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**AB-1688 Community health services: California Mental Health Planning Council, California Children's Services program, Alameda County pilot program, and Medi-Cal managed care. (2017-2018)**

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Date Published: 10/05/2017 09:00 PM

**Assembly Bill No. 1688**

**CHAPTER 511**

An act to amend Section 128456 of the Health and Safety Code, and to amend Sections 4033, 5400, 5514, 5604.2, 5610, 5614.5, 5664, 5701.1, 5750, 5771, 5771.1, 5771.3, 5771.5, 5772, 5814, 5820, 5821, 5845, 5848, 5892, 5897, 14094.18, 14102.5, 14124.1, 14149.8, 14304, 14459.5, 14459.6, and 14682.1 of, and to repeal Sections 14133.5 and 14133.51 of, the Welfare and Institutions Code, relating to public health.

[ Approved by Governor October 05, 2017. Filed with Secretary of State October 05, 2017. ]

**LEGISLATIVE COUNSEL'S DIGEST**

AB 1688, Committee on Health. Community health services: California Mental Health Planning Council, California Children's Services program, Alameda County pilot program, and Medi-Cal managed care.

(1) Existing law, the Bronzan-McCorquodale Act, contains provisions governing the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Existing law establishes the California Mental Health Planning Council, consisting of 40 members appointed from both the local and state levels, for the purpose of fulfilling certain mental health planning requirements mandated by federal law. Existing law requires members of the planning council to be appointed in a manner that will ensure that at least  $\frac{1}{2}$  of the members are persons with mental disabilities and family members of, and organizations advocating on behalf of, those persons.

This bill would rename the California Mental Health Planning Council as the California Behavioral Health Planning Council and would make conforming changes. The bill would require the membership of the planning council to also include adults with serious mental illness, including persons who are dually diagnosed with serious mental illness and substance use disorders, and families of, those persons, families of children with emotional disturbance, and representatives from organizations advocating on behalf of persons with mental illness, including persons who are dually diagnosed with mental illness and substance use disorders, and would require the Director of Health Care Services to make appointments from among nominees from various substance use disorder constituency organizations and representatives from mental health or mental health and substance use disorder professional and provider organizations. The bill would revise the planning council's duties to include reviewing, assessing, and making recommendations with respect to substance use disorders, and would make related changes to the planning council's duties to incorporate substance use disorders. The bill would require, if the department determines that California's Community Mental Health Services Block Grant funding is in jeopardy due to the planning council's noncompliance with a specified federal law, the department to notify and consult with the planning council and would require the planning council to make the changes necessary to comply with federal law.

(2) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by

federal Medicaid program provisions. Existing law requires each provider, as defined, of health care services rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contracts to keep and maintain records of specified information, including the beneficiary or person to whom the service was rendered and the date the service was rendered. Existing law requires the provider to retain the records required to be kept and maintained under this provision for a period of 3 years from the date the service was rendered.

This bill would instead require those records to be retained by the provider for a period of 10 years from the final date of the contract period between the plan and the provider, from the date of completion of any audit, or from the date the service was rendered, whichever is later.

(3) Existing law requires the State Department of Health Care Services to develop and prepare one or more reports issued on at least a quarterly basis and make the reports public within 30 days for the purpose of informing the California Health and Human Services Agency, the California Health Benefit Exchange, the Legislature, and the public about the enrollment process for all insurance affordability programs. Existing law further requires the department to collect the data for these reports pursuant to specified administrative procedures.

This bill would instead require these ongoing reports to be issued on at least a biannual basis and to be made public within 90, rather than 30, days. The bill would further require the data within the reports to be aggregated and calculated on at least a quarterly basis. The bill would delete the requirement for the department to collect the data pursuant to the specified administrative procedures.

(4) Existing law provides for the California Children's Services (CCS) program, which is a statewide program that provides medically necessary services for physically handicapped children whose parents are unable to pay for those services. Existing law authorizes the department to establish, no sooner than July 1, 2017, a Whole Child Model program, under which managed care plans served by a county organized health system or Regional Health Authority in designated counties provide CCS program services to Medi-Cal-eligible CCS children and youth. Existing law requires the department to contract with an independent entity that has experience in performing robust program evaluations to conduct an evaluation to assess Medi-Cal managed care plan performance and the outcomes and experience of CCS-eligible children and youth participating in the Whole Child Model program. Existing law requires the department to provide a report on the results of that evaluation by January 1, 2021.

This bill would instead require the department to provide that report by January 1, 2021, or 3 years from the date when all counties in which the department is authorized to establish the Whole Child Model program are fully operational under the program, whichever is later.

(5) Existing law establishes a program in the County of Alameda in which utilization controls are prohibited from being required when a county hospital-based utilization review committee has been established to determine the level of authorization for payment and a utilization plan has been filed with the department and approved by it.

