WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 8.9. Transition of Community-Based Medi-Cal Mental Health [14700 - 14727] *(Chapter 8.9 added by Stats. 2011, Ch. 29, Sec. 20.)*

14700. (a) (1) It is the intent of the Legislature to transfer to the State Department of Health Care Services, no later than July 1, 2012, the state administration of Medi-Cal specialty mental health managed care, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, and applicable functions related to federal Medicaid requirements, from the State Department of Mental Health.

(2) It is further the intent of the Legislature for this transfer to occur in an efficient and effective manner, with no unintended interruptions in service delivery to clients and families. This transfer is intended to do all of the following:

(A) Improve access to culturally appropriate community-based mental health services, including a focus on client recovery, social rehabilitation services, and peer support.

(B) Effectively integrate the financing of services, including the receipt of federal funds, to more effectively provide services.

(C) Improve state accountabilities and outcomes.

(D) Provide focused, high-level leadership for behavioral health services within the state administrative structure.

(b) Effective July 1, 2012, the state administrative functions for the operation of Medi-Cal specialty mental health managed care, the EPSDT Program, and applicable functions related to federal Medicaid requirements, that were performed by the State Department of Mental Health shall be transferred to the State Department of Health Care Services. This state administrative transfer shall conform to a state administrative transition plan provided to the fiscal and applicable policy committees of the Legislature as soon as feasible, but no later than October 1, 2011. This state administrative transition plan may also be updated by the Governor and provided to all fiscal and applicable policy committees of the Legislature upon its completion, but no later than May 15, 2012.

(c) All regulations and orders concerning Medi-Cal specialty mental health managed care and the EPSDT Program shall remain in effect and shall be fully enforceable unless and until readopted, amended, or repealed by the State Department of Health Care Services, or until they expire by their own terms.

(Added by Stats. 2011, Ch. 29, Sec. 20. (AB 102) Effective June 29, 2011. Conditionally inoperative as provided in Section 14721.)

14701. (a) The State Department of Health Care Services, in collaboration with the State Department of State Hospitals and the California Health and Human Services Agency, shall create a state administrative and programmatic transition plan, either as one comprehensive transition plan or separately, to guide the transfer of the Medi-Cal specialty mental health managed care and the EPSDT Program to the State Department of Health Care Services effective July 1, 2012.

(b) (1) Commencing no later than July 15, 2011, the State Department of Health Care Services, together with the State Department of State Hospitals, shall convene a series of stakeholder meetings and forums to receive input from clients, family members, providers, counties, and representatives of the Legislature concerning the transition and transfer of Medi-Cal specialty mental health managed care and the EPSDT Program. This consultation shall inform the creation of a state administrative transition plan and a programmatic transition plan that shall include, but is not limited to, the following components:

(A) The plan shall ensure that it is developed in a way that continues access and quality of service during and immediately after the transition, preventing any disruption of services to clients and family members, providers and counties, and others affected by this transition.

(B) A detailed description of the state administrative functions currently performed by the State Department of Mental Health regarding Medi-Cal specialty mental health managed care and the EPSDT Program.

(C) Explanations of the operational steps, timelines, and key milestones for determining when and how each function or program will be transferred. These explanations shall also be developed for the transition of positions and staff serving Medi-Cal specialty mental health managed care and the EPSDT Program, and how these will relate to, and align with, positions at the State Department of Health Care Services. The State Department of Health Care Services and the California Health and Human Services Agency shall consult with the Department of Human Resources in developing this aspect of the transition plan.

(D) A list of any planned or proposed changes or efficiencies in how the functions will be performed, including the anticipated fiscal and programmatic impacts of the changes.

(E) A detailed organization chart that reflects the planned staffing at the State Department of Health Care Services in light of the requirements of subparagraphs (A) to (C), inclusive, and includes focused, high-level leadership for behavioral health issues.

(F) A description of how stakeholders were included in the various phases of the planning process to formulate the transition plans and a description of how their feedback will be taken into consideration after transition activities are underway.

(2) The State Department of Health Care Services, together with the State Department of State Hospitals and the California Health and Human Services Agency, shall convene and consult with stakeholders at least twice following production of a draft of the transition plans and before submission of transition plans to the Legislature. Continued consultation with stakeholders shall occur in accordance with the requirement in subparagraph (F) of paragraph (1).

(Amended by Stats. 2014, Ch. 71, Sec. 200. (SB 1304) Effective January 1, 2015. Conditionally inoperative as provided in Section 14721.)

14702. For purposes of this chapter, the following definitions shall apply:

(a) “Department” means the State Department of Health Care Services.

(b) “Director” means the Director of Health Care Services.

(Added by Stats. 2012, Ch. 34, Sec. 245. (SB 1009) Effective June 27, 2012. Conditionally inoperative as provided in Section 14721.)

14703. Contracts entered into pursuant to this chapter shall be exempt from the requirements of Chapter 1 (commencing with Section 10100) and Chapter 2 (commencing with section 10290) of Part 2 of Division 2 of the Public Contract Code.

(Added by Stats. 2012, Ch. 34, Sec. 246. (SB 1009) Effective June 27, 2012. Conditionally inoperative as provided in Section 14721.)

14704. A regulation or order concerning Medi-Cal specialty mental health services adopted by the State Department of Mental Health pursuant to Division 5 (commencing with Section 5000), as in effect preceding the effective date of this section, shall remain in effect and shall be fully enforceable, unless and until the readoption, amendment, or repeal of the regulation or order by the department, or until it expires by its own terms.

(Added by Stats. 2012, Ch. 34, Sec. 247. (SB 1009) Effective June 27, 2012. Conditionally inoperative as provided in Section 14721.)

14705. (a) (1) This section shall apply to specialty 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 persons with mental illnesses.

(2) To the extent permitted under federal law and Section 5892, funds distributed to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, and the Vehicle License Collection Account of the Local Revenue Fund, funds from the Mental Health Account and the Behavioral Health Subaccount of the Local Revenue Fund 2011, funds from the Behavioral Health Services Fund, and any other funds from which the Controller makes distributions to the counties may be used to pay for services provided by these funds that the counties can then certify as public expenditures in order to achieve the maximum federal reimbursement possible for services pursuant to this chapter.

(3) The standards and guidelines for the administration of specialty mental health services to Medi-Cal eligible persons shall be consistent with federal Medicaid requirements, as specified in 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 specialty mental health services from a mental health plan, the mental health plan shall verify 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 that 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 specialty 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 yearend cost reports by December 31 following the close of the fiscal year.

(d) Counties shall certify to the state that they have incurred public expenditures prior to requesting the reimbursement of federal funds.

(Amended by Stats. 2024, Ch. 40, Sec. 73. (SB 159) Effective June 29, 2024. Operative January 1, 2025, pursuant to Sec. 85 of Stats. 2024, Ch. 40. Conditionally inoperative as provided in Section 14721.)

14705.5. Each public or private facility or agency providing local specialty mental health services pursuant to a county performance contract plan shall make a written certification within 30 days after a patient is admitted to the facility as a patient or first given services by such a facility or agency, to the local mental health director of the county, stating whether or not each of these patients is presumed to be eligible for specialty mental health services under the Medi-Cal program.

(Added by renumbering Section 5719 by Stats. 2012, Ch. 34, Sec. 153. (SB 1009) Effective June 27, 2012. Operative July 1, 2012, by Sec. 254 of Ch. 34. Conditionally inoperative as provided in Section 14721.)

14705.7. Mental health plans may contract with providers on a negotiated net amount basis in the same manner as set forth in Section 5705. Negotiated net amounts or rates shall not be in contracts between the state and mental health plans for specialty mental health services. Reimbursement to mental health plans that have certified public expenditures shall be consistent with federal Medicaid requirements for calculating upper payment limits, as specified in the approved Medicaid state plan and waivers.

(Added by renumbering Section 5716 by Stats. 2012, Ch. 34, Sec. 150. (SB 1009) Effective June 27, 2012. Conditionally inoperative as provided in Section 14721.)

