SENATE JUDICIARY COMMITTEE
Senator Thomas Umberg, Chair
2023-2024 Regular Session

SB 1017 (Eggman)
Version: February 5, 2024
Hearing Date: April 2, 2024
Fiscal: Yes
Urgency: No
AM

SUBJECT

Available facilities for inpatient and residential mental health or substance use disorder treatment

DIGEST

This bill requires the State Department of Health Care Services (DHCS), in consultation with the State Department of Public Health and the State Department of Social Services, to develop a solution to collect, aggregate, and display information about beds to identify the availability of inpatient and residential mental health or substance use disorder treatment for specified types of facilities, as provided. The bill requires the solution to be operational by January 1, 2026, or a date DHCS communicates to the Department of Finance that the solution has been implemented, whichever is later. The bill provides that DHCS has the authority to impose a plan of correction or assess civil money penalties, or both, against a facility that fails to submit data accurately, timely, or as required under the bill and provides for an appeal process.

EXECUTIVE SUMMARY

This bill is intended to address the need for inpatient psychiatric services by providing a centralized solution that can identify and locate the appropriate bed for an individual seeking mental health or substance abuse services so that treatment services can be expedited. This bill is substantially similar to several prior bills introduced by the author, the majority of which were not heard by this Committee. The bill is sponsored by the California State Association of Psychiatrists and the Psychiatric Physicians Alliance of California. The bill is supported by organizations representing local governments, law enforcement, and emergency physicians, and organizations representing persons with mental illness. The bill is opposed by the County Behavioral Health Directors Association. The bill passed out of the Senate Health Committee on a vote of 11 to 0.

PROPOSED CHANGES TO THE LAW

Existing law:

1) Requires the Department of Health Care Services (DHCS) to license and regulate residential alcoholism or drug abuse (or substance use disorder) recovery or treatment facilities (RTFs). (Health & Saf. Code § 11834.02, et seq.)

2) Requires DHCS and counties to provide specialty mental health services for Medi-Cal beneficiaries through a county mental health plan, as specified, which may include crisis stabilization services and inpatient psychiatric care. (Welf. & Inst. Code § 14705 & § 14712.)

3) Requires the California Department of Public Health (CDPH) to license and regulate hospitals, including a general acute care hospital (GACH) and an acute psychiatric hospital (APH). (Health & Saf. Code §1250, et. seq.)

4) Requires mental health rehabilitation centers (MHRCs) to be licensed only by DHCS subsequent to application by counties, county contract providers, or other organizations and requires DHCS to conduct annual licensing inspections of MHRCs. (Welf. & Ins. Code §5675.)

5) Requires chemical dependency recovery hospitals (CDRHs) to be licensed by CDPH and authorizes them to provide 24-hour inpatient care for persons who have a dependency on alcohol or other drugs, or both alcohol and other drugs, and includes the following basic services: patient counseling, group therapy, physical conditioning, family therapy, outpatient services, and dietetic services. (Health & Saf. Code § 1250.3.)

6) Requires psychiatric health facilities (PHFs) to be licensed by DHCS and authorizes them to provide 24-hour inpatient care for people with mental health disorders that includes, but is not limited to, the following services: psychiatry; clinical psychology; psychiatric nursing; social work; rehabilitation drug administration; and appropriate food services for those persons whose physical health needs can be met in an affiliated hospital or in outpatient settings. (Health & Saf. Code § 1250.2 & Welf. & Inst. Code §4080.)

7) Requires the California Department of Social Services (CDSS) to license community care facilities (CCFs), including any facility, place, or building that is maintained and operated to provide nonmedical residential care, day treatment, adult day care, or foster family agency services for children, adults, or children and adults, including, but not limited to, the physically handicapped, mentally impaired, incompetent

persons, and abused or neglected children, and may include crisis residential services. (Health & Saf. Code § 1501, et seq.)

8) Establishes the Lanterman-Petris-Short (LPS) Act, which provides for the involuntary detention for treatment and evaluation of people who are gravely disabled or a danger to self or others. (Welf. & Inst. Code, § 5000 et seq.)
    a) Requires facilities, for the purposes of detaining a person for up to 72-hours of treatment and evaluation, to be designated by a county and approved by DHCS, which may be a licensed psychiatric hospital, a licensed PHF, and a certified crisis stabilization unit (CSU). (Welf. & Inst. Code § 5008.)

