California Behavioral Health Planning Council
Legislation and Public Policy Committee Meeting

June 18, 2025
Meeting Minutes

Members Present:

Barbara Mitchell, Chairperson
Karen Baylor
Jason Bradley
Monica Caffey
Erin Franco
Ian Kemmer
Noel O'Neill
Liz Oseguera
Danielle Sena
Javier Moreno, Chair-Elect
Karrie Sequeira
Daphne Shaw
Deborah Starkey
Tony Vartan
Susan Wilson
Milan Zavala
Uma Zykofsky

Staff Present: Jenny Bayardo, Maydy Lo

Agenda Item: Welcome, Introductions, and Housekeeping

Chairperson Barbara Mitchell called the meeting to order and welcomed Council Members and attendees. Council Members, Council staff, and attendees were invited to introduce themselves. A quorum was established with 17 of 21 members present.

Agenda Item: Review and Accept April 2025 Meeting Minutes

The committee reviewed the meeting minutes from April 2025. The minutes were accepted with no revisions.

Agenda Item: Review of Committee's Updated Legislation Process

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Council Staff Maydy Lo provided an overview of the updates made to the committee's legislation process based on the committee's recommendations during the April 2025 meeting. The updates included steps for responding to significant amendments made to legislation that the Council has already taken a position on. The updates were accepted with no revisions.

Agenda Item: **June 2025 Legislative Positions List and Advocacy Activities Update**

Council Staff Maydy Lo highlighted advocacy activities accomplished for bills that the Council took positions on, including Assembly Concurrent Resolution 23 (Quirk-Silva), Assembly Joint Resolution 3 (Schiavo), and Senate Bill 531 (Rubio). Letters outlining the Council's support position were sent to the legislature.

Chairperson Barbara Mitchell explained that bills the Council has taken a position on had not yet been assigned a priority tier. Priority tiers indicate the level of advocacy activities to be implemented for each bill; therefore, Barbara led a discussion with the committee to determine priority tiers for the bills on the Legislative Positions List. Due to time limits, the committee was only able to assign priority tier numbers to the following bills:

- Assembly Bill 73 (Jackson): Tier 3 – Lower Priority
- Assembly Bill 255 (Haney): Tier 2 – Medium Priority
- Assembly Bill 339 (Ortega): Tier 2 – Medium Priority

Agenda Item: **Assembly Bill 255 (Action Item)**

This agenda item was canceled as the invited guest speaker did not confirm attendance.

Agenda Item: **Assembly Bill 1037 (Action Item)**

Kyle Kennedy, Policy and Strategic Initiatives Section Manager, and Denise Tugade, Legislative Unit Manager of the Substance Abuse Prevention and Control (SAPC) Bureau from the Los Angeles County Department of Public Health, presented to the committee on their sponsored bill, Assembly Bill (AB) 1037 (Elhawary).

AB 1037 aims to address two goals: (1) update outdated requirements within existing California statutes, and (2) align statutes with current best practices that will lead to increased access to substance use disorder treatment. AB 1037 would allow anyone to use opioid overdose reversal medication to help someone who is at risk of an overdose. It would also protect these individuals from legal liability if they act in good faith, even if they have not received formal training. The bill also intends to support counties to expend drug program funds by allowing primary prevention programs to include activities aligned with evidenced-based practices and prohibits a substance use recovery or treatment facility from requiring abstinence as a condition for admission of care or continued treatment. Additionally, it would require the Department of Health Care Services (DHCS) to offer a combined application for entities to be certified as an

alcohol or other drug program and to provide incidental medical services on or before July 1, 2026.

Following the presentation, the committee engaged in a question-and-answer discussion with the guest speakers. Some of the key discussion points, responses, and additional information included:

- Outpatient services typically do not have medical staff on-site to support individuals who have used substances within the last 24 hours. As a result, these individuals are generally unable to be admitted for treatment as this would increase the liability for providers.
- Although the bill would remove the requirement of abstinence for treatment admission, providers still have discretion to admit individuals as appropriate.
- Los Angeles County has been communicating with DHCS regarding the proposed provisions in the bill.
- DHCS can utilize Behavioral Health Information Notices to share updated regulations while regulatory packages are finalized.

Motion: Tony Vartan made a motion to support AB 1037 with an assigned priority tier number two. Danielle Sena seconded the motion.