14706. (a) The department shall have responsibility for conducting investigations and audits of claims and reimbursements for expenditures for specialty mental health services provided by mental health plans to Medi-Cal eligible individuals.

(b) The amount of the payment or repayment of federal funds in accordance with audit findings pertaining to Medi-Cal specialty mental health services shall be determined by the department pursuant to the existing administrative appeals process of the department.

(Added by renumbering Section 5722 by Stats. 2012, Ch. 34, Sec. 157. (SB 1009) Effective June 27, 2012. Operative July 1, 2012, by Sec. 254 of Ch. 34. Conditionally inoperative as provided in Section 14721.)

14707. (a) In the case of federal audit exceptions, the department shall follow federal audit appeal processes unless the department, in consultation with the County Behavioral Health Directors Association of California, determines that those appeals are not cost beneficial.

(b) Whenever there is a final federal audit exception against the state resulting from expenditure of federal funds by individual counties, the department may offset federal reimbursement and request the Controller's office to offset the distribution of funds to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, and the Vehicle License Collection Account of the Local Revenue Fund, funds from the Mental Health Account and the Behavioral Health Subaccount of the Local Revenue Fund 2011, and any other mental health realignment funds from which the Controller makes distributions to the counties by the amount of the exception. The department shall provide evidence to the Controller that the county has been notified of the amount of the audit exception no less than 30 days before the offset is to occur. The department shall involve the appropriate counties in developing responses to any draft federal audit reports that directly impact the county.

(Amended by Stats. 2015, Ch. 455, Sec. 56. (SB 804) Effective January 1, 2016. Conditionally inoperative as provided in Section 14721.)

14707.5. (a) It is the intent of the Legislature to develop a performance outcome system for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services that will improve outcomes at the individual and system levels and will inform fiscal decisionmaking related to the purchase of services.

(b) The State Department of Health Care Services, in collaboration with the California Health and Human Services Agency and in consultation with the Behavioral Health Services Oversight and Accountability Commission, shall create a plan for a performance outcome system for EPSDT mental healthservices provided to eligible Medi-Cal beneficiaries under the age of 21 pursuant to 42 U.S.C. Section 1396d(a)(4)(B).

(1) (A) Commencing no later than September 1, 2012, the department shall convene a stakeholder advisory committee comprised of representatives of child and youth clients, family members, providers, counties, and the Legislature.

(B) This consultation shall inform the creation of a plan for a performance outcome system for EPSDT mental health services.

(2) In developing a plan for a performance outcomes system for EPSDT mental health services, the department shall consider the following objectives, among others:

(A) High-quality and accessible EPSDT mental health services for eligible children and youth, consistent with federal law.

(B) Information that improves practice at the individual, program, and system levels.

(C) Minimization of costs by building upon existing resources to the fullest extent possible.

(D) Reliable data that is collected and analyzed in a timely fashion.

(3) At a minimum, the plan for a performance outcome system for EPSDT mental health services shall consider evidence-based models for performance outcome systems, such as the Child and Adolescent Needs and Strengths (CANS), federal requirements, including the review by the External Quality Review Organization (EQRO), and timelines for implementation at the provider, county, and state levels.

(c) The State Department of Health Care Services shall provide the performance outcomes system plan, including milestones and timelines, for EPSDT mental health services described in subdivision (a) to all fiscal committees and appropriate policy committees of the Legislature no later than October 1, 2013.

(d) The State Department of Health Care Services shall propose how to implement the performance outcomes system plan for EPSDT mental health services described in subdivision (a) no later than January 10, 2014.

(e) (1) (A) Commencing no later than February 1, 2014, the department shall convene a stakeholder advisory committee comprised of advocates for, and representatives of, child and youth clients, family members, managed care health plans, providers, counties, and the Legislature.

(B) The committee shall develop methods to routinely measure, assess, and communicate program information regarding informing, identifying, screening, assessing, referring, and linking Medi-Cal eligible beneficiaries to mental health services and supports.

(C) The committee shall also review health plan screenings for mental health, health plan referrals to Medi-Cal fee-for-service providers, and health plan referrals to county mental health plans, among others.

(D) The committee shall make recommendations to the department regarding performance and outcome measures that will contribute to improving timely access to appropriate care for Medi-Cal eligible beneficiaries.

(2) The department shall incorporate into the performance outcomes system established pursuant to this section the screenings and referrals described in this subdivision, including milestones and timelines, and shall provide an updated performance outcomes system plan to all fiscal committees and the appropriate policy committees of the Legislature no later than October 1, 2014.

(3) The department shall propose how to implement the updated performance systems outcome plan described in paragraph (2) no later than January 10, 2015.

(f) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

(Repealed (in Sec. 113) and added by Stats. 2023, Ch. 790, Sec. 114. (SB 326) Effective October 12, 2023. Operative January 1, 2025, by its own provisions. Conditionally inoperative as provided in Section 14721.)

14707.7. (a) It is the intent of the Legislature to build upon performance outcomes system reports the department has developed pursuant to Section 14707.5 and the Special Terms and Conditions of the Medi-Cal Specialty Mental Health Services Waiver, as approved pursuant to Section 1915(b) of the federal Social Security Act (42 U.S.C. Sec. 1396n(b)), in order to provide data to inform strategies to reduce mental health disparities.

(b) (1) Commencing no later than January 15, 2018, and as needed thereafter, the department shall consult with stakeholders, including, but not limited to, subject-matter experts who represent providers, consumer advocates, consumers, family members, counties, and the Legislature, to inform the updates to the performance outcomes reports for specialty mental health that the department developed pursuant to Section 14707.5 and the Special Terms and Conditions of the Medi-Cal Specialty Mental Health Services Waiver. The stakeholder consultation shall continuously inform the development of performance outcome and disparities reduction measures.

(2) In building upon the performance outcomes reports for specialty mental health services, the department shall also consider both of the following objectives, among others:

(A) High-quality, culturally and linguistically competent, and accessible specialty mental health services for all eligible beneficiaries, consistent with federal law.

(B) Strategies to reduce mental health disparities.

(3) The performance outcomes reports for specialty mental health services shall also consider the Special Terms and Conditions of the Medi-Cal Specialty Mental Health Services Waiver, as approved pursuant to Section 1915(b) of the federal Social Security Act (42 U.S.C. Sec. 1396n(b)) and the Medicaid Managed Care Quality Rating System.

(4) In order to identify mental health disparities, at a minimum, the performance outcomes reports for specialty mental health services shall be produced using existing data collected by the state, stratified by both the statewide and county levels in the following areas:

(A) Access, such as timely access to services, including waiting time to assessment and waiting time to first appointment.

(B) Language capacity and language access.

(C) Quality.

(D) Utilization and penetration.

(5) (A) Data required pursuant to paragraph (4) shall be stratified by age, sex, gender identity, race, ethnicity, primary language, sexual orientation, and any other data elements for which there is peer-reviewed evidence to assess performance outcomes related to mental health disparities.

(B) The department shall not report any demographic data under paragraph (4) or this paragraph that would permit identification of individuals.

(6) (A) The department shall publish the performance outcomes reports based on available data for specialty mental health services described in this section on the department's Internet Web site by December 31, 2018. The department shall also provide the performance outcomes reports to the Legislature by December 31, 2018.

(B) Commencing January 1, 2019, and annually thereafter, the department shall update the performance outcomes reports for specialty mental health and shall post the updated reports on the department's Internet Web site.

(7) Commencing January 1, 2019, the department shall consult, as needed, with the stakeholders specified in paragraph (1) to do both of the following:

(A) Incorporate additional components into the performance outcomes reports, including, but not limited to, components concerning the reduction of mental health disparities, such as timely access to services, language access, and quality and utilization measures, relating to mental health services obtained through Medi-Cal managed care plans.

(B) Make recommendations for statewide quality improvement and efforts to reduce mental health disparities based on information reported in the performance outcomes reports.

(8) Upon completion of the activities specified in paragraph (7), the department shall consult with stakeholders on an as-needed basis.

(9) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

(Added by Stats. 2017, Ch. 550, Sec. 1. (AB 470) Effective January 1, 2018. Conditionally inoperative as provided in Section 14721.)