This bill:

1) Requires DHCS, in consultation with CDPH and CDSS, to develop a solution to collect, aggregate, and display information about beds to identify the availability of inpatient and residential mental health or substance use disorder treatment for all of the following facilities:
    a) supplemental psychiatric services in GACHs;
    b) chemical dependency recovery services in CDRHs, a distinct part of a GACH, or APH;
    c) APHs and licensed long-term care facilities with mental health program approval or certification from DHCS;
    d) PHFs;
    e) MHRCs;
    f) inpatient psychiatric facilities;
    g) CSUs;
    h) licensed CCFs with a mental health program approval or certification from DHCS; and
    i) licensed RTFs.

2) Requires the solution to be operational by January 1, 2026, or a date DHCS communicates to the Department of Finance in writing that the solution has been implemented, whichever is later.
    a) The solution is required to, at a minimum, be capable of collecting data and enabling searches to identify beds that are appropriate for individuals in need of inpatient or residential mental health or substance use disorder treatment.
    b) The solution is not to include any information relating to state hospitals under the jurisdiction of the California Department of State Hospitals.
    c) The solution is to be maintained in a manner that complies with all applicable state and federal confidentiality laws.
    d) The solution and the information contained within is not to be publicly available, and DHCS may limit access to entities authorized by DHCS in a manner that is consistent with state and federal confidentiality laws.

3) Requires DHCS to confer with stakeholders to inform implementation of the solution, including, but not limited to: DHCS; DSS; organizations representing providers, consumers, and family members; and organizations that have experience providing inpatient psychiatric care, psychiatric crisis stabilization, residential community mental health, and RTF services.

4) Authorizes DHCS and DSS to enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis for the purposes of administering or implementing the requirements of the bill.
    a) The bill exempts contracts entered into or amended or changes to existing information technology systems made pursuant to the bill from specified provisions of law related to contracting, the Statewide Information Management Manual, the State Administrative Manual, and from review or approval by the Department of General Services.

5) Authorizes DHCS to implement, interpret, or make specific these provisions, in whole or in part, by means of information notices, provider bulletins, or other similar instructions, without further regulatory action.

6) Grants DHCS the authority to impose a plan of correction against a facility that fails to submit data accurately, timely, or as required, and authorizes DHCS to determine a reasonable length of time for a facility to complete a plan of correction.

7) Authorizes DHCS to issue a notice of imposition of civil money penalties if a facility fails to complete a plan of correction by the time specified in the amount of $100 per day from the date of notice of imposition of penalties.
    a) A facility may appeal in writing within 15 working days. A facility is required to include any supporting documentation and explain any mitigating circumstances in its appeal.
    b) DHCS is required to make a determination on the appeal within 30 calendar days of receipt of a complete appeal.
    c) A facility may request a formal hearing within 30 calendar days of the determination of DHCS on the appeal, as provided.
    d) Authorizes DHCS to obtain a court order to recover unpaid civil money penalties against a facility.

COMMENTS

1. Stated need for the bill

The author writes:

> While California has seen a small increase in the number of psychiatric beds since 2012, we are still falling well below nationally established standards of 40-60 beds

per 100,000 adults and have 30% fewer beds than we had in 1995. Finding beds in this environment is hard. Hospital emergency departments continue to be frontline responders in behavioral health crises, and often board patients until an open bed in an appropriate facility is found. The backdrop here is that 16% of California adults live with serious mental illness, and 60% of those individuals do not receive any treatment whatsoever. Identifying open beds so that timely transfers can take place expedites the connection to critical and badly needed treatment. It decreases adverse incidents and improves outcomes. Mental illness or substance use disorders, like many other health conditions, when treated early and with appropriate supports and services, is less disabling with fewer serious consequences. Bed registries are an essential tool to speed access to care and provide timely coordination between service settings. The access to a solution that displays available beds in SB 1017 fits perfectly with current behavioral health infrastructure building initiatives – helping to map and connect patients and facilities and as such contributes to a badly needed transformation of our mental health system.

