WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 5. COMMUNITY MENTAL HEALTH SERVICES [5000 - 5987] *(Division 5 repealed and added by Stats. 1967, Ch. 1667.)*

PART 5. INSTITUTIONS FOR MENTAL DISEASE [5900 - 5912] *(Part 5 added by Stats. 1991, Ch. 89, Sec. 198.)*

CHAPTER 1. General Provisions [5900 - 5912] *(Chapter 1 added by Stats. 1991, Ch. 89, Sec. 198.)*

ARTICLE 2. Interim Contracting Mechanism [5902 - 5903.5] *(Article 2 added by Stats. 1991, Ch. 89, Sec. 198.)*

5902. (a) In the 1991–92 fiscal year, funding sufficient to cover the cost of the basic level of care in institutions for mental disease at the rate established by the State Department of Health Care Services shall be made available to the department for skilled nursing facilities, plus the rate established for special treatment programs. The department may authorize a county to administer institutions for mental disease services if the county with the consent of the affected providers makes a request to administer services and an allocation is made to the county for these services. The department shall continue to contract with these providers for the services necessary for the operation of the institutions for mental disease.

(b) In the 1992–93 fiscal year, the department shall consider county-specific requests to continue to provide administrative services relative to institutions for mental disease facilities when no viable alternatives are found to exist.

(c) (1) By October 1, 1991, the department, in consultation with the County Behavioral Health Directors Association of California and the California Association of Health Facilities, shall develop and publish a county-specific allocation of institutions for mental disease funds that will take effect on July 1, 1992.

(2) By November 1, 1991, counties shall notify the providers of any intended change in service levels to be effective on July 1, 1992.

(3) By April 1, 1992, counties and providers shall have entered into contracts for basic institutions for mental disease services at the rate described in subdivision (e) for the 1992–93 fiscal year at the level expressed on or before November 1, 1991, except that a county shall be permitted additional time, until June 1, 1992, to complete the processing of the contract, when any of the following conditions are met:

(A) The county and the affected provider have agreed on all substantive institutions for mental disease contract issues by April 1, 1992.

(B) Negotiations are in process with the county on April 1, 1992, and the affected provider has agreed in writing to the extension.

(C) The service level committed to on November 1, 1991, exceeds the affected provider’s bed capacity.

(D) The county can document that the affected provider has refused to enter into negotiations by April 1, 1992, or has substantially delayed negotiations.

(4) If a county and a provider are unable to reach agreement on substantive contract issues by June 1, 1992, the department may, upon request of either the affected county or the provider, mediate the disputed issues.

(5) When contracts for service at the level committed to on November 1, 1991, have not been completed by April 1, 1992, and additional time is not permitted pursuant to the exceptions specified in paragraph (3) the funds allocated to those counties shall revert for reallocation in a manner that shall promote equity of funding among counties. With respect to counties with exceptions permitted pursuant to paragraph (3), funds shall not revert unless contracts are not completed by June 1, 1992. In no event shall funds revert under this section if there is no harm to the provider as a result of the county contract not being completed. During the

1992–93 fiscal year, funds reverted under this paragraph shall be used to purchase institution for mental disease/skilled nursing/special treatment program services in existing facilities.

(6) Nothing in this section shall apply to negotiations regarding supplemental payments beyond the rate specified in subdivision (e).

(d) On or before April 1, 1992, counties may complete contracts with facilities for the direct purchase of services in the 1992–93 fiscal year. Those counties for which facility contracts have not been completed by that date shall be deemed to continue to accept financial responsibility for those patients during the subsequent fiscal year at the rate specified in subdivision (a).

(e) As long as contracts with institutions for mental disease providers require the facilities to maintain skilled nursing facility licensure and certification, reimbursement for basic services shall be at the rate established by the State Department of Health Care Services. Except as provided in this section, reimbursement rates for services in institutions for mental diseases shall be the same as the rates in effect on July 31, 2004. Effective July 1, 2005, through June 30, 2008, the reimbursement rate for institutions for mental disease shall increase by 6.5 percent annually. Effective July 1, 2008, the reimbursement rate for institutions for mental disease shall increase by 4.7 percent annually.