Vote: A roll call vote was taken. The motion passed with 15 members voting “Yes”. Jason Bradley abstained. 1 member in attendance was not present during the roll call vote.

Public Comment:
There was no public comment.

Agenda Item: A Peer Perspective on Assembly Bill 348 (Action Item)

Karen Vicari, Director of Public Policy from Mental Health America of California (MHAC) presented to the committee on their support for Assembly Bill (AB) 348 (Krell). AB 348 would establish presumptive eligibility for individuals with a serious mental illness who, among other things, may be transitioning to the community after six months or more in state prison or county jail, for Full-Service Partnership (FSP) services.

Mental Health America of California (MHAC) is a peer-run organization for the statewide affiliate of National Mental Health America. MHAC advocates and supports voluntary community-based services and believes in upstream services that keep people out of involuntary treatment. MHAC supports the expansion of Full-Service Partnership (FSP) programs as they are an effective community-based service. Karen shared that eligibility criteria for FSPs have not yet been established. The bill would contribute to the development of FSP criteria and remove barriers for individuals who typically do not

access services. This includes those who are unhoused or transitioning out of carceral settings, therefore encouraging greater utilization.

Following the presentation, the committee engaged in a question-and-answer discussion with the guest speaker. Some of the key discussion points, responses, and additional information included:

- Given the current inconsistencies across counties in FSP implementation, the passage of the bill is expected to support the Department of Health Care Services (DHCS) in developing guidelines that help reduce barriers for the population.
- Members expressed concerns about the increased restrictions that the bill would place on counties. It was emphasized that counties would not have flexibility in how they respond to the needs of the local community and clinical oversight to determine the appropriate level of care and services for beneficiaries.
- Members expressed that although there are positive intentions with the bill, presumptive eligibility has not been determined to increase access to treatment.
- Members stated that the bill would create additional challenges for counties with the inclusion of the eligibility criteria of individuals placed on 72-hour psychiatric holds five or more times over the last five years, due to the lack of a statewide database for recording and tracking these holds.

The committee decided not to take any action on the bill.

Agenda Item: Pending Legislation Discussion (Action Item)

Due to time limits, the committee was only able to discuss some of the bills on the Pending Legislative Positions Chart. The following is a summary of legislations discussed, and actions taken:

Senate Bill 331 (Menjivar)

Current Chairperson for the Patient Rights Committee, Mike Phillips, led a discussion on Senate Bill 331 (Menjivar), which seeks to align the definition of “mental health disorder” within the Lanterman-Petris-Short (LPS) Act with the current Diagnostic and Statistical Manual of Mental Disorders (DSM). It also expands “gravely disabled” to include those with chronic alcoholism.

Mike shared the following reasons for the Patient Rights Committee’s opposition to the bill:

- The Diagnostic and Statistical Manual of Mental Disorders (DSM) contains nearly 300 different disorders, including conditions such as gender dysphoria, restless leg syndrome, and insomnia disorder, which do not constitute appropriate grounds for detention or involuntary commitment.

- The diagnosis of intellectual disability (intellectual developmental disorder) included in the DSM conflicts with the statutory provision that intellectual disability alone cannot warrant involuntary commitment.
- The expansion of the definition of grave disability to include chronic alcoholism further obscures an already broad standard.

Motion: Daphne Shaw made a motion to oppose Senate Bill 331 with an assigned priority tier number two. Susan Wilson seconded the motion.

Vote: A roll call vote was taken. The motion passed with 16 members voting “Yes”. and Jason Bradley abstained.

Public Comment:
There were no public comments.

Senate Bill 820 (Stern)

Current Chairperson for the Patient Rights Committee, Mike Phillips, led a discussion on Senate Bill 820 (Stern), which would, among other things, expand the authority to administer psychiatric medication to defendants who have been found incompetent to stand trial without consent. Under the bill, emergency involuntary medication could continue for up to one year after the date of the initial determination of the emergency or ninety days after referral to a mental health diversion program, whichever occurs first.

Mike shared the Patient Rights Committee’s concerns and opposition to the bill:

- Forcing medication on individuals without the standard protections afforded under the law for up to a year is excessive and undermines current legal rights of those confined in a correctional facility.
- SB 820 also attempts to address California’s shortage of inpatient treatment capacity to support the behavioral health needs of these individuals, but expanding involuntary medication protocols in jails is neither justified nor an appropriate solution.

