ASSEMBLY BILL No. 1808

Introduced by Assembly Member Galgiani

February 10, 2010

An act to amend Section 5777 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 1808, as introduced, Galgiani. Medi-Cal: Mental health services.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services, under which qualified low-income persons are provided with health care services, including mental health services.

This bill would make technical, nonsubstantive changes in Medi-Cal Mental health provisions.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

SECTION 1. Section 5777 of the Welfare and Institutions Code is amended to read:

5777. (a) (1) Except as otherwise specified in this part, a contract entered into pursuant to this part shall include a provision that the mental health plan contractor shall bear the financial risk for the cost of providing medically necessary mental health services to Medi-Cal beneficiaries irrespective of whether the cost of those services exceeds the payment set forth in the contract. If the expenditures for services do not exceed the payment set forth in

the contract, the mental health plan contractor shall report the unexpended amount to the department, but shall not be required to return the excess to the department.

(2) If the mental health plan is not the county's, the mental health plan may not transfer the obligation for any mental health services to Medi-Cal beneficiaries to the county. The mental health plan may purchase services from the county. The mental health plan shall establish mutually agreed-upon protocols with the county that clearly establish conditions under which beneficiaries may obtain non-Medi-Cal reimbursable services from the county. Additionally, the plan shall establish mutually agreed-upon protocols with the county for the conditions of transfer of beneficiaries who have lost Medi-Cal eligibility to the county for care under Part 2 (commencing with Section 5600), Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850).

(3) The mental health plan shall be financially responsible for ensuring access and a minimum required scope of benefits, consistent with state and federal requirements, to the services to the Medi-Cal beneficiaries of that county regardless of where the beneficiary resides. The department shall require that the definition of medical necessity used, and the minimum scope of benefits offered, by each mental health contractor be the same, except to the extent that any variations receive prior federal approval and are consistent with state and federal statutes and regulations.

(b) ~~Any~~ *A* contract entered into pursuant to this part may be renewed if the plan continues to meet the requirements of this part, regulations promulgated pursuant thereto, and the terms and conditions of the contract. Failure to meet these requirements shall be cause for nonrenewal of the contract. The department may base the decision to renew on timely completion of a mutually agreed-upon plan of correction of any deficiencies, submissions of required information in a timely manner, or other conditions of the contract. At the discretion of the department, each contract may be renewed for a period not to exceed three years.

(c) (1) The obligations of the mental health plan shall be changed only by contract or contract amendment.

(2) A change may be made during a contract term or at the time of contract renewal, where there is a change in obligations required by federal or state law or when required by a change in the

interpretation or implementation of any law or regulation. To the extent permitted by federal law and except as provided under paragraph (10) of subdivision (c) of Section 5778, if ~~any~~ *a* change in obligations occurs that affects the cost to the mental health plan of performing under the terms of its contract, the department may reopen contracts to negotiate the state General Fund allocation to the mental health plan under Section 5778, if the mental health plan is reimbursed through a fee-for-service payment system, or the capitation rate to the mental health plan under Section 5779, if the mental health plan is reimbursed through a capitated rate payment system. During the time period required to redetermine the allocation or rate, payment to the mental health plan of the allocation or rate in effect at the time the change occurred shall be considered interim payments and shall be subject to increase or decrease, as the case may be, effective as of the date on which the change is effective.

(3) To the extent permitted by federal law, either the department or the mental health plan may request that contract negotiations be reopened during the course of a contract due to substantial changes in the cost of covered benefits that result from an unanticipated event.

(d) The department shall immediately terminate a contract when the director finds that there is an immediate threat to the health and safety of Medi-Cal beneficiaries. Termination of the contract for other reasons shall be subject to reasonable notice of the department's intent to take that action and notification of affected beneficiaries. The plan may request a public hearing by the Office of Administrative Hearings.

(e) A plan may terminate its contract in accordance with the provisions in the contract. The plan shall provide written notice to the department at least 180 days prior to the termination or nonrenewal of the contract.

(f) Upon the request of the Director of Mental Health, the Director of Managed Health Care may exempt a mental health plan contractor or a capitated rate contract from the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code). These exemptions may be subject to conditions the director deems appropriate. Nothing in this part shall be construed to impair or diminish the authority of the Director of Managed Health Care

under the Knox-Keene Health Care Service Plan Act of 1975, nor shall anything in this part be construed to reduce or otherwise limit the obligation of a mental health plan contractor licensed as a health care service plan to comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of Managed Health Care promulgated thereunder. The Director of Mental Health, in consultation with the Director of Managed Health Care, shall analyze the appropriateness of licensure or application of applicable standards of the Knox-Keene Health Care Service Plan Act of 1975.

(g) (1) The department, pursuant to an agreement with the State Department of Health Care Services, shall provide oversight to the mental health plans to ensure quality, access, and cost efficiency. At a minimum, the department shall, through a method independent of any agency of the mental health plan contractor, monitor the level and quality of services provided, expenditures pursuant to the contract, and conformity with federal and state law.

(2) (A) Commencing July 1, 2008, county mental health plans, in collaboration with the department, the federally required external review organization, providers, and other stakeholders, shall establish an advisory statewide performance improvement project (PIP) to increase the coordination, quality, effectiveness, and efficiency of service delivery to children who are either receiving at least three thousand dollars ($3,000) per month in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program services or children identified in the top 5 percent of the county EPSDT cost, whichever is lowest. The statewide PIP shall replace one of the two required PIPs that mental health plans must perform under federal regulations outlined in the mental health plan contract.

(B) The federally required external quality review organization shall provide independent oversight and reviews with recommendations and findings or summaries of findings, as appropriate, from a statewide perspective. This information shall be accessible to county mental health plans, the department, county welfare directors, providers, and other interested stakeholders in a manner that both facilitates, and allows for, a comprehensive quality improvement process for the EPSDT Program.

(C) Each July, the department, in consultation with the federally required external quality review organization and the county mental

health plans, shall determine the average monthly cost threshold for counties to use to identify children to be reviewed who are currently receiving EPSDT services. The department shall consult with representatives of county mental health directors, county welfare directors, providers, and the federally required external quality review organization in setting the annual average monthly cost threshold and in implementing the statewide PIP. The department shall provide an annual update to the Legislature on the results of this statewide PIP by October 1 of each year for the prior fiscal year.

(D) It is the intent of the Legislature for the EPSDT PIP to increase the coordination, quality, effectiveness, and efficiency of service delivery to children receiving EPSDT services and to facilitate evidence-based practices within the program, and other high-quality practices consistent with the values of the public mental health system within the program to ensure that children are receiving appropriate mental health services for their mental health wellness.

(E) This paragraph shall become inoperative on September 1, 2011.

(h) County employees implementing or administering a mental health plan act in a discretionary capacity when they determine whether or not to admit a person for care or to provide any level of care pursuant to this part.

(i) If a county chooses to discontinue operations as the local mental health plan, the new plan shall give reasonable consideration to affiliation with nonprofit community mental health agencies that were under contract with the county and that meet the mental health plan's quality and cost efficiency standards.

(j) Nothing in this part shall be construed to modify, alter, or increase the obligations of counties as otherwise limited and defined in Chapter 3 (commencing with Section 5700) of Part 2. The county's maximum obligation for services to persons not eligible for Medi-Cal shall be no more than the amount of funds remaining in the mental health subaccount pursuant to Sections 17600, 17601, 17604, 17605, 17606, and 17609 after fulfilling the Medi-Cal contract obligations.

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