(f) (1) Providers that agree to contract with the county for services under an alternative mental health program pursuant to Section 5768 that does not require skilled nursing facility licensure shall retain return rights to licensure as skilled nursing facilities.

(2) Providers participating in an alternative program that elect to return to skilled nursing facility licensure shall only be required to meet those requirements under which they previously operated as a skilled nursing facility.

(g) In the 1993–94 fiscal year and thereafter, the department shall consider requests to continue administrative services related to institutions for mental disease facilities from counties with a population of 150,000 or less based on the most recent available estimates of population data as determined by the Demographic Research Unit of the Department of Finance.

(Amended by Stats. 2019, Ch. 29, Sec. 142. (SB 82) Effective June 27, 2019.)

5903. (a) For the purposes of this section, the following definitions shall apply:

(1) “Client” means an individual who is all of the following:

(A) A person with a mental health disability.

(B) Medi-Cal eligible.

(C) Under 65 years of age.

(D) Certified for placement in an institution for mental disease by a county.

(E) Eligible for Supplemental Security Income/State Supplementary Program for the Aged, Blind, and Disabled (SSI/SSP) benefits.

(2) “Client’s payee” means an authorized representative who may receive revenue resources, including SSI/SSP benefits, on behalf of a client.

(3) “SSI/SSP benefits” means revenue resources paid to an eligible client, or the client’s payee, by the federal Social Security Administration pursuant to Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code, and Chapter 3 (commencing with Section 12000) of Part 3 of Division 9.

(b) (1) Between August 1, 1991, and June 30, 1992, institution for mental disease providers shall make reasonable efforts to collect SSI/SSP benefits from a client or a client’s payee. The provider shall invoice the client or the client’s payee for the SSI/SSP benefits, minus the personal and incidental allowance amount as established by the Social Security Administration, and remit all SSI/SSP funds collected to the department pursuant to procedures established by the department.

(2) Commencing July 1, 1992, and to the extent permitted by federal law, institution for mental disease providers may collect SSI/SSP benefits from a client or a client’s payee. The amount to be invoiced shall be the amount of the client’s SSI/SSP benefits, minus the personal and incidental allowance amount as established by the Social Security Administration. The administrative mechanism for collection of SSI/SSP benefits, including designation of the party responsible for collection, shall be determined by negotiation between the counties and the providers.

(c) In collecting SSI/SSP benefits from the client or the client’s payee, the provider shall not be deemed to be the authorized representative, as defined in Section 72015 of Title 22 of the California Code of Regulations, for purposes of handling the client’s

moneys or valuables.

(d) Providers shall make all reasonable efforts, as specified in procedures developed by the department in consultation with providers, to collect SSI/SSP benefits from the client or the client's payee. Providers shall establish an accounting procedure, approved by the department, for the actual collection and remittance of these funds.

(e) Providers shall prorate the client's SSI/SSP benefits by the number of days spent in the facility.

(f) After June 30, 1992, and not later than January 1, 1993, the department shall make data available to the Legislature, upon request, regarding the SSI/SSP collections made by institution for mental disease providers pursuant to this section.

(Amended by Stats. 2024, Ch. 948, Sec. 59. (AB 2119) Effective January 1, 2025.)

5903.5. Notwithstanding any other provision of law, the department may liquidate accounts receivable from individual clients or payees of clients from institution for mental disease funds appropriated by the Legislature, when they have been determined by the department to be uncollectible, including accounts receivable in existence prior to the effective date of this section. Liquidation shall occur no sooner than 12 months after the original date of the accounts receivable debt.

(Added by Stats. 1991, Ch. 918, Sec. 2. Effective October 14, 1991.)