Motion: Daphne Shaw made a motion to oppose Senate Bill 820 with an assigned priority tier number two. Susan Wilson seconded the motion.

Vote: A roll call vote was taken. The motion passed with 10 members voting “Yes”. Ian Kemmer, Jason Bradley, Karrie Sequeira, Tony Vartan, and Milan Zavala abstained. Erin Franco and Danielle Sena voted “No”.

Public Comment:
There were no public comments.

Assembly Bill 669 (Haney)

The committee discussed Assembly Bill 669 (Haney), which intends to prohibit concurrent or retrospective review of medical necessity for the first 28 days of substance use disorder inpatient and outpatient care. It would additionally prohibit concurrent review after 28 days from being conducted more frequently than two-week intervals and establishes an expedited appeal process for denials of continued inpatient care.

Committee members expressed the following points during the discussion:

- In many cases, non-specialist clinicians are making determinations for medical necessities in the interest of insurance companies, rather than the patients.
- When insurance companies deny authorization for the medically recommended treatment plan of patients, it creates challenges for the continued care of patients.
- It is important for medical providers to be able to maintain patients in treatment for a sufficient amount of time to stabilize them before they are transitioned out. Disrupting treatment prior to patients stabilizing can increase the risk of relapse.

Motion: Danielle Sena made a motion to support Assembly Bill 669. Erin Franco seconded the motion. A priority tier number was not assigned.

Vote: A roll call vote was taken. The motion passed unanimously with all present 17 members voting “Yes”.

Public Comment:
There were no public comments.

Senate Bill 812 (Allen)

The committee discussed Senate Bill 812 (Allen) which seeks to expand existing law that requires health care service plan contracts or health insurance policies to cover medically necessary treatment of mental health and substance use disorders for individuals aged 25 or younger when delivered at a school site, by additionally requiring coverage when such services are provided at a qualified youth drop-in center.

Some key points from the committee’s discussion included the following:

- Parents have expressed concerns that if school districts are billing for services, there is the possibility that health care insurances may not cover services their children might receive from external private practitioners.
- There are challenges at the state level for the Children and Youth Behavioral Health Initiative (CYBHI) that still need to be addressed.
- Committee members questioned whether local educational agencies are billing the Department of Health Care Services directly or counties for the services rendered. The committee also questioned who is responsible for paying the match if counties are being billed for the services.

Motion: Susan Wilson made a motion to support Senate Bill 812 with an assigned priority tier number two. Erin Franco seconded the motion.

Vote: A roll call vote was taken. The motion passed with 6 members voting “Yes”. Karen Baylor, Barbara Mitchell, Liz Oseguera, Jason Bradley, Danielle Sena, and Daphne Shaw abstained. Karrie Sequeira, Deborah Starkey, Susan Wilson, and Uma Zykofsky voted “No”.

Public Comment:
There were no public comments.

Agenda Item: **Recovery Housing in California’s Public Behavioral Health System**

Christopher Martin, Policy Director from Housing California, presented to the committee about recovery housing and their position for Assembly Bill (AB) 255 (Haney). Housing California is a statewide nonprofit advocacy organization focused on the production of affordable housing and supportive housing, ending homelessness, and protecting renters.

Christopher provided an overview of Housing First and explained the concept of recovery housing. In a policy brief published by the U.S. Housing and Urban Development, recovery housing is defined as “a housing model that uses substance use specific services, peer support, and physical design features to support individuals and families on a particular path to recovery from addiction, typically emphasizing abstinence.” The core components of recovery housing include: (1) voluntary participation unless court ordered, (2) long term housing stability is a primary goal for individuals, (3) low barrier access for participation, (4) tailored services for individual needs, and (5) relapse alone is not grounds for eviction.

Following the overview of recovery housing, Christopher spoke about AB 255 which seeks to allow each county jurisdiction to use up to 25% of state funding from the Homeless Housing Assistance and Prevention Program toward supportive recovery residences. Housing California initially opposed the bill. Christopher highlighted a key concern about the use of the term “automatic” in the provision that “relapse is not an automatic cause for eviction”. He emphasized that precise wording is crucial in state statutes, as vague terminology can lead to inconsistent interpretation and enforcement.

