AB 1297- Medi-Cal: mental health

SUMMARY OF THE BILL

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 require the standards, guidelines, and reimbursement amounts to be set in accordance with federal Medicaid requirements and the approved Medicaid state plan and waivers. The bill also would require bills for service to be submitted by MHPs within the timeframes required by federal Medicaid requirements and the approved Medicaid state plan and waivers. Existing law requires the State Department of Health Care Services and the State Department of Mental Health to jointly develop a new ratesetting methodology for reimbursements for direct client services that meets specified requirements, including that administrative cost be claimed separately and limited to 15% of the total cost of direct client services. This bill would instead require the development of a ratesetting methodology that conforms with federal Medicaid requirements and the approved Medicaid state plan and waivers.

- For purposes of federal reimbursement, require reimbursement amounts to be consistent with federal Medicaid requirements and approved state plan and waivers. The goal of this provision is to eliminate California's use of administratively-established Statewide Maximum Allowances (SMAs), and instead, utilize existing federal Medicaid Upper Payment Limits. The current use of SMAs places a ceiling on Mental Health Plans' abilities to obtain federal reimbursement.
- Clarify that administrative costs should be consistent with federal Medicaid requirements and approved state plan and waivers. Delete the provision in current law limiting administrative costs to 15% of the total cost of direct client services.
- Require claims to be submitted by Mental Health Plans within the timeframes specified in federal Medicaid requirements and approved state plan and waivers. The goal of this provision is to eliminate California's use of an administratively-established submission deadline of six months for Specialty Medi-Cal Mental Health Managed Care claims. At present, the federal timeframe for Medicaid claims submission is twelve months.

RECOMMENDED ACTION: Support/Oppose

Support

REASON FOR RECOMMENDATION/IMPACT TO COUNTY

This purpose of the bill includes ensuring full and timely federal reimbursement to counties for services that are rendered and claimed consistent with federal Medicaid requirements. Move federal Medicaid reimbursement as quickly as possible to support direct mental health services to consumers. Reduce unnecessary state-only requirements that limit federal Medicaid reimbursement.

POSSIBLE SUPPORTERS

County Mental Health Directors Association

POSSIBLE OPPOSITION

COUNTY CONTACT

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CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1297

Introduced by Assembly Member Chesbro

February 18, 2011

An act to amend Sections 5718, 5720, 5724, 5778, 14680, and 14684 of the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1297, as introduced, Chesbro. Medi-Cal: mental health.

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 provide specialty mental health services for Medi-Cal recipients through fee-for-service or capitated contracts with mental health plans (MHPs). The department establishes standards, guidelines, and reimbursement amounts for specialty mental health services based on the federal Medicaid requirements. Existing law establishes procedures, including reimbursement and claiming procedures, reviews and oversight, and appeal processes for MHPs and MHP subcontractors.

This bill would require the standards, guidelines, and reimbursement amounts to be set in accordance with federal Medicaid requirements and the approved Medicaid state plan and waivers. The bill also would require bills for service to be submitted by MHPs within the timeframes required by federal Medicaid requirements and the approved Medicaid state plan and waivers.

Existing law requires the State Department of Health Care Services and the State Department of Mental Health to jointly develop a new ratesetting methodology for reimbursements for direct client services that meets specified requirements, including that administrative costs be claimed separately and limited to 15% of the total cost of direct client services.

This bill would instead require the development of a ratesetting methodology that conforms with the federal Medicaid requirements and the approved Medicaid state plan and waivers.

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 5718 of the Welfare and Institutions Code is amended to read:

5718. (a) (1) This section and Sections 5719 to 5724, inclusive, shall apply to mental health services provided by counties to Medi-Cal eligible individuals. Counties shall provide services to Medi-Cal beneficiaries and seek the maximum federal reimbursement possible for services rendered to the mentally ill.

(2) To the extent permitted under federal law, funds deposited into the local health and welfare trust fund from the Sales Tax Account of the Local Revenue Fund may be used to match federal medicaid funds in order to achieve the maximum federal reimbursement possible for services pursuant to this chapter. If a county applies to use local funds, the department may enforce any additional federal requirements that use may involve, based on standards and guidelines designed to enhance, protect, and maximize the claiming of those resources.

(3) The *department's* standards and guidelines for the administration of mental health services to Medi-Cal eligible persons shall be based on federal medicaid requirements *and the approved Medicaid state plan and waivers to ensure full and timely federal reimbursement to counties for services that are rendered and claimed consistent with federal Medicaid requirements*.

(b) With regard to each person receiving mental health services from a county mental health program, the county shall determine whether the person is Medi-Cal eligible and, if determined to be Medi-Cal eligible, the person shall be referred when appropriate

to a facility, clinic, or program which is certified for Medi-Cal reimbursement.

(c) With regard to county operated facilities, clinics, or programs for which claims are submitted to the department for Medi-Cal reimbursement for mental health services to Medi-Cal eligible individuals, the county shall ensure that all requirements necessary for Medi-Cal reimbursement for these services are complied with, including, but not limited to, utilization review and the submission of year-end cost reports by December 31 following the close of the fiscal year.

(d) Counties shall certify to the state that required matching funds are available prior to the reimbursement of federal funds.

SEC. 2. Section 5720 of the Welfare and Institutions Code is amended to read:

5720. (a) Notwithstanding any other provision of law, the director, in the 1993–94 fiscal year and fiscal years thereafter, subject to the approval of the Director of Health *Care* Services, shall establish the amount of reimbursement for services provided by county mental health programs to Medi-Cal eligible individuals. *For purposes of federal reimbursement, the reimbursement amounts shall be consistent with federal Medicaid requirements and the approved Medicaid state plan and waivers.*

(b) Notwithstanding this section, in the event that a health facility has entered into a negotiated rate agreement pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 4 of Division 9, the facility's rates shall be governed by that agreement.

