AMENDED IN SENATE SEPTEMBER 2, 2009

AMENDED IN ASSEMBLY JUNE 2, 2009

AMENDED IN ASSEMBLY APRIL 23, 2009

AMENDED IN ASSEMBLY APRIL 14, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 754

Introduced by Assembly Member Chesbro

February 26, 2009

An act to amend ~~Sections 5777 and~~ *Section* 5778 of the Welfare and Institutions Code, relating to Medi-Cal mental health services.

LEGISLATIVE COUNSEL'S DIGEST

AB 754, as amended, Chesbro. Medi-Cal: mental health plans.

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. The Medi-Cal program is partially governed and funded under federal Medicaid provisions.

Under existing law, the State Department of Mental Health (department) is required to implement managed mental health care for Medi-Cal recipients through fee-for-service or ~~capitated~~ *capitate* contracts with mental health plans~~, including individual counties, counties acting jointly, qualified individuals or organizations, or nongovernmental entities. The department is responsible for assuming specified program oversight authority formerly provided by the State Department of Health Care Services, including, but not limited to, oversight of certain utilization controls~~. *Existing law requires, for*

funding allocations and risk-sharing determinations and arrangements for specialty mental health services reimbursed through a fee-for-service payment system, that the department allocate the contracted amount at the beginning of the contract period to the mental health plan.

~~Existing law provides that a change may be made during the term of a contract entered into pursuant to the above provisions or at the time of renewal of that contract, 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. Existing law provides, to the extent permitted by federal law and except as provided, if any 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, as specified.~~

~~This bill would provide that either the department or the mental health plan may reopen the contract.~~

~~Existing law contains various provisions relating to, among other things, reimbursement and claiming procedures for mental health plans and mental health plan subcontractors.~~

~~This bill would require mental health plan claims for federal financial participation to be submitted to the federal Centers for Medicare and Medicaid Services by the department and the State Department of Health Care Services throughout the fiscal year as claims are received. The bill would also require payments to be made directly to the mental health plans after the federal payments have been received by the state.~~

~~Existing law requires the department to allocate the amount of payment set forth in the contract at the beginning of the contract period to the mental health plan. Existing law requires the funds to be considered to be funds of the plan that may be held by the department.~~

~~This bill would require the department to allocate and distribute the full amount of payment set forth in the contract to the mental health plan at the beginning of the contract period.~~

~~Existing law requires the allocation method for the state funds transferred for fiscal years following the 1994–95 fiscal year for acute inpatient psychiatric and other specialty mental health services to be determined by the department in consultation with a statewide organization representing counties.~~

~~This bill would require the allocation method to be determined no later than June 1 of the previous fiscal year.~~

This bill would, beginning July 1, 2011, exclude the Early Periodic Screening Diagnosis and Treatment (EPSDT) specialty mental health

services provided under a Medi-Cal specialty mental health services waiver from being allocated at the beginning of the contract period.

Vote: majority. Appropriation: no. Fiscal committee: yes. 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 requiring 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 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 that has been agreed to by all parties to the contract.~~

~~(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 change in obligations occurs that affects the cost to the mental health plan of performing under the terms of its contract, the department or the mental health plan 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 the Department 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 the Department 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 the Department of Managed Health Care promulgated thereunder. The Director of Mental Health, in consultation with the Director of the Department 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.~~

~~SEC. 2.~~

SECTION 1. Section 5778 of the Welfare and Institutions Code is amended to read:

5778. (a) This section shall be limited to specialty mental health services reimbursed through a fee-for-service payment system.

(b) The following provisions shall apply to matters related to specialty mental health services provided under the Medi-Cal specialty mental health services waiver, including, but not limited to, reimbursement and claiming procedures, reviews and oversight, and appeal processes for mental health plans (MHPs) and MHP subcontractors.

(1) During the initial phases of the implementation of this part, as determined by the department, the MHP contractor and subcontractors shall submit claims under the Medi-Cal program for eligible services on a fee-for-service basis.

(2) A qualifying county may elect, with the approval of the department, to operate under the requirements of a capitated, integrated service system field test pursuant to Section 5719.5 rather than this part, in the event the requirements of the two programs conflict. A county that elects to operate under that section shall comply with all other provisions of this part that do not conflict with that section.

(3) (A) No sooner than October 1, 1994, state matching funds for Medi-Cal fee-for-service acute psychiatric inpatient services, and associated administrative days, shall be transferred to the department. No later than July 1, 1997, upon agreement between the department and the State Department of Health Care Services, state matching funds for the remaining Medi-Cal fee-for-service mental health services and the state matching funds associated with field test counties under Section 5719.5 shall be transferred to the department.