Housing California, in collaboration with Corporation for Supportive Housing, and National Alliance to End Homelessness proposed the following amendments to the bill: (1) reduce percentage to be used on recovery housing from 25% to 10%, and (2) remove “automatic” in “relapse is not an automatic cause for eviction”.

The Senate Housing Committee is accepting the proposed amendments; therefore, Housing CA will take a neutral position on the bill.

Agenda Item: **Behavioral Health Services Act: Housing Interventions**

Ilana Rub, Assistant Division Chief of the Community Services Division from the Department of Health Care Services, presented on Housing Interventions under the Behavioral Health Services Act (BHSA). Ilana shared that under BHSA, 30 percent of each county's allocation must be used for Housing Interventions and 50 percent of these funds must be used for persons who are chronically homeless, with a focus on individuals living in encampments. Additionally, counties are allowed to use up to 25 percent of the Housing Interventions fund for Capital Development Projects such as infrastructure, purchasing, and renovating properties. Capital Development Projects that prioritize chronically homeless individuals would contribute toward the 50 percent requirement. Counties are also allowed flexibility to move seven percent of funds to or from Housing Interventions into Full-Service Partnership programs or Behavioral Health Services Supports. In addition, counties with a population of less than 200,000 may request an exemption from the required 30 percent allocation toward Housing Interventions.

Ilana explained that Housing Interventions are not limited to only individuals enrolled in Full-Service Partnership programs or Medi-Cal. Housing Intervention funds may not be used for housing services that are covered by Medi-Cal Managed Care Plans (MCP). Counties are required to collaborate with MCPs to ensure that funds are used to complement, not supplant, MCP-covered services. Additionally, Housing Interventions must be combined with access to clinical and supportive behavioral health care and housing services.

The Department of Health Care Services (DHCS) has identified and developed guidelines in alignment with Transitional Rent benefits for allowable settings under Housing Interventions. Although emphasis is on helping individuals find permanent supportive housing, DHCS recognizes the integral role of interim time-limited settings and allows the use of funds for both non-time-limited permanent settings and interim time-limited housing. Eligible individuals receiving transitional rent benefits may receive up to six months of rent support in an interim setting. It can be extended with Housing Interventions funds for an additional six months if more time is needed to identify permanent supportive housing. Individuals who are not Medi-Cal recipients but are otherwise receiving Housing Intervention services may receive up to 12 months of support in an interim setting.

Assisted living settings are the only allowable setting that is not consistent between Housing Interventions and Transitional Rent benefits. These are licensed facilities that are not time-limited for which Housing Intervention funds may be used to support individuals with serious behavioral health conditions, require assistance with activities of daily living, or have severe cognitive impairment. Examples of assisted living settings include adult residential facilities, residential care facilities for the elderly, board and care facilities, and license-exempt room and board facilities.

Following the presentation, committee members engaged in a question-and-answer discussion. Some of the key discussion points, responses, and additional information included:

- DHCS has come to an agreed definition for “License Exempt Room and Board” with the Department of Social Services, which Ilana expressed that can be shared with the Council.
- Technical assistance and guidance for assisted residential facilities to access behavioral health services through Medi-Cal or the Behavioral Health Services and Supports bucket are still under development.

Public Comment:

Barbara Wilson from Los Angeles County expressed gratitude for the presentation and inquired if the slide deck would be made available to the public. Barbara also inquired if reimbursement rates for assisted residential facilities would be increased under the Behavioral Health Transformation.

Agenda Item: General Public Comment

Patricia Wentzel from Sacramento County expressed that the National Alliance on Mental Illness (NAMI) California has been working on addressing challenges regarding the Sacramento County Sheriff’s Department’s recent policy change to no longer respond to mental health crisis calls and provide support with transporting individuals for a 5150 hold. Patricia encouraged the committee to monitor legislation that may include the use of similar practices.

Agenda Item: Meeting Wrap-Up & Next Steps

The committee provided comments and recommendations for the planning of the next meeting, which included the following:

- Using the Consent Agenda to get through bills more efficiently.
- Setting time aside on the agenda for a report out from the Patients’ Rights Committee regarding legislative requests.

The committee had previously agreed to hold more in-between meetings to discuss legislation. Council staff will work with the committee to schedule an in-between meeting before the October 2025 quarterly meeting.

Agenda Item: **Adjourn**

The meeting was adjourned at 4:51pm.