14708. (a) For purposes of federal reimbursement to counties that have certified to the state that they have incurred certified public expenditures, the reimbursement amounts shall be consistent with federal Medicaid requirements for calculating federal upper payment limits, as specified in the approved Medicaid state plan and waivers.

(b) If the reimbursement methodology utilizes federal upper payment limits and the total cost of services exceeds the state maximum rates in effect for the 2011–12 fiscal year, a county may use certified public expenditures to claim the costs of services that exceed the state maximum rates, up to the federal upper payment limits. If a county chooses to claim costs that exceed the state maximum rates with certified public expenditures, the county shall use only local funds, and not state funds, to claim the portion of the costs over the state maximum rates. As a condition of receiving reimbursement up to the federal upper payment limits, a county shall enter into and maintain an agreement with the department implementing this subdivision.

(c) 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.

(d) This section shall become operative on July 1, 2012.

(Added by renumbering Section 5720 (as added by Stats. 2011, Ch. 651, Sec. 4) by Stats. 2012, Ch. 34, Sec. 155. (SB 1009) Effective June 27, 2012. Section operative July 1, 2012, by its own provisions. Conditionally inoperative as provided in Section 14721.)

14709. The provisions of subdivision (a) of Section 14000 shall not be construed to prevent providers of specialty mental health services pursuant to this chapter from also being providers of medical assistance mental health services for the purposes of Chapter 7 (commencing with Section 14000). Clinics providing Medi-Cal specialty mental health services pursuant to this chapter shall be required to be certified as a condition to reimbursement for providing those medical assistance mental health services.

(Added by renumbering Section 5723 by Stats. 2012, Ch. 34, Sec. 158. (SB 1009) Effective June 27, 2012. Operative July 1, 2012, by Sec. 254 of Ch. 34. Conditionally inoperative as provided in Section 14721.)

14710. Except as otherwise provided in this section, in determining the amounts which may be paid, fees paid by persons receiving services or fees paid on behalf of persons receiving services by the federal government, by the Medi-Cal program set forth in Chapter 7 (commencing with Section 14000), and by other public or private sources, shall be deducted from the costs of providing services. However, a mental health plan may negotiate a contract that permits a specialty mental health care provider to retain unanticipated funds above the budgeted contract amount, provided that the unanticipated revenues are utilized for the specialty mental health services specified in the contract. If a provider is permitted by contract to retain unanticipated revenues above the budgeted amount, the specialty mental health provider shall specify the services funded by those revenues in the yearend cost report submitted to the mental health plan. A mental health plan shall not permit the retention of any fees paid by private resources on behalf of Medi-Cal beneficiaries without having those fees deducted from the costs of providing services. Whenever feasible, persons with mental illness who are eligible for specialty mental health services under the Medi-Cal program shall be treated in a facility approved for reimbursement in that program. General unrestricted or undesignated private charitable donations and contributions made to charitable or nonprofit organizations shall not be considered as "fees paid by persons" or "fees paid on behalf of persons receiving services" under this section and the contributions shall not be applied in determining the amounts to be paid. These unrestricted contributions shall not be used in part or in whole to defray the costs or the allocated costs of the Medi-Cal program.

(Added by renumbering Section 5721 by Stats. 2012, Ch. 34, Sec. 156. (SB 1009) Effective June 27, 2012. Operative July 1, 2012, by Sec. 254 of Ch. 34. Conditionally inoperative as provided in Section 14721.)

14711. (a) The department shall develop, in consultation with the County Behavioral Health Directors Association of California, a reimbursement methodology for use in the Medi-Cal claims processing and interim payment system that maximizes federal funding and utilizes, as much as practicable, federal Medicaid and Medicare reimbursement principles. The department shall work with the federal Centers for Medicare and Medicaid Services in the development of the methodology required by this section.

(b) Reimbursement amounts developed through the methodology required by this section shall be consistent with federal Medicaid requirements and the approved Medicaid state plan and waivers.

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

(d) The cost of performing quality assurance and utilization review activities shall be reimbursed separately and shall not be included in administrative cost.

(e) The reimbursement methodology established pursuant to this section shall be based upon certified public expenditures, which encourage economy and efficiency in service delivery.

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

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

(h) This section shall become operative on July 1, 2012.

(Amended by Stats. 2015, Ch. 455, Sec. 57. (SB 804) Effective January 1, 2016. Conditionally inoperative as provided in Section 14721.)

14712. (a) Notwithstanding any other state law, the department shall implement managed mental health care for Medi-Cal beneficiaries through contracts with mental health plans. Mental health plans may include individual counties, counties acting jointly, or an organization or nongovernmental entity determined by the department to meet mental health plan standards. A contract may be exclusive and may be awarded on a geographic basis.

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of specialty mental health services subject to the approval by the department. The agreement may encompass all or any portion of the specialty mental health services

provided pursuant to this chapter. This agreement shall not relieve the individual counties of fiscal responsibility for providing these services. Any agreement between counties shall delineate each county's responsibilities and fiscal liability for overpayments.

(c) (1) The department shall contract with a county or counties acting jointly for the delivery of specialty mental health services to each county's eligible Medi-Cal beneficiary population. If a county decides not to contract with the department, does not renew its contract, or is unable to meet the standards set by the department, the county shall inform the department of this decision in writing.

(2) If the county is unwilling to contract for the delivery of specialty mental health services, the department shall ensure that specialty mental health services are provided to Medi-Cal beneficiaries.

(3) If the department or county determines that the county is unable to adequately provide specialty mental health services, or that the county does not meet the standards of a mental health plan, the department shall ensure that specialty mental health services are provided to Medi-Cal beneficiaries.

(4) The department may contract with qualifying individual counties, counties acting jointly, or other qualified entities approved by the department for the delivery of specialty mental health services in any county that is unable or unwilling to contract with the department. The county may not subsequently contract to provide specialty mental health services under this chapter unless the department elects to contract with the county.

(d) If a county does not contract with the department or other department-approved entity to provide specialty mental health services, the department shall work with the Department of Finance and the Controller to sequester funds from the county that is unable or unwilling to contract in accordance with Section 30027.10 of the Government Code.

(Amended by Stats. 2019, Ch. 465, Sec. 11. (AB 1642) Effective January 1, 2020. Conditionally inoperative as provided in Section 14721.)

14713. (a) The department and mental health plans shall comply with all applicable federal laws, regulations, and the guidelines, standards, and requirements specified in the state plan, waiver, and mental health plan contract, and, except as provided in this chapter, all applicable state statutes and regulations.

(b) If the department determines that a mental health plan has failed to comply with the requirements of Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), Chapter 8.8 (commencing with Section 14600), or this chapter, the department may impose sanctions and plans of correction pursuant to Section 14197.7.

(c) If federal requirements that affect this chapter are changed, it is the intent of the Legislature that state requirements be revised to comply with those changes.

(Amended by Stats. 2019, Ch. 465, Sec. 12. (AB 1642) Effective January 1, 2020. Conditionally inoperative as provided in Section 14721.)

14714. (a) (1) Except as otherwise specified in this chapter, a contract entered into pursuant to this chapter shall include a provision that the mental health plan contractor shall bear the financial risk for the cost of providing medically necessary specialty mental health services to Medi-Cal beneficiaries.

(2) If the mental health plan is not administered by a county, the mental health plan shall not transfer the obligation for any specialty 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) of Division 5.

(3) The mental health plan shall be financially responsible for ensuring access and a minimum required scope of benefits and services, consistent with state and federal requirements, to Medi-Cal beneficiaries who are residents of that county regardless of where the beneficiary resides, except as provided for in Section 14717.1 or 14717.2. The department shall require that the same definition of medical necessity be used, and the minimum scope of benefits offered by each mental health plan be the same, except to the extent that prior federal approval is received and is consistent with state and federal laws.

(b) (1) Any contract entered into pursuant to this chapter may be renewed if the mental health plan continues to meet the requirements of this chapter, regulations promulgated pursuant to this chapter, 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.