(B) The department, in consultation with the State Department of Health Care Services, a statewide organization representing counties, and a statewide organization representing health maintenance organizations shall develop a timeline for the transfer of funding and responsibility for fee-for-service mental health services from Medi-Cal managed care plans to MHPs. In developing the timeline, the department shall develop screening, referral, and coordination guidelines to be used by Medi-Cal managed care plans and MHPs.

(4) (A) (i) A MHP subcontractor providing specialty mental health services shall be financially responsible for federal audit exceptions or disallowances to the extent that these exceptions or disallowances are based on the MHP subcontractor's conduct or determinations.

(ii) The state shall be financially responsible for federal audit exceptions or disallowances to the extent that these exceptions or disallowances are based on the state's conduct or determinations. The state shall not withhold payment from a MHP for exceptions or disallowances that the state is financially responsible for pursuant to this clause.

(iii) A MHP shall be financially responsible for state audit exceptions or disallowances to the extent that these exceptions or disallowances are based on the MHP's conduct or determinations. A MHP shall not withhold payment from a MHP subcontractor for exceptions or disallowances for which the MHP is financially responsible pursuant to this clause.

(B) For purposes of subparagraph (A), a "determination" shall be shown by a written document expressly stating the determination, while "conduct" shall be shown by any credible, legally admissible evidence.

(C) The department and the State Department of Health Care Services shall work jointly with MHPs in initiating any necessary appeals. The department may invoice or offset the amount of any federal disallowance or audit exception against subsequent claims from the MHP or MHP subcontractor. This offset may be done at any time, after the audit exception or disallowance has been withheld from the federal financial participation claim made by the State Department of Health Care Services. The maximum amount that may be withheld shall be 25 percent of each payment to the plan or subcontractor.

(5) (A) Oversight by the department of the MHPs and MHP subcontractors may include client record reviews of Early Periodic Screening Diagnosis and Treatment (EPSDT) specialty mental health services under the Medi-Cal specialty mental health services waiver in addition to other audits or reviews that are conducted.

(B) The department may contract with an independent, nongovernmental entity to conduct client record reviews. The contract awarded in connection with this section shall be on a competitive bid basis, pursuant to the Department of General Services contracting requirements, and shall meet both of the following additional requirements:

(i) Require the entity awarded the contract to comply with all federal and state privacy laws, including, but not limited to, the federal Health Insurance Portability and Accountability Act (HIPAA; 42 U.S.C. Sec. 1320d et seq.) and its implementing regulations, the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code), and Section 1798.81.5 of the Civil Code. The entity shall be subject to existing penalties for violation of these laws.

(ii) Prohibit the entity awarded the contract from using, selling, or disclosing client records for a purpose other than the one for which the record was given.

(C) For purposes of this paragraph, the following terms shall have the following meanings:

(i) “Client record” means a medical record, chart, or similar file, as well as other documents containing information regarding an individual recipient of services, including, but not limited to, clinical information, dates and times of services, and other information relevant to the individual and services provided and

that evidences compliance with legal requirements for Medi-Cal reimbursement.

(ii) "Client record review" means examination of the client record for a selected individual recipient for the purpose of confirming the existence of documents that verify compliance with legal requirements for claims submitted for Medi-Cal reimbursement.

(D) The department shall recover overpayments of federal financial participation from MHPs within the timeframes required by federal law and regulation and return those funds to the State Department of Health Care Services for repayment to the federal Centers for Medicare and Medicaid Services. The department shall recover overpayments of General Fund moneys utilizing the recoupment methods and timeframes required by the State Administrative Manual.

(6) (A) The department, in consultation with mental health stakeholders, the California Mental Health Directors Association, and MHP subcontractor representatives, shall provide an appeals process that specifies a progressive process for resolution of disputes about claims or recoupments relating to specialty mental health services under the Medi-Cal specialty mental health services waiver.

(B) The department shall provide MHPs and MHP subcontractors the opportunity to directly appeal findings in accordance with procedures that are similar to those described in Article 1.5 (commencing with Section 51016) of Chapter 3 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations, until new regulations for a progressive appeals process are promulgated. When an MHP subcontractor initiates an appeal, it shall give notice to the MHP. The department shall propose a rulemaking package by no later than the end of the 2008–09 fiscal year to amend the existing appeals process. The reference in this subparagraph to the procedures described in Article 1.5 (commencing with Section 51016) of Chapter 3 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations, shall only apply to those appeals addressed in this subparagraph.