2. Bill requires the establishment of a solution to provide real-time data on availability of beds in specified types of facilities

   a. Background

The Senate Health Committee provided a detailed analysis of the state of access to treatment beds in California, the current status of grants being awarded under the Behavioral Health Continuum Infrastructure Program (Asm. Comm. on Budget, Ch. 143, Stats. 2021.), and federal initiatives in this policy area.[1] The Senate Health Committee analysis notes:

> According to a 2021 RAND report, California requires 50.5 inpatient psychiatric beds per 100,000 adults: 26.0 per 100,000 at the acute level (7,945 beds) and 24.6 per 100,000 at the subacute level (7,518 beds). At the community residential level, the estimated need is 22.3 beds per 100,000 adults. RAND estimated that California has a total of 5,975 beds at the acute level (19.5 per 100,000 adults) and 4,724 at the subacute level (15.4 per 100,000 adults), excluding state hospital beds. If state hospital beds are included, these figures increase to 7,679 (25.1 per 100,000 adults) and 9,168 beds (29.9 per 100,000 adults), respectively. RAND also observed large regional variation. For example, excluding state hospitals, acute bed capacity ranged from 9.1 beds per 100,000 adults in the Northern San Joaquin Valley to 27.9 beds per 100,000 adults in the Superior region of the state. For subacute bed capacity, regional estimates ranged from 7.4 to 31.8 beds per 100,000 adults. At the community residential level, RAND estimated that California has a total of 3,872 beds (12.7 per 100,000 adults). California has a shortfall of approximately 1,971 beds at the acute level (6.4 additional beds required per 100,000 adults) and a shortage of 2,796 beds at

[1] Sen. Health Comm. analysis of SB 1017 (2023-24 reg. session) as introduced Feb. 5, 2024.

the subacute level (9.1 additional beds required per 100,000 adults), or 4,767 subacute and acute beds combined, excluding state hospital beds. If state hospitals were included in this estimate, the shortage of acute inpatient beds would shrink to 267, and there would be no observable shortage in beds at the subacute level. Separately, RAND estimated a shortage of 2,963 community residential beds.[2]

b. This bill is substantially similar to prior bills, the majority of which were not heard by this Committee

This bill is almost identical to last year's SB 363 (Eggman, 2023), which passed this Committee on a vote of 10 to 0 but was held in the Assembly Appropriations Committee. This bill is also substantially similar to SB 1154 (Eggman, 2022), AB 682 (Eggman, 2019), AB 1136 (Eggman, 2018), and AB 2743 (Eggman, 2016), which were not heard by this Committee. SB 1154, AB 682, and AB 2743 were held in the Assembly Appropriations Committee and AB 1136 was held in the Senate Appropriations Committee.

This bill is different from SB 363 (Eggman, 2023) in one major way—instead of requiring DHCS, in consultation with CDPH and CDSS, to develop a real-time, internet-based database to collect, aggregate, and display information about beds to identify the availability of inpatient and residential mental health or substance use disorder treatment options for the specified types of facilities—the bill instead requires those state agencies to develop a *solution*. The solution and the information contained in the solution is not to be publicly available and must be maintained in a manner that complies with all applicable state and federal confidentiality laws. Under the bill, DHCS may limit access to the solution and information contained therein to entities authorized by DHCS in a manner that is consistent with state and federal confidentiality laws; however, the bill does not specifically state who or what entities are authorized to access the solution. The author may wish to make it clear who or what entities should or should not be authorized to access the solution once it is operative.

The bill authorizes DHCS to impose a plan of correction or civil money penalties, or both, for failure to submit data accurately, timely, or as required by the bill. Under the bill, DHCS is authorized to determine a reasonable length of time for completion of a plan of correction and can assess civil penalties if the facility fails to complete a plan of correction by the specified time in an amount of $100 per day from the date of notice of imposition of the penalties. A facility may appeal issuance of a correction plan or imposition of penalties to the department within 15 working days of the issuance of the notice. DHCS is required to make a determination on the appeal within 30 calendar days of receipt of the appeal. The bill provides for a formal adjudicative hearing process within 30 days of DHCS's determination on the appeal that is to be conducted pursuant to existing provisions of law governing formal adjudicative proceedings for DHCS. (*See*

[2] *Id.* at 4.

Health & Saf. Code § 10017 & § 11834.3.7.) The bill authorizes DHCS to obtain a court order to recover any unpaid civil penalties assessed against a facility. Under the bill, civil penalties collected by DHCS are to be deposited into a specified fund created by the bill and are continuously appropriated, without regard to fiscal year, to DHCS to fund its administrative costs associated with implementing the bill's provisions.