(2) If the contract is not renewed based on the reasons specified in paragraph (1), the department shall notify the Department of Finance, the fiscal and policy committees of the Legislature, and the Controller of the amounts to be sequestered from the Mental Health Subaccount, the Mental Health Equity Account, and the Vehicle License Fee Collection Account of the Local Revenue Fund

and the Mental Health Account and the Behavioral Health Subaccount of the Local Revenue Fund 2011, and the Controller shall sequester those funds in the Behavioral Health Subaccount pursuant to Section 30027.10 of the Government Code. Upon this sequestration, the department shall use the funds in accordance with Section 30027.10 of the Government Code.

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

(2) Notwithstanding paragraph (1), the mental health plan shall comply with federal and state requirements, including the applicable sections of the state plan and waiver.

(3) A change may be made during a contract term or at the time of contract renewal, when 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.

(4) 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 to affected beneficiaries. The plan may request a hearing by the Office of Administrative Hearings and Appeals.

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

(f) Upon the request of the director, the Director of the Department of Managed Health Care may exempt a mental health plan 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. This section does not 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 does it 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 under the Knox-Keene Health Care Service Plan Act of 1975. The director, 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) The department shall provide oversight to the mental health plans to ensure quality, access, cost efficiency, and compliance with data and reporting requirements. At a minimum, the department shall monitor, through a method independent of any agency of the mental health plan contractor, the level and quality of services provided, expenditures pursuant to the contract, and conformity with federal and state law.

(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 chapter.

(i) If a county discontinues operations as the mental health plan, the department shall approve any new mental health plan. The new mental health 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) This chapter does not modify, alter, or increase the obligations of counties as otherwise limited and defined in Chapter 3 (commencing with Section 5700) of Part 2 of Division 5. The county's maximum obligation for services to persons ineligible 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, and 17609 after fulfilling the Medi-Cal contract obligations.

(Amended by Stats. 2022, Ch. 402, Sec. 1. (AB 1051) Effective January 1, 2023. Conditionally inoperative as provided in Section 14721.)

14715. (a) (1) The department shall require any mental health plan that provides Medi-Cal specialty mental health services to enter into a memorandum of understanding with any Medi-Cal managed care plan that provides Medi-Cal health services to some of the same Medi-Cal recipients served by the mental health plan. The memorandum of understanding shall comply with applicable regulations.

(2) For purposes of this section, a "Medi-Cal managed care plan" means any prepaid health plan or Medi-Cal managed care plan contracting with the department to provide services to enrolled Medi-Cal beneficiaries under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200), or Part 4 (commencing with Section 101525) of Division 101 of the Health and Safety Code.

(b) The department shall require the memorandum of understanding to include both of the following:

(1) A process or entity to be designated by the local mental health plan to receive notice of actions, denials, or deferrals from the Medi-Cal managed care plan, and to provide any additional information requested in the deferral notice as necessary for a medical

necessity determination.

(2) A requirement that the local mental health plan respond by the close of the business day following the day the deferral notice is received.

(c) This section shall apply to any contracts entered into, amended, modified, extended, or renewed on or after January 1, 2001.

(Amended by Stats. 2019, Ch. 465, Sec. 13. (AB 1642) Effective January 1, 2020. Conditionally inoperative as provided in Section 14721.)

14716. (a) Each local mental health plan shall establish a procedure to ensure access to outpatient specialty mental health services, as required by the Early Periodic Screening and Diagnostic Treatment program standards, for any child in foster care who has been placed outside his or her county of adjudication.

(b) The procedure required by subdivision (a) may be established through one or more of the following:

(1) The establishment of, and federal approval, if required, of, a statewide system or procedure.

(2) An arrangement between local mental health plans for reimbursement for services provided by a mental health plan other than the mental health plan in the county of adjudication and designation of an entity to provide additional information needed for approval or reimbursement. This arrangement shall not require providers who are already credentialed or certified by the mental health plan in the beneficiary's county of residence to be credentialed or certified by, or to contract with, the mental health plan in the county of adjudication.

(3) Arrangements between the mental health plan in the county of adjudication and mental health providers in the beneficiary's county of residence for authorization of, and reimbursement for, services. This arrangement shall not require providers credentialed or certified by, and in good standing with, the mental health plan in the beneficiary's county of residence to be credentialed or certified by the mental health plan in the county of adjudication.

(c) The department shall collect and keep statistics that will enable the department to compare access to outpatient specialty mental health services by foster children placed in their county of adjudication with access to outpatient specialty mental health services by foster children placed outside of their county of adjudication.

(Added by renumbering Section 5777.6 by Stats. 2012, Ch. 34, Sec. 177. (SB 1009) Effective June 27, 2012. Operative July 1, 2012, by Sec. 254 of Ch. 34. Conditionally inoperative as provided in Section 14721.)

14717. (a) In order to facilitate the receipt of medically necessary specialty mental health services by a foster child who is placed outside his or her county of original jurisdiction, the department shall take all of the following actions:

(1) On or before July 1, 2008, create all of the following items, in consultation with stakeholders, including, but not limited to, the California Institute for Mental Health, the Child and Family Policy Institute of California, the County Behavioral Health Directors Association of California, and the California Alliance of Child and Family Services:

(A) A standardized contract for the purchase of medically necessary specialty mental health services from organizational providers when a contract is required.

(B) A standardized specialty mental health service authorization procedure.

(C) A standardized set of documentation standards and forms, including, but not limited to, forms for treatment plans, annual treatment plan updates, day treatment intensive and day treatment rehabilitative progress notes, and treatment authorization requests.

(2) On or before January 1, 2009, use the standardized items as described in paragraph (1) to provide medically necessary specialty mental health services to a foster child who is placed outside his or her county of original jurisdiction, so that organizational providers who are already certified by a mental health plan are not required to be additionally certified by the mental health plan in the county of original jurisdiction.

(3) (A) On or before January 1, 2009, use the standardized items described in paragraph (1) to provide medically necessary specialty mental health services to a foster child placed outside his or her county of original jurisdiction to constitute a complete contract, authorization procedure, and set of documentation standards and forms, so that no additional documents are required.

(B) Authorize a county mental health plan to be exempt from subparagraph (A) and have an addendum to a contract, authorization procedure, or set of documentation standards and forms, if the county mental health plan has an externally placed requirement, such as a requirement from a federal integrity agreement, that would affect one of these documents.

(4) Following consultation with stakeholders, including, but not limited to, the California Institute for Mental Health, the Child and Family Policy Institute of California, the County Behavioral Health Directors Association of California, the California State Association of Counties, and the California Alliance of Child and Family Services, require the use of the standardized contracts, authorization procedures, and documentation standards and forms as specified in paragraph (1) in the 2008–09 state-county mental health plan contract and each state-county mental health plan contract thereafter.

(5) The mental health plan shall complete a standardized contract, as provided in paragraph (1), if a contract is required, or another mechanism of payment if a contract is not required, with a provider or providers of the county's choice, to deliver approved specialty mental health services for a specified foster child, within 30 days of an approved treatment authorization request.

(b) The California Health and Human Services Agency shall coordinate the efforts of the department and the State Department of Social Services to do all of the following:

(1) Participate with the stakeholders in the activities described in this section.

(2) During budget hearings in 2008 and 2009, report to the Legislature regarding the implementation of this section and subdivision (c) of Section 14716.

(3) On or before July 1, 2008, establish the following, in consultation with stakeholders, including, but not limited to, the County Behavioral Health Directors Association of California, the California Alliance of Child and Family Services, and the County Welfare Directors Association of California:

(A) Informational materials that explain to foster care providers how to arrange for specialty mental health services on behalf of the beneficiary in their care.

(B) Informational materials that county child welfare agencies can access relevant to the provision of services to children in their care from the out-of-county local mental health plan that is responsible for providing those services, including, but not limited to, receiving a copy of the child's treatment plan within 60 days after requesting services.

