).

(e) To ensure the proper use of the criteria described in subdivision (b), every disability insurer shall do all of the following:

(1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the disability insurer's staff, including any third parties contracted with the disability insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.

(2) Make the education program available to other stakeholders, including the insurer's participating providers and covered lives.

(3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and insured patients.

(4) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(5) Conduct interrater reliability testing to ensure consistency in utilization review decisionmaking covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in paragraph (3) of subdivision (f).

(6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

(7) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(f) The following definitions apply for purposes of this section:

(1) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 10144.51. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) "Mental health and substance use disorders" has the same meaning as defined in paragraph (2) of subdivision (a) of Section 10144.5.

(3) "Utilization review" means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to insureds.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a disability insurance policy is covered as medically necessary for an insured.

(4) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a disability insurer to conduct utilization review.

(g) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders covered by a disability insurance policy, including prescription drugs.

(h) This section applies to a disability insurer that covers hospital, medical, or surgical expenses and conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf.

(i) If the commissioner determines that a disability insurer has violated this section, the commissioner may, after appropriate notice and opportunity for hearing in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), by order, assess a civil penalty not to exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each violation.

(j) A disability insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(k) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies.

SEC. 9. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 10. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within

the meaning of Section 6 of Article XIII B of the California Constitution.

Approved _____, 2020

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Governor