This bill would repeal those provisions that apply to the program in the County of Alameda.

(6) Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Existing law, the Waxman-Duffy Prepaid Health Plan Act, authorizes the department to contract with prepaid health plans to provide the benefits authorized under Medi-Cal, providing Medi-Cal beneficiaries the opportunity to enroll as regular subscribers in prepaid health plans, as specified. Existing law requires the Director of Health Care Services to terminate a contract with a prepaid health plan or a Medi-Cal managed health care plan if he or she makes a finding of noncompliance or for other good cause, as described, in accordance with specified procedures, or, in lieu of contract termination, authorizes the director to take one or more specified sanctions, including the imposition of civil penalties, against the contractor for noncompliance. Existing federal regulations set forth the maximum civil monetary penalty that a state may impose depending on the nature of the managed care plans action or failure to act.

The bill would authorize the Director of Health Care Services to impose a civil penalty in specified amounts that are consistent with those federal regulations depending on the nature of the plans action or failure to act, as specified.

Existing law requires the State Department of Health Care Services to monitor the quality of all Medicaid services provided in the state, and specifies that a key component of this monitoring function is the performance of annual, independent, external reviews of the quality of services furnished under each contract with a health maintenance organization, such as a Medi-Cal managed care plan or prepaid health plan.

This bill, effective for the rating period for managed care plan contracts beginning on or after July 1, 2017, would require the department, through its contracts with Medi-Cal managed care plans and prepaid health plans, to require each managed care plan to inform the department whether it has been accredited by a private independent accrediting entity, and would require each managed care plan that has received accreditation by a private independent accrediting agency to authorize the private independent accrediting agency to provide the department with a copy of its most recent accreditation review, as specified. The

bill would require the department to make the accreditation status for each contracted entity available on its Internet Web site, and would require the department to update this information at least annually.

(7) Existing law provides for a schedule of benefits under the Medi-Cal program, which, with some exceptions, includes certain dental services that are referred to as the Medi-Cal dental program, or Denti-Cal. Under existing law, one of the methods by which Denti-Cal services are provided is pursuant to contracts with dental managed care plans.

This bill would require, effective for the rating period for contracts with dental managed care plans beginning on or after July 1, 2017, the department to require each dental managed care plan to authorize the department, the federal Centers for Medicare and Medicaid Services, the federal Office of the Inspector General, the federal Comptroller General, and their designees, to inspect and audit, at any time, any records or documents of the managed care entity, or its subcontractors, and to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted, and would specify that the right to audit under this provision exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. The bill would require, effective for the rating period for contracts with dental managed care plans beginning on or after July 1, 2017, the department to require each dental managed care plan, and their subcontractors, as applicable, to retain for a period of no less than 10 years certain information, such as enrollee grievance and appeals records, and medical loss ratio reports.

Existing law requires the department to designate an external quality review organization (EQRO) that is required to conduct an external quality review for any dental health plan contracting with the department pursuant to a specified authority. Existing law requires an external quality review (EQR) to include specified information, including performance on the selected performance measures and benchmarks established and updated by the department.

This bill would instead require the EQR to be conducted by a qualified external quality review organization, and would also require the EQR to include information that is consistent with specified federal regulations. The bill would require the department, no later than July 1, 2018, to require that the dental EQRO shall have sufficient information to use in performing its review, and would require the department to require the EQR to comply with specified requirements, including that, for each EQR-related activity, the information gathered for use in the EQR includes the elements described in a specified federal regulation. The bill would require the EQRO to produce and submit to the department an annual EQR technical report in accordance with a specified federal regulation, and would require the department to finalize this report by April 30 of each year. The bill would require the department to post by April 30 of each year the most recent copy of the annual EQR technical report on a specified Internet Web site operated by the department. The bill would require the department to provide, upon request, printed or electronic copies of the EQR results to interested parties, and would require the department to make this information available in alternative formats for persons with disabilities, when requested.

(8) This bill would incorporate additional changes to Section 5845 of the Welfare and Institutions Code proposed by AB 850 and to Section 5892 of the Welfare and Institutions Code proposed by AB 727, to be operative only if this bill is enacted last.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

## THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

**SECTION 1.** Section 128456 of the Health and Safety Code is amended to read:

**128456.** In developing the program established pursuant to this article, the Health Professions Education Foundation shall solicit the advice of representatives of the Board of Behavioral Sciences, the Board of Psychology, the State Department of Health Care Services, the County Behavioral Health Directors Association of California, the California Behavioral Health Planning Council, professional mental health care organizations, the California Healthcare Association, the Chancellor of the California Community Colleges, and the Chancellor of the California State University. The foundation shall solicit the advice of representatives who reflect the demographic, cultural, and linguistic diversity of the state.