(C) It is the intent of the Legislature to ensure that foster children who are adopted or placed permanently with relative guardians, and who move to a county outside their original county of residence, can access specialty mental health services in a timely manner. It is the intent of the Legislature to enact this section as a temporary means of ensuring access to these services, while the appropriate stakeholders pursue a long-term solution in the form of a change to the Medi-Cal Eligibility Data System that will allow these children to receive specialty mental health services through their new county of residence.

(Amended by Stats. 2015, Ch. 455, Sec. 58. (SB 804) Effective January 1, 2016. Conditionally inoperative as provided in Section 14721.)

14717.1. (a) (1) For purposes of this section, "foster child" or "foster children" means a Medi-Cal eligible child or children younger than 21 years of age who have been placed into foster care by a county child welfare agency or a county probation department.

(2) It is the intent of the Legislature to ensure that foster children who are placed outside of their county of original jurisdiction are able to access specialty mental health services in a timely manner, consistent with their individual strengths and needs and the requirements of federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

(3) It is the further intent of the Legislature to overcome any barriers to care that may result when responsibility for providing or arranging for specialty mental health services to foster children who are placed outside of their county of original jurisdiction is retained by the county of original jurisdiction.

(b) In order to facilitate the receipt of medically necessary specialty mental health services by a foster child who is placed outside of their county of original jurisdiction, the California Health and Human Services Agency shall coordinate with the department and the State Department of Social Services to take all of the following actions on or before July 1, 2017:

(1) The department shall issue policy guidance on the conditions for, and exceptions to, presumptive transfer, as described in subdivisions (c) and (d), in consultation with the State Department of Social Services and with the input of stakeholders that include the County Welfare Directors Association of California, the Chief Probation Officers of California, the County Behavioral Health Directors Association of California, provider representatives, and family and youth advocates.

(2) Policy guidance concerning the conditions for, and exceptions to, presumptive transfer shall ensure all of the following:

(A) The transfer of responsibility improves access to specialty mental health care services consistent with the mental health needs of the foster child.

(B) Presumptive transfer does not disrupt the continuity of care.

(C) Conditions and exceptions are applied consistently statewide, giving due consideration to the varying capabilities of small, medium, and large counties.

(D) Presumptive transfer can be waived only with an individualized determination that an exception applies.

(E) A party to the case who disagrees with the presumptive transfer individualized exception determination made by the county placing agency pursuant to subdivision (d) is afforded an opportunity to request judicial review before a transfer or exception being finalized.

(F) There is a procedure for expedited transfer within 48 hours of placement of the child outside of the county of original jurisdiction.

(c) For purposes of this section, "presumptive transfer" means that absent any exceptions as established pursuant to this section, responsibility for providing or arranging for specialty mental health services shall promptly transfer from the county of original jurisdiction to the county in which the foster child resides, under either of the following conditions:

(1) A foster child is placed in a county other than the county of original jurisdiction on or after July 1, 2017.

(2) A foster child who resides in a county other than the county of original jurisdiction after June 30, 2017, and is not receiving specialty mental health services consistent with their mental health needs, requests transfer of responsibility. A foster child who resided in a county other than the county of original jurisdiction after June 30, 2017, and who continues to reside outside the county of original jurisdiction after December 31, 2017, shall have jurisdiction transferred no later than the child's first regularly scheduled status review hearing conducted pursuant to Section 366 in the 2018 calendar year unless an exception described under subdivision (d) applies.

(d) (1) On a case-by-case basis, and when consistent with the medical rights of children in foster care, presumptive transfer may be waived and the responsibility for the provision of specialty mental health services shall remain with the county of original jurisdiction if any of the exceptions described in paragraph (5) exist.

(2) A request for waiver in a manner established by the department may be made by the foster child, the person or agency that is responsible for making mental health care decisions on behalf of the foster child, the county probation agency or the child welfare services agency with responsibility for the care and placement of the child, or any other interested party who owes a legal duty to the child involving the child's health or welfare, as defined by the department.

(3) The county probation agency or the child welfare services agency with responsibility for the care and placement of the child, in consultation with the child and their parent, the child and family team, as defined in paragraph (4) of subdivision (a) of Section 16501, if one exists, and other professionals who serve the child as appropriate, is responsible for determining whether waiver of the presumptive transfer is appropriate pursuant to the conditions and exceptions established under this section. The person who requested the exception, along with any other parties to the case, shall receive notice of the county agency's determination.

(4) The individual who requested the exception or any other party to the case who disagrees with the determination made by the county agency pursuant to paragraph (3) may request judicial review before the county's determination becoming final. The court may set the matter for hearing and may confirm or deny the transfer of jurisdiction or application of an exception based on the best interest of the child.

(5) Presumptive transfer may be waived under any of the following exceptions:

(A) It is determined that the transfer would disrupt continuity of care or delay access to services provided to the foster child.

(B) It is determined that the transfer would interfere with family reunification efforts documented in the individual case plan.

(C) The foster child's placement in a county other than the county of original jurisdiction is expected to last less than six months.

(D) The foster child's residence is within 30 minutes of travel time to the child's established specialty mental health care provider in the county of original jurisdiction.

(6) A waiver processed based on an exception to presumptive transfer shall be contingent upon the mental health plan in the county of original jurisdiction demonstrating an existing contract with a specialty mental health care provider, or the ability to enter into a contract, single case agreement, or other service payment mechanism within 30 days of the waiver decision, and the ability to deliver timely specialty mental health services directly to the foster child. That information shall be documented in the child's case plan.

(7) A request for waiver, the exceptions claimed as the basis for the request, a determination whether a waiver is determined to be appropriate under this section, and any objections to the determination shall be documented in the foster child's case plan

pursuant to Section 16501.1.

(e) If the mental health plan in the county of original jurisdiction has completed an assessment of needed services for the foster child, the mental health plan in the county in which the foster child resides shall accept that assessment. The mental health plan in the county in which the foster child resides may conduct additional assessments if the foster child's needs change or an updated assessment is needed to determine the child's needs and identify the needed treatment and services to address those needs.

(f) (1) Upon presumptive transfer, the mental health plan in the county in which the foster child resides shall assume responsibility for the authorization and provision of specialty mental health services and payments for services. The foster child transferred to the mental health plan in the county in which the foster child resides shall be considered part of the county of residence caseload for claiming purposes from the Behavioral Health Subaccount and the Behavioral Health Services Growth Special Account, both created pursuant to Section 30025 of the Government Code.

(2) To support service delivery, continuity of care, and timely payment, the placing agency shall provide notification to the mental health plan that will be responsible for arranging and providing specialty mental health services for the foster child before placing a foster child out of county. The placing agency may complete these notifications through email. If notification before placement is not possible, the placing agency shall notify the appropriate mental health plan no later than three business days after making the out-of-county placement.

(g) The State Department of Social Services and the department shall adopt regulations by July 1, 2027, to implement this section. Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the State Department of Social Services and the department may implement and administer the changes made by this legislation through all-county letters, information notices, or similar written instructions until regulations are adopted.

(h) (1) If the department determines it is necessary, it shall seek approval from the United States Department of Health and Human Services, federal Centers for Medicare and Medicaid Services before implementing this section.

(2) If the department makes the determination that it is necessary to seek federal approval pursuant to paragraph (1), the department shall make an official request for approval from the federal government no later than January 1, 2017.

(i) This section shall be implemented only if, and to the extent that, federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available and all necessary federal approvals have been obtained.

(j) Commencing July 1, 2024, in the case of placement of foster children in short-term residential therapeutic programs, community treatment facilities, or group homes, or in the case of admission of foster children to children's crisis residential programs, this section shall apply only if the circumstances described in paragraph (1) or (2) of subdivision (b) of Section 14717.2 exist.

(Amended by Stats. 2023, Ch. 42, Sec. 160. (AB 118) Effective July 10, 2023.)

14717.2. (a) (1) For purposes of this section, "foster child" or "foster children" means a Medi-Cal eligible child or children younger than 21 years of age who have been placed into foster care by a county child welfare agency or a county probation department.