(C) The department shall develop regulations as necessary to implement this paragraph.

(7) The department shall assume the applicable program oversight authority formerly provided by the State Department of

Health Care Services, including, but not limited to, the oversight of utilization controls as specified in Section 14133. The MHP shall include a requirement in any subcontracts that all inpatient subcontractors maintain necessary licensing and certification. MHPs shall require that services delivered by licensed staff are within their scope of practice. Nothing in this part shall prohibit the MHPs from establishing standards that are in addition to the minimum federal and state requirements, provided that these standards do not violate federal and state Medi-Cal requirements and guidelines.

(8) Subject to federal approval and consistent with state requirements, the MHP may negotiate rates with providers of mental health services.

(9) Under the fee-for-service payment system, any excess in the payment set forth in the contract over the expenditures for services by the plan shall be spent for the provision of specialty mental health services under the Medi-Cal specialty mental health service waiver and related administrative costs.

(10) Nothing in this part shall limit the MHP from being reimbursed appropriate federal financial participation for any qualified services even if the total expenditures for service exceeds the contract amount with the department. Matching nonfederal public funds shall be provided by the plan for the federal financial participation matching requirement. ~~MHP claims for federal financial participation shall be submitted to the federal Centers for Medicare and Medicaid Services by the department and the State Department of Health Care Services throughout the fiscal year as the claims are received from MHPs. Payments shall be made directly to the MHP after the federal payments have been received by the state.~~

(c) The provisions of this subdivision shall apply to managed mental health care funding allocations and risk-sharing determinations and arrangements.

(1) The department shall allocate ~~and distribute the full~~ *the* contracted amount *for the managed mental health care program, exclusive of the EPSDT specialty mental health services provided under the Medi-Cal specialty mental health services waiver,* at the beginning of the contract period to the MHP. The allocated funds shall be considered to be funds of the plan that may be held by the department. The department shall develop a methodology to ensure

that these funds are held as the property of the plan and shall not be reallocated by the department or any other entity of state government for other purposes.

(2) Each fiscal year the state matching funds for Medi-Cal specialty mental health services shall be included in the annual budget for the department. The amount included shall be based on historical cost, adjusted for changes in the number of Medi-Cal beneficiaries and other relevant factors. The appropriation for funding the state share of the costs for EPSDT specialty mental health services provided under the Medi-Cal specialty mental health services waiver shall only be used for reimbursement payments of claims for those services.

(3) Initially, the MHP shall use the fiscal intermediary of the Medi-Cal program of the State Department of Health Care Services for the processing of claims for inpatient psychiatric hospital services and may be required to use that fiscal intermediary for the remaining mental health services. The providers for other specialty mental health Medi-Cal services shall not be initially required to use the fiscal intermediary but may be required to do so on a date to be determined by the department. The department and its MHPs shall be responsible for the initial incremental increased matching costs of the fiscal intermediary for claims processing and information retrieval associated with the operation of the services funded by the transferred funds.

(4) The MHPs shall have sufficient funds on deposit with the department as the matching funds necessary for federal financial participation to ensure timely payment of claims for acute psychiatric inpatient services and associated administrative days. The department and the State Department of Health Care Services, in consultation with a statewide organization representing counties, shall establish a mechanism to facilitate timely availability of those funds. Any funds held by the state on behalf of a plan shall be deposited in a mental health managed care deposit fund and shall accrue interest to the plan. The department shall exercise any necessary funding procedures pursuant to Section 12419.5 of the Government Code and Sections 8776.6 and 8790.8 of the State Administrative Manual regarding county claim submission and payment.

(5) The goal for funding of the future capitated system shall be to develop statewide rates for beneficiary, by aid category and

with regional price differentiation, within a reasonable time period. The formula for distributing the state matching funds transferred to the department for acute inpatient psychiatric services to the participating counties shall be based on the following principles:

(A) Medi-Cal state General Fund matching dollars shall be distributed to counties based on historic Medi-Cal acute inpatient psychiatric costs for the county's beneficiaries and on the number of persons eligible for Medi-Cal in that county.

(B) All counties shall receive a baseline based on historic and projected expenditures up to October 1, 1994.