SEC. 3. Section 5724 of the Welfare and Institutions Code is amended to read:

5724. (a) The department and the State Department of Health *Care* Services shall jointly develop a new ratesetting methodology for use in the Short-Doyle Medi-Cal system that maximizes federal funding and utilizes, as much as practicable, federal ~~medicare~~ *Medicaid and Medicare* reimbursement principles. The departments shall work with the counties and the federal ~~Health Care Financing Administration~~ *Centers for Medicare and Medicaid Services* in the development of the methodology required by this section.

(b) Rates developed through the methodology required by this section shall ~~apply only to reimbursement for direct client services~~

conform to federal Medicaid requirements and the approved Medicaid state plan and waivers.

(c) Administrative costs shall be claimed ~~separately and shall be limited to 15 percent of the total cost of direct client services~~ *in a manner consistent with federal Medicaid requirements and the approved Medicaid state plan and waivers*.

(d) The cost of performing utilization reviews shall be claimed separately and shall not be included in administrative cost.

(e) The ratesetting methodology established pursuant to this section shall contain incentives relating to economy and efficiency in service delivery.

(f) The rates established for direct client services pursuant to this section shall be based on increments of time for all noninpatient services.

(g) The ratesetting methodology shall not be implemented until it has received any necessary federal approvals.

SEC. 4. 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 *the full and* 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.

(11) Notwithstanding Section 14115, bills for service pursuant to this part shall be submitted by MHPs within the timeframes required by federal Medicaid requirements and the approved Medicaid state plan and waivers.

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

(1) The department shall allocate and distribute annually the full appropriated amount to each MHP for the managed mental health care program, exclusive of the EPSDT specialty mental health services program, provided under the mental health services waiver. The allocated funds shall be considered to be funds of the plan to be used as specified in this part.

(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 Short-Doyle 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 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.

(5) 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

County	Percentage
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
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

County	Percentage
Sonoma	.5766
Stanislaus	1.7855
Sutter/Yuba	.7980
Tehama	.1842
Trinity	.0271
Tulare	2.1314
Tuolumne	.2646
Ventura	.8058
Yolo	.4043

(6) 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.

(7) 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.

(8) 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.

(9) (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.

(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. 5. Section 14680 of the Welfare and Institutions Code is amended to read:

14680. (a) The Legislature finds and declares that there is a need to establish a standard set of guidelines that governs the provision of managed Medi-Cal mental health services at the local level, consistent with federal law.

(b) Therefore, in order to ensure quality and continuity, and to efficiently utilize mental health services under the Medi-Cal program, there shall be developed mental health plans for the provision of those services that are consistent with guidelines established by the State Department of Mental Health. *The guidelines shall be based on federal Medicaid requirements and the approved Medicaid state plan and waivers to ensure full and timely federal reimbursement to mental health plans for services that are rendered and claimed consistent with federal Medicaid requirements.*

(c) It is the intent of the Legislature that mental health plans be developed and implemented regardless of whether other systems of Medi-Cal managed care are implemented.

(d) It is further the intent of the Legislature that Sections 14681 to 14685, inclusive, shall not be construed to mandate the

participation of counties in Medi-Cal managed mental health care plans.

SEC. 6. Section 14684 of the Welfare and Institutions Code is amended to read:

14684. Notwithstanding any other provision of state law, and to the extent permitted by federal law, mental health plans, whether administered by public or private entities, shall be governed by the following guidelines:

(a) State and federal Medi-Cal funds identified for the diagnosis and treatment of mental disorders shall be used solely for those purposes. Administrative costs shall be clearly identified and shall be limited to reasonable amounts in relation to the scope of services and the total funds available. Administrative requirements *shall be based on and limited to federal Medicaid requirements and the approved Medicaid state plan and waivers, and* shall not impose costs exceeding funds available for that purpose.

(b) The development of the mental health plan shall include a public planning process that includes a significant role for Medi-Cal beneficiaries, family members, mental health advocates, providers, and public and private contract agencies.

(c) The mental health plan shall include appropriate standards relating to quality, access, and coordination of services within a managed system of care, and costs established under the plan, and shall provide opportunities for existing Medi-Cal providers to continue to provide services under the mental health plan, as long as the providers meet those standards.

(d) Continuity of care for current recipients of services shall be ensured in the transition to managed mental health care.

(e) Medi-Cal covered mental health services shall be provided in the beneficiary's home community, or as close as possible to the beneficiary's home community. Pursuant to the objectives of the rehabilitation option described in subdivision (a) of Section 14021.4, mental health services may be provided in a facility, a home, or other community-based site.

(f) Medi-Cal beneficiaries whose mental or emotional condition results or has resulted in functional impairment, as defined by the department, shall be eligible for covered mental health services. Emphasis shall be placed on adults with serious and persistent mental illness and children with serious emotional disturbances, as defined by the department.

(g) Each mental health plan shall include a mechanism for monitoring the effectiveness of, and evaluating accessibility and quality of, services available. The plan shall utilize and be based upon state-adopted performance outcome measures and shall include review of individual service plan procedures and practices, a beneficiary satisfaction component, and a grievance system for beneficiaries and providers.

(h) Each mental health plan shall provide for culturally competent and age-appropriate services, to the extent feasible. The mental health plan shall assess the cultural competency needs of the program. The mental health plan shall include, as part of the quality assurance program required by Section 4070, a process to accommodate the significant needs with reasonable timeliness. The department shall provide demographic data and technical assistance. Performance outcome measures shall include a reliable method of measuring and reporting the extent to which services are culturally competent and age-appropriate.

O