(2) It is the intent of the Legislature to ensure that foster children who are placed in community treatment facilities, group homes, or short-term residential therapeutic programs, or who are admitted to children's crisis residential programs, outside of their county of original jurisdiction, are able to access specialty mental health services in a timely manner, consistent with their individual strengths and needs and the requirements of federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

(3) The Legislature finds that because group home placements or short-term residential therapeutic program placements are intended to be short term, and because community treatment facility placements and children's crisis residential program admissions are intended to be time-limited based on medical necessity, the responsibility for the provision of or arrangement for specialty mental health services for a foster child throughout the short-term or time-limited placement or admission shall remain with the county of original jurisdiction.

(4) The Legislature intends that the placement of a foster child in a group home, community treatment facility, or short-term residential therapeutic program, or the admission of the child to a children's crisis residential program outside of the county of original jurisdiction should not disrupt continuity of care or adversely impact timely payment to the provider of specialty mental health services.

(b) Commencing July 1, 2024, a foster child's county of original jurisdiction shall retain responsibility to arrange and provide specialty mental health services if the foster child is placed out of the county of original jurisdiction in a community treatment facility, group home, or short-term residential therapeutic program, or is admitted to a children's crisis residential program, as these settings are defined in paragraph (8), (13), (18), or (21), respectively, of subdivision (a) of Section 1502 of the Health and Safety Code, unless either of the following circumstances exist:

(1) The case plan for the foster child specifies that the child will transition to a less restrictive placement in the same county as the facility in which the child has been placed.

(2) The placing agency determines, as informed by the child and family team, as defined in paragraph (4) of subdivision (a) of Section 16501, that the child will be negatively impacted if responsibility for providing or arranging for specialty mental health services is not transferred to the same county as the facility in which the child has been placed. The placing agency shall document the basis for making this determination in the child's case record and may include in a child and family team meeting the mental health plan of the receiving county where the facility is located. It is the intent of the Legislature to encourage local coordination with the receiving county mental health plan.

(c) If the circumstances in paragraph (1) or (2) of subdivision (b) exist, the process for presumptive transfer of responsibility for arranging and providing specialty mental health services set forth in Section 14717.1 shall apply.

(d) (1) To support service delivery, continuity of care, and timely payment, the placing agency shall provide notification to the mental health plan that will be responsible for arranging and providing specialty mental health services for the foster child before placing a foster child out of county in a community treatment facility, group home, or short-term residential therapeutic program, or admitting a foster child to a children's crisis residential program. The placing agency may complete these notifications through email. If notification before placement or admission is not possible, the placing agency shall notify the appropriate mental health plan no later than three business days after making the out-of-county placement.

(2) Upon accepting placement or admission of a foster child, a group home, short-term residential therapeutic program, community treatment facility, or children's crisis residential program may notify the mental health plan that will be responsible for arranging and providing specialty mental health services for the foster child that the foster child has been admitted to a children's crisis residential program or placed in a group home, short-term residential therapeutic program, or community treatment facility.

(e) If the circumstances in paragraph (1) or (2) of subdivision (b) exist at any point during the foster child's placement or admission out of county, Section 14717.1 shall apply.

(f) The placing agency shall document which mental health plan is responsible for providing or arranging for specialty mental health services.

(g) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department and the State Department of Social Services may implement, interpret, or make specific this section, in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or similar written instructions, until regulations are adopted.

(2) By July 1, 2027, the department and the State Department of Social Services shall adopt regulations to implement this section in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(h) (1) If the department determines it is necessary, it shall seek approval from the United States Department of Health and Human Services, federal Centers for Medicare and Medicaid Services before implementing this section.

(2) If the department makes the determination that it is necessary to seek federal approval pursuant to paragraph (1), the department shall make an official request for approval from the federal government no later than July 1, 2025.

(i) This section shall be implemented only if, and to the extent that, federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available and all necessary federal approvals have been obtained.

(Amended by Stats. 2023, Ch. 42, Sec. 161. (AB 118) Effective July 10, 2023.)

14717.25. (a) (1) For purposes of this section, "foster child" or "foster children" means a Medi-Cal eligible child or children younger than 21 years of age who have been placed into foster care by a county child welfare agency or a county probation department.

(2) It is the intent of the Legislature to support timely payment to the provider for services to help ensure foster children placed out of county receive the care and treatment that they need.

(b) If a foster child who needs to receive, or who is already receiving, specialty mental health services is placed out of county in a group home, community treatment facility, children's crisis residential program, or short-term residential therapeutic program, and responsibility for providing and arranging for the child's specialty mental health services is not transferred, in accordance with Sections 14717.1 and 14717.2, the mental health plan in the county of original jurisdiction and the specialty mental health services provider may choose one of the following options in order to ensure timely payment for specialty mental health services provided to the foster child:

(1) Utilize an existing contract between the mental health plan in the county of original jurisdiction and the specialty mental health services provider for payment of services within a mutually agreed upon timeframe.

(2) Establish a contract for payment of specialty mental health services for a foster child or multiple foster children for payment of services within a mutually agreed upon timeframe.

(c) (1) If neither of the options described in paragraph (1) or (2) of subdivision (b) is available, and if the responsibility for arranging and providing specialty mental health services was not transferred, in accordance with Sections 14717.1 and 14717.2, payment for the specialty mental health services shall be made by the mental health plan in the county of original jurisdiction or through an agreement between the mental health plan in the county of residence and the mental health plan in the county of original jurisdiction.

(2) The mental health plan in the county of original jurisdiction and the mental health plan in the county of residence shall enter into the agreement for payment of services within 30 days of notice, by either the placing agency or the placement provider, of the out-of-county placement.

(Added by Stats. 2022, Ch. 402, Sec. 4. (AB 1051) Effective January 1, 2023.)

14717.26. (a) For purposes of this section, "foster children" means Medi-Cal eligible children younger than 21 years of age who have been placed into foster care by a county child welfare agency or a county probation department.

(b) The department and the State Department of Social Services shall collect data on the receipt of specialty mental health services by foster children who are placed outside of their county of original jurisdiction. These data shall be included in the department's Medi-Cal specialty mental health services performance dashboard, in compliance with all applicable state and federal privacy and confidentiality laws, and shall contain all of the following statewide information:

(1) The number of foster children placed out of county.

(2) The number of foster children placed out of county who receive specialty mental health services.

(3) For foster children placed out of county who receive specialty mental health services, the number of foster children for whom the county of original jurisdiction is responsible for providing or arranging for those services, and the number of foster children for whom the county of residence is responsible for that provision or arrangement.

(Added by Stats. 2022, Ch. 402, Sec. 5. (AB 1051) Effective January 1, 2023.)

14717.5. (a) A mental health plan review shall be conducted annually by an external quality review organization (EQRO) pursuant to federal regulations at 42 C.F.R. 438.350 et seq. Commencing July 1, 2018, the review shall include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including all of the following:

(1) The number of Medi-Cal eligible minor and nonminor dependents in foster care served each year.

(2) Details on the types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to, screenings, assessments, home-based mental health services, outpatient services, day treatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.

(3) Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in foster care.

(4) Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in foster care.

(5) Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in foster care.

(6) Performance data for Medi-Cal eligible minor and nonminor dependents in foster care.

(7) Utilization data for Medi-Cal eligible minor and nonminor dependents in foster care.

(8) Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following:

(A) Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).

(B) Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).

(C) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

(D) Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).

(b) (1) The department shall post the EQRO data disaggregated by Medi-Cal eligible minor and nonminor dependents in foster care on the department's Internet Web site in a manner that is publicly accessible.

(2) The department shall review the EQRO data for Medi-Cal eligible minor and nonminor dependents in foster care.

(3) If the EQRO identifies deficiencies in a mental health plan's ability to serve Medi-Cal eligible minor and nonminor dependents in foster care, the department shall notify the mental health plan in writing of identified deficiencies.

(4) The mental health plan shall provide a written corrective action plan to the department within 60 days of receiving the notice required pursuant to paragraph (3). The department shall notify the mental health plan of approval of the corrective action plan or shall request changes, if necessary, within 30 days after receipt of the corrective action plan. Final corrective action plans shall be made publicly available by, at minimum, posting on the department's Internet Web site.