(C) Projected inpatient growth for the period October 1, 1994, to June 30, 1995, inclusive, shall be distributed to counties below the statewide average per eligible person on a proportional basis. The average shall be determined by the relative standing of the aggregate of each county's expenditures of mental health Medi-Cal dollars per beneficiary. Total Medi-Cal dollars shall include both fee-for-service Medi-Cal and Short-Doyle Medi-Cal dollars for both acute inpatient psychiatric services, outpatient mental health services, and psychiatric nursing facility services, both in facilities that are not designated as institutions for mental disease and for beneficiaries who are under 22 years of age and beneficiaries who are over 64 years of age in facilities that are designated as institutions for mental disease.

(D) There shall be funds set aside for a self-insurance risk pool for small counties. The department may provide these funds directly to the administering entity designated in writing by all counties participating in the self-insurance risk pool. The small counties shall assume all responsibility and liability for appropriate administration of these funds. For purposes of this subdivision, "small counties" means counties with less than 200,000 population. Nothing in this paragraph shall in any way obligate the state or the department to provide or make available any additional funds beyond the amount initially appropriated and set aside for each particular fiscal year, unless otherwise authorized in statute or regulations, nor shall the state or the department be liable in any way for mismanagement of loss of funds by the entity designated by the counties under this paragraph.

(6) The allocation method for state funds transferred for acute inpatient psychiatric services shall be as follows:

(A) For the 1994–95 fiscal year, an amount equal to 0.6965 percent of the total shall be transferred to a fund established by small counties. This fund shall be used to reimburse MHPs in small counties for the cost of acute inpatient psychiatric services in excess of the funding provided to the MHP for risk reinsurance, acute inpatient psychiatric services and associated administrative days, alternatives to hospital services as approved by participating small counties, or for costs associated with the administration of these moneys. The methodology for use of these moneys shall be determined by the small counties, through a statewide organization representing counties, in consultation with the department.

(B) The balance of the transfer amount for the 1994–95 fiscal year shall be allocated to counties based on the following formula:

County	Percentage
Alameda	3.5991
Alpine	.0050
Amador	.0490
Butte	.8724
Calaveras	.0683
Colusa	.0294
Contra Costa	1.5544
Del Norte	.1359
El Dorado	.2272
Fresno	2.5612
Glenn	.0597
Humboldt	.1987
Imperial	.6269
Inyo	.0802
Kern	2.6309
Kings	.4371
Lake	.2955
Lassen	.1236
Los Angeles	31.3239
Madera	.3882
Marin	1.0290
Mariposa	.0501
Mendocino	.3038
Merced	.5077
Modoc	.0176

County	Percentage
Mono	.0096
Monterey	.7351
Napa	.2909
Nevada	.1489
Orange	8.0627
Placer	.2366
Plumas	.0491
Riverside	4.4955
Sacramento	3.3506
San Benito	.1171
San Bernardino	6.4790
San Diego	12.3128
San Francisco	3.5473
San Joaquin	1.4813
San Luis Obispo	.2660
San Mateo	.0000
Santa Barbara	.0000
Santa Clara	1.9284
Santa Cruz	1.7571
Shasta	.3997
Sierra	.0105
Siskiyou	.1695
Solano	.0000
Sonoma	.5766
Stanislaus	1.7855
Sutter/Yuba	.7980
Tehama	.1842
Trinity	.0271
Tulare	2.1314
Tuolumne	.2646
Ventura	.8058
Yolo	.4043

(7) The allocation method for the state funds transferred for subsequent years for acute inpatient psychiatric and other specialty mental health services shall be determined by the department in consultation with a statewide organization representing ~~counties no later than June 1 of the previous fiscal year.~~ *counties.*

(8) The allocation methodologies described in this section shall only be in effect while federal financial participation is received on a fee-for-service reimbursement basis. When federal funds are capitated, the department, in consultation with a statewide organization representing counties, shall determine the methodology for capitation consistent with federal requirements. The share of cost ratio arrangement for EPSDT specialty mental health services provided under the Medi-Cal specialty mental health services waiver between the state and the counties in existence during the 2007–08 fiscal year shall remain as the share of cost ratio arrangement for these services unless changed by statute.

(9) The formula that specifies the amount of state matching funds transferred for the remaining Medi-Cal fee-for-service mental health services shall be determined by the department in consultation with a statewide organization representing counties. This formula shall only be in effect while federal financial participation is received on a fee-for-service reimbursement basis.