3. Statements in support

The Steinberg Institute writes in support stating:

> For decades, California has failed to properly invest in a continuum of behavioral health services and facilities. The result is that far too many are left without care until their illness reaches a crisis point. Furthermore, in these moments of crisis hospital emergency rooms – not behavioral health facilities – are the frontline responders. The consequences are devastating. Too often individuals in crisis languish untreated in emergency departments for long periods of time as staff struggle to find open beds in more appropriate settings.
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> Behavioral health bed databases, and other similar solutions, are proven tools to help ensure people in need can be quickly referred to the most appropriate facility to gain the treatment they urgently need. A critical component to addressing the needs of people living with mental illness or a substance use disorder and supporting their recovery is to assure that critically important, safe, and intensive care in the least-restrictive setting is accessible when needed.
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> By requiring the Department of Health Care Services to establish a solution in consultation with the State Department of Public Health and the State Department of Social Services, this bill takes a critical step forward in ensuring people get the care they need when they need it.

4. Statements in opposition

The County Behavioral Health Directors Association of California writes in opposition stating:

> We commend the author for seeking to address the delays that those in psychiatric crisis too frequently experience when attempting to access vital services. These delays cause unnecessary suffering for patients and their families and stand in the way of a goal we all share – the hope of a continuum of crisis services where patients are connected to care and a bed in an appropriate inpatient facility, without delay. The approach of SB 1017 – which includes conferring with stakeholders to inform the development of this database – recognizes how critical stakeholder buy-in is for ensuring the effectiveness of a bed registry. […]

> However, we are concerned about the punitive provisions in SB 1017 which would allow DHCS to assess a plan of correction or penalties against a facility for failing to submit data in an accurately or timely manner when the scope and parameters of those requirements have not yet been developed. We believe a bed registry inventory must be feasible, realistic and workable, particularly when it will require frequent, manual updating by facility staff. We also believe that county behavioral health directors should be part of the stakeholder process to develop a bed registry. For that reason, we request an amendment that would remove sanctions against facilities for their inability to keep a database updated and an amendment to ensure that county behavioral health directors are part of the stakeholder process to develop a database[.]

SUPPORT

California State Association of Psychiatrists (sponsor)
Psychiatric Physicians Alliance of California (sponsor)
Alameda County Families Advocating for the Seriously Mentally Ill
California Chapter of the American College of Emergency Physicians
California State Sheriffs' Association
League of California Cities
Steinberg Institute

OPPOSITION

County Behavioral Health Directors Association of California

RELATED LEGISLATION

Pending Legislation: None known

Prior Legislation:

SB 363 (Eggman, 2023) would have required the State Department of Health Care Services (DHCS), in consultation with the DPH and DSS, to develop a real-time, internet-based database to collect, aggregate, and display information about beds to identify the availability of inpatient and residential mental health or substance use disorder treatment for specified types of facilities, as provided. SB 363 was held on the Assembly Appropriations Committee suspense file.

AB 512 (Waldron, 2023) would have required the California Health and Human Services Agency, either on its own or through the Behavioral Health Task Force established by the Governor, to create an ad hoc committee to study how to develop a real-time, internet-based system, usable by specified entities, to display information about available beds in specified facilities for the transfer to, and temporary treatment

of, individuals in mental health or substance use disorder crisis. AB 512 was held on the Assembly Appropriations Committee suspense file.

SB 929 (Eggman, Ch. 539, Stats. 2022) expanded DHCS's responsibility in current law to collect and publish information about involuntary detentions to include additional information, such as clinical outcomes, services provided, and availability of treatment beds, as specified.

SB 1154 (Eggman, 2022), was substantially similar to this bill. SB 1154 was held on the Assembly Appropriations Committee suspense file.

AB 2768 (Waldron, 2022) was identical to AB 512. AB 2768 was held on the Senate Appropriations Committee suspense file.

AB 682 (Eggman, 2019), was substantially similar to this bill. AB 682 was held on the Assembly Appropriations Committee suspense file.

AB 1136 (Eggman, 2018), was substantially similar to this bill. AB 1136 was held on the Senate Appropriations Committee suspense file.

AB 2743 (Eggman, 2016) were substantially similar to this bill. AB 2743 was held on the Assembly Appropriations Committee suspense file.

PRIOR VOTES

Senate Health Committee (Ayes 11, Noes 0)

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