(c) To the extent possible, the department shall, in connection with its duty to implement Section 14707.5, share with county boards of supervisors data that will assist in the development of mental health service plans, such as data described in federal regulations at 42 C.F.R. 438.350 et seq., in subdivision (c) of Section 16501.4 of this code, and in paragraph (1) of subdivision (a) of Section 1538.8 of the Health and Safety Code.

(d) The department shall annually share performance outcome system data with county boards of supervisors for the purpose of informing mental health service plans. Performance outcome system data shared with county boards of supervisors shall include, but not be limited to, the following disaggregated data for Medi-Cal eligible minor and nonminor dependents in foster care:

(1) The number of youth receiving specialty mental health services.

(2) The racial distribution of youth receiving specialty mental health services.

(3) The gender distribution of youth receiving specialty mental health services.

(4) The number of youth, by race, with one or more specialty mental health service visits.

(5) The number of youth, by race, with five or more specialty mental health service visits.

(6) Utilization data for intensive home services, intensive care coordination, case management, therapeutic behavioral services, medication support services, crisis intervention, crisis stabilization, full-day intensive treatment, full-day treatment, full-day rehabilitation, and hospital inpatient days.

(7) A unique count of youth receiving specialty mental health services who are arriving, exiting, and continuing with services.

(e) The department shall ensure that the performance outcome system data metrics include disaggregated data for Medi-Cal eligible minor and nonminor dependents in foster care. These data shall be in a format that can be analyzed.

(Amended by Stats. 2017, Ch. 561, Sec. 290. (AB 1516) Effective January 1, 2018.)

14718. (a) This section shall be limited to specialty mental health services reimbursed to a mental health plan that certifies public expenditures subject to cost settlement or specialty mental health services reimbursed through the department's fiscal intermediary.

(b) The following provisions shall apply to matters related to specialty mental health services provided under the approved Medi-Cal state plan and the 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) As determined by the department, the MHP shall submit claims for reimbursement to the Medi-Cal program for eligible services.

(2) The department may offset the amount of any federal disallowance, audit exception, or overpayment against subsequent claims from the MHP. The department may offset the amount of any state disallowance, or audit exception or overpayment against subsequent claims from the mental health plan, through the 2010–11 fiscal year. This offset may be done at any time, after the department has invoiced or otherwise notified the mental health plan about the audit exception, disallowance, or overpayment. The department shall determine the amount that may be withheld from each payment to the mental health plan. The maximum withheld amount shall be 25 percent of each payment as long as the department is able to comply with the federal requirements for repayment of federal financial participation pursuant to Section 1903(d)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396b(d)(2)). The department may increase the maximum amount when necessary for compliance with federal laws and regulations.

(3) (A) Oversight by the department of the MHPs may include client record reviews of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) specialty mental health services rendered by MHPs and MHP subcontractors 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 or disclosing client records or client information for a purpose other than the one for which the record was given.

(iii) Prohibit the entity awarded the contract from selling client records or client information.

(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 for repayment to the federal Centers for Medicare and Medicaid Services.

(4) (A) The department, in consultation with mental health stakeholders, the County Behavioral Health Directors Association of California, 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 consistent with the department’s appeals process that is in effect on July 1, 2012, by no later than the end of the 2013–14 fiscal year. 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.

(5) The department shall conduct 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 chapter shall prohibit the MHPs from establishing standards that are in addition to the federal and state requirements, provided that these standards do not violate federal and state requirements and guidelines.

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

(B) Any excess in the distribution of funds over the expenditures for services by the mental health plan shall be spent for the provision of specialty mental health services and related administrative costs.

(7) Nothing in this chapter shall limit the MHP from being reimbursed appropriate federal financial participation for any qualified services. To receive federal financial participation, the mental health plan shall certify its public expenditures for specialty mental health services to the department.

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

(9) 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 rendered in fee-for-service Medi-Cal hospitals. The department shall request the Controller to offset the distribution of funds to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, or the Vehicle License Collection Account of the Local Revenue Fund, or funds from the Mental Health Account or the Behavioral Health Subaccount of the Local Revenue Fund 2011 for the nonfederal financial participation share for these claims.

(c) Counties may set aside funds for self-insurance, audit settlement, and statewide program risk pools. The counties shall assume all responsibility and liability for appropriate administration of the funds. Special consideration may be given to small counties with a population of less than 200,000. This subdivision shall not make the state or department liable for mismanagement or loss of funds by the entity designated by counties under this subdivision.

(d) The department shall consult with the County Behavioral Health Directors Association of California in February and September of each year to obtain data and methodology necessary to forecast future fiscal trends in the provision of specialty mental health services provided under the Medi-Cal specialty mental health services waiver, to estimate yearly specialty mental health services related costs, and to estimate the annual amount of federal funding participation to reimburse costs of specialty mental health services provided under the Medi-Cal specialty mental health services waiver. This shall include a separate presentation of the data and methodology necessary to forecast future fiscal trends in the provision of Early Periodic Screening, Diagnosis, and Treatment specialty mental health services provided under the Medi-Cal specialty mental health services waiver, to estimate annual EPSDT specialty mental health services related costs, and to estimate the annual amount of EPSDT specialty mental health services provided under the state Medi-Cal specialty mental health services waiver, including federal funding participation to reimburse costs of EPSDT.

(e) When seeking federal approval for any federal Medicaid state plan amendment or waiver associated with Medi-Cal specialty mental health services, the department shall consult with staff of the Legislature, counties, providers, and other stakeholders in the development of the state plan amendment or waiver.

(f) This section shall become operative on July 1, 2012.

(Amended by Stats. 2015, Ch. 455, Sec. 59. (SB 804) Effective January 1, 2016. Conditionally inoperative as provided in Section 14721.)

14718.5. Notwithstanding any other law, including subdivision (b) of Section 16310 of the Government Code, the Controller may use the moneys in the Mental Health Managed Care Deposit Fund for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Interest shall be paid on all moneys loaned to the General Fund from the Mental Health Managed Care Deposit Fund. Interest payable shall be computed at a rate determined by the Pooled Money Investment Board to be the current earning rate of the fund from which loaned. This subdivision does not authorize any transfer that will interfere with the carrying out of the object for which the Mental Health Managed Care Deposit Fund was created.

(Added by renumbering Section 5778.3 by Stats. 2012, Ch. 34, Sec. 180. (SB 1009) Effective June 27, 2012. Conditionally inoperative as provided in Section 14721.)

14721. (a) This chapter shall only be implemented to the extent that the necessary federal waivers are obtained. The director shall execute a declaration, to be retained by the director, that a waiver necessary to implement any provision of this chapter has been obtained.

(b) This chapter shall become inoperative on the date that, and only if, the director executes a declaration, to be retained by the director, that more than 10 percent of all counties fail to become mental health plan contractors, and acceptable alternative contractors are not available, or if more than 10 percent of all funds allocated for Medi-Cal mental health services must be administered by the department because an acceptable plan is not available.

(Added by renumbering Section 5780 by Stats. 2012, Ch. 34, Sec. 182. (SB 1009) Effective June 27, 2012. Operative July 1, 2012, by Sec. 254 of Ch. 34. Note: Termination clause applies to Chapter 8.9, comprising Sections 14700 to 14726.)

14722. (a) Notwithstanding any other law, a mental health plan may enter into a contract for the provision of specialty mental health services for Medi-Cal beneficiaries with a hospital that provides for a per diem reimbursement rate for services that include room and board, routine hospital services, and all hospital-based ancillary services and that provides separately for the attending mental health professional's daily visit fee. The payment of these negotiated reimbursement rates to the hospital by the mental health plan shall be considered payment in full for each day of inpatient psychiatric and hospital care rendered to a Medi-Cal beneficiary, subject to third-party liability and patient share of costs, if any.

(b) This section shall not be construed to allow a hospital to interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 of the Business and Professions Code or any other provision of law.

(c) For purposes of this section, “hospital” means a hospital that submits reimbursement claims for Medi-Cal psychiatric inpatient hospital services through the Medi-Cal fiscal intermediary.