(10) (A) For the managed mental health care program, exclusive of EPSDT specialty mental health services provided under the Medi-Cal specialty mental health services waiver, the department shall establish, by regulation, a risk-sharing arrangement between the department and counties that contract with the department as MHPs to provide an increase in the state General Fund allocation, subject to the availability of funds, to the MHP under this section, where there is a change in the obligations of the MHP required by federal or state law or regulation, or required by a change in the interpretation or implementation of any such law or regulation which significantly increases the cost to the MHP of performing under the terms of its contract.

(B) During the time period required to redetermine the allocation, payment to the MHP of the allocation in effect at the time the change occurred shall be considered an interim payment, and shall be subject to increase effective as of the date on which ~~the change is effective as determined in the MHP contract or contract amendment.~~ *the change is effective.*

(C) In order to be eligible to participate in the risk-sharing arrangement, the county shall demonstrate, to the satisfaction of the department, its commitment or plan of commitment of all annual funding identified in the total mental health resource base,

from whatever source, but not including county funds beyond the required maintenance of effort, to be spent on specialty mental health services. This determination of eligibility shall be made annually. The department may limit the participation in a risk-sharing arrangement of any county that transfers funds from the mental health account to the social services account or the health services account, in accordance with Section 17600.20 during the year to which the transfers apply to MHP expenditures for the new obligation that exceed the total mental health resource base, as measured before the transfer of funds out of the mental health account and not including county funds beyond the required maintenance of effort. The State Department of Mental Health shall participate in a risk-sharing arrangement only after a county has expended its total annual mental health resource base.

(d) The following provisions govern the administrative responsibilities of the department and the State Department of Health Care Services:

(1) It is the intent of the Legislature that the department, and the State Department of Health Care Services consult and collaborate closely regarding administrative functions related to and supporting the managed mental health care program in general, and the delivery and provision of EPSDT specialty mental health services provided under the Medi-Cal specialty mental health services waiver, in particular. To this end, the following provisions shall apply:

(A) Commencing in the 2009–10 fiscal year, and each fiscal year thereafter, the department shall consult with the State Department of Health Care Services and amend the interagency agreement between the two departments as necessary to include improvements or updates to procedures for the accurate and timely processing of Medi-Cal claims for specialty mental health services provided under the Medi-Cal specialty mental health services waiver. The interagency agreement shall ensure that there are consistent and adequate time limits, consistent with federal and state law, for claims submitted and the need to correct errors.

(B) Commencing in the 2009–10 fiscal year, and each fiscal year thereafter, upon a determination by the department and the State Department of Health Care Services that it is necessary to amend the interagency agreement, the department and the State Department of Health Care Services shall process the interagency

agreement to ensure final approval by January 1, for the following fiscal year, and as adjusted by the budgetary process.

(C) The interagency agreement shall include, at a minimum, all of the following:

(i) A process for ensuring the completeness, validity, and timely processing of Medi-Cal claims as mandated by the federal Centers for Medicare and Medicaid Services.

(ii) Procedures and timeframes by which the department shall submit complete, valid, and timely invoices to the State Department of Health Care Services, which shall notify the department of inconsistencies in invoices that may delay payments.

(iii) Procedures and timeframes by which the department shall notify MHPs of inconsistencies that may delay payment.

(2) (A) The department shall consult with the State Department of Health Care Services and the California Mental Health Directors Association in February and September of each year to review the methodology used to forecast future trends in the provision of EPSDT specialty mental health services provided under the Medi-Cal specialty mental health services waiver, to estimate these yearly EPSDT specialty mental health services related costs, and to estimate the annual amount of funding required for reimbursements for EPSDT specialty mental health services to ensure relevant factors are incorporated in the methodology. The estimates of costs and reimbursements shall include both federal financial participation amounts and any state General Fund amounts for EPSDT specialty mental health services provided under the State Medi-Cal specialty mental health services waiver. The department shall provide the State Department of Health Care Services the estimate adjusted to a cash basis.

(B) The estimate of annual funding described in subparagraph (A) shall, include, but not be limited to, the following factors:

(i) The impacts of interactions among caseload, type of services, amount or number of services provided, and billing unit cost of services provided.

(ii) A systematic review of federal and state policies, trends over time, and other causes of change.

(C) The forecasting and estimates performed under this paragraph are primarily for the purpose of providing the Legislature and the Department of Finance with projections that are as accurate as possible for the state budget process, but will also be informative

and useful for other purposes. Therefore, it is the intent of the Legislature that the information produced under this paragraph shall be taken into consideration under paragraph (10) of subdivision (c).

SEC. 2. Section 1 of this act shall become operative on July 1, 2011.

O