(Added by renumbering Section 5781 by Stats. 2012, Ch. 34, Sec. 183. (SB 1009) Effective June 27, 2012. Operative July 1, 2012, by Sec. 254 of Ch. 34. Conditionally inoperative as provided in Section 14721.)

14723. (a) Each eligible public agency, as described in subdivision (b), may, in addition to reimbursement or other payments that the agency would otherwise receive for Medi-Cal specialty mental health services, receive supplemental Medi-Cal reimbursement to the extent provided for in this section.

(b) A public agency shall be eligible for supplemental reimbursement only if it is a county, city, or city and county and if, consistent with Section 14718 it provides as a mental health plan, or subcontracts for, specialty mental health services to Medi-Cal beneficiaries pursuant to the Medi-Cal Specialty Mental Health Consolidation Waiver (Number CA.17), as approved by the federal Centers for Medicare and Medicaid Services.

(c) (1) Subject to paragraph (2), an eligible public agency’s supplemental reimbursement pursuant to this section shall be equal to the amount of federal financial participation received as a result of the claims submitted pursuant to paragraph (2) of subdivision (f).

(2) Notwithstanding paragraph (1), in computing an eligible public agency’s reimbursement, in no instance shall the expenditures certified pursuant to paragraph (1) of subdivision (e), when combined with the amount received from other sources of payment and with reimbursement from the Medi-Cal program, including expenditures otherwise certified for purposes of claiming federal financial participation, exceed 100 percent of actual, allowable costs, as determined pursuant to California’s Medicaid State Plan, for the specialty mental health services to which the expenditure relates. Supplemental payment may be made on an interim basis until the time when actual, allowable costs are finally determined.

(3) The supplemental Medi-Cal reimbursement provided by this section shall be distributed under a payment methodology based on specialty mental health services provided to Medi-Cal patients by each eligible public agency, on a per-visit basis, a per-procedure basis, a time basis, in one or more lump sums, or on any other federally permissible basis. The department shall seek approval from the federal Centers for Medicare and Medicaid Services for the payment methodology to be utilized, and shall not make any payment pursuant to this section prior to obtaining that federal approval.

(d) (1) It is the intent of the Legislature in enacting this section to provide the supplemental reimbursement described in this section without any expenditure from the General Fund. The department may require an eligible public agency, as a condition of receiving supplemental reimbursement pursuant to this section, to enter into, and maintain, an agreement with the department for the purposes of implementing this section and reimbursing the department for the costs of administering this section.

(2) Expenditures submitted to the department for purposes of claiming federal financial participation under this section shall have been paid only with funds from the public agencies described in subdivision (b) and certified to the state as provided in subdivision (e).

(e) An eligible public agency shall do all of the following:

(1) Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for the specialty mental health services are eligible for federal financial participation.

(2) Provide evidence supporting the certification as specified by the department.

(3) Submit data as specified by the department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.

(4) Keep, maintain, and have readily retrievable, any records specified by the department to fully disclose reimbursement amounts to which the eligible public agency is entitled, and any other records required by the federal Centers for Medicare and Medicaid Services.

(f) (1) The department shall promptly seek any necessary federal approvals for the implementation of this section. If necessary to obtain federal approval, the program shall be limited to those costs that the federal Centers for Medicare and Medicaid Services determines to be allowable expenditures under Title XIX of the federal Social Security Act (Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code). If federal approval is not obtained for implementation of this section, this section shall not be implemented.

(2) The department shall submit claims for federal financial participation for the expenditures described in subdivision (e) related to specialty mental health services that are allowable expenditures under federal law.

(3) The department shall, on an annual basis, submit any necessary materials to the federal Centers for Medicare and Medicaid Services to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

(g) (1) The director may adopt regulations as are necessary to implement this section. The adoption, amendment, repeal, or readoption of a regulation authorized by this subdivision shall be deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe specific facts showing the need for immediate action.

(2) As an alternative to the adoption of regulations pursuant to paragraph (1), and notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement and administer this article, in whole or in part, by means of provider bulletins or similar instructions, without taking regulatory action, provided that no bulletin or similar instruction shall remain in effect after June 30, 2011. It is the intent that regulations adopted pursuant to paragraph (1) shall be in place on or before June 30, 2011.

(Added by renumbering Section 5783 by Stats. 2012, Ch. 34, Sec. 185. (SB 1009) Effective June 27, 2012. Operative July 1, 2012, by Sec. 254 of Ch. 34. Conditionally inoperative as provided in Section 14721.)

14725. (a) The State Department of Health Care Services shall develop a quality assurance program to govern the delivery of Medi-Cal specialty mental health services, in order to ensure quality patient care based on community standards of practice.

(b) The department shall issue standards and guidelines for local quality assurance activities. These standards and guidelines shall be reviewed and revised in consultation with the County Behavioral Health Directors Association of California, as well as other stakeholders from the mental health community, including, but not limited to, individuals who receive services, family members, providers, mental health advocacy groups, and other interested parties. The standards and guidelines shall be based on federal Medicaid requirements.

(c) The standards and guidelines developed by the department shall reflect the special problems that small rural counties have in undertaking comprehensive quality assurance systems.

(Amended by Stats. 2015, Ch. 455, Sec. 60. (SB 804) Effective January 1, 2016. Conditionally inoperative as provided in Section 14721.)

14726. The department shall approve each local program's initial quality assurance plan, and shall thereafter review and approve each program's Medi-Cal specialty mental health services quality assurance plan whenever the plan is amended or changed.

(Added by renumbering Section 4071 by Stats. 2012, Ch. 34, Sec. 58. (SB 1009) Effective June 27, 2012. Operative July 1, 2012, by Sec. 254 of Ch. 34. Conditionally inoperative as provided in Section 14721.)

14727. (a) A mental health plan shall notify beneficiaries, prospective beneficiaries, and members of the public of all of the following information:

(1) The availability of language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner, when those services are necessary to provide meaningful access to an individual with limited English proficiency (LEP).

(2) The availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

(3) A mental health plan does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

(4) The availability of the grievance procedure and how to file a grievance, including identification of, and contact information for, the designated mental health plan representative.

(5) How to file a discrimination complaint with the United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

(b) Written notice of the availability of free language assistance services shall be provided in English and in the top 15 languages spoken by LEP individuals in California, as determined by the department, and consistent with the requirements identified in Part 92 of Title 45 of the Code of Federal Regulations and Section 1557 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18116).

(c) (1) The information described in subdivisions (a) and (b) shall be provided in the following manner:

(A) In the beneficiary handbook.

(B) Posted in conspicuous physical locations where the mental health plan interacts with the public.

(C) On the internet website published and maintained by the mental health plan, in a manner that allows beneficiaries, prospective beneficiaries, and members of the public to easily locate the information.

(2) To the extent the information described in subdivisions (a) and (b) is not included in existing informational notices, a mental health plan shall add this information at the time of the next regularly scheduled update of the applicable publication.

(d) Oral interpretation services shall be provided to an LEP beneficiary by an interpreter that, at a minimum, meets all of the following qualifications:

(1) Demonstrated proficiency in speaking and understanding both English and the language spoken by the LEP beneficiary.

(2) The ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from the language spoken by the LEP beneficiary and English, using any necessary specialized vocabulary, terminology, and phraseology.

(3) Adherence to generally accepted interpreter ethics principles, including client confidentiality.

(e) A mental health plan shall not require an LEP beneficiary to provide the beneficiary's own interpreter or rely on a staff member who does not meet the qualifications described in subdivision (d) to communicate directly with the LEP beneficiary.

(f) A mental health plan shall not rely on an adult or minor child accompanying the LEP beneficiary to interpret or facilitate communication except under either of the following circumstances:

(1) In an emergency, as defined by the department, and an interpreter who meets the qualifications described in subdivision (d) is not immediately available for the LEP beneficiary.

(2) If the LEP beneficiary specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.

(g) This section shall be implemented only to the extent that federal financial participation is available and is not otherwise jeopardized.

(Amended by Stats. 2019, Ch. 497, Sec. 322. (AB 991) Effective January 1, 2020. Conditionally inoperative as provided in Section 14721.)