**SEC. 2.** Section 4033 of the Welfare and Institutions Code is amended to read:

**4033.** (a) The State Department of Health Care Services shall, to the extent resources are available, comply with the Substance Abuse and Mental Health Services Administration federal planning requirements. The department shall update and issue a state plan, which may also be any federally required state service plan, so that citizens may be informed regarding the implementation of, and long-range goals for, programs to serve mentally ill persons in the state. The department shall gather information from counties necessary to comply with this section.

(b) (1) If the State Department of Health Care Services makes a decision not to comply with any Substance Abuse and Mental Health Services Administration federal planning requirement to which this section applies, the State Department of Health Care

Services shall submit the decision, for consultation, to the County Behavioral Health Directors Association of California, the California Behavioral Health Planning Council, and affected mental health entities.

(2) The State Department of Health Care Services shall not implement any decision not to comply with the Substance Abuse and Mental Health Services Administration federal planning requirements sooner than 30 days after notification of that decision, in writing, by the Department of Finance, to the chairperson of the committee in each house of the Legislature that considers appropriations, and the Chairperson of the Joint Legislative Budget Committee.

**SEC. 3.** Section 5400 of the Welfare and Institutions Code is amended to read:

**5400.** (a) The Director of Health Care Services shall administer this part and shall adopt rules, regulations, and standards as necessary. In developing rules, regulations, and standards, the Director of Health Care Services shall consult with the County Behavioral Health Directors Association of California, the California Behavioral Health Planning Council, and the office of the Attorney General. Adoption of these standards, rules, and regulations shall require approval by the County Behavioral Health Directors Association of California by majority vote of those present at an official session.

(b) Wherever feasible and appropriate, rules, regulations, and standards adopted under this part shall correspond to comparable rules, regulations, and standards adopted under the Bronzan-McCorquodale Act. These corresponding rules, regulations, and standards shall include qualifications for professional personnel.

(c) Regulations adopted pursuant to this part may provide standards for services for persons with chronic alcoholism that differ from the standards for services for persons with mental health disorders.

**SEC. 4.** Section 5514 of the Welfare and Institutions Code is amended to read:

**5514.** There shall be a five-person Patients' Rights Committee formed through the California Behavioral Health Planning Council. This committee, supplemented by two ad hoc members appointed by the chairperson of the committee, shall advise the Director of Health Care Services and the Director of State Hospitals regarding department policies and practices that affect patients' rights. The committee shall also review the advocacy and patients' rights components of each county mental health plan or performance contract and advise the Director of Health Care Services and the Director of State Hospitals concerning the adequacy of each plan or performance contract in protecting patients' rights. The ad hoc members of the committee shall be persons with substantial experience in establishing and providing independent advocacy services to recipients of mental health services.

**SEC. 5.** Section 5604.2 of the Welfare and Institutions Code is amended to read:

**5604.2.** (a) The local mental health board shall do all of the following:

(1) Review and evaluate the community's mental health needs, services, facilities, and special problems.

(2) Review any county agreements entered into pursuant to Section 5650.

(3) Advise the governing body and the local mental health director as to any aspect of the local mental health program.

(4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.

(5) Submit an annual report to the governing body on the needs and performance of the county's mental health system.

(6) Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.

(7) Review and comment on the county's performance outcome data and communicate its findings to the California Behavioral Health Planning Council.

(8) Nothing in this part shall be construed to limit the ability of the governing body to transfer additional duties or authority to a mental health board.

(b) It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall assess the impact of the realignment of services from the state to the county, on services delivered to clients and on the local community.

**SEC. 6.** Section 5610 of the Welfare and Institutions Code is amended to read:

**5610.** (a) Each county mental health system shall comply with reporting requirements developed by the State Department of Health Care Services, in consultation with the California Behavioral Health Planning Council and the Mental Health Services Oversight and Accountability Commission, which shall be uniform and simplified. The department shall review existing data requirements to eliminate unnecessary requirements and consolidate requirements which are necessary. These requirements shall provide comparability between counties in reports.

(b) The department shall develop, in consultation with the Performance Outcome Committee, the California Behavioral Health Planning Council, and the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5611, and with the California Health and Human Services Agency, uniform definitions and formats for a statewide, nonduplicative client-based information system that includes all information necessary to meet federal mental health grant requirements and state and federal Medicaid reporting requirements, and any other state requirements established by law. The data system, including performance outcome measures reported pursuant to Section 5613, shall be developed by July 1, 1992.

(c) Unless determined necessary by the department to comply with federal law and regulations, the data system developed pursuant to subdivision (b) shall not be more costly than that in place during the 1990–91 fiscal year.

(d) (1) The department shall develop unique client identifiers that permit development of client-specific cost and outcome measures and related research and analysis.

(2) The department's collection and use of client information, and the development and use of client identifiers, shall be consistent with clients' constitutional and statutory rights to privacy and confidentiality.

(3) Data reported to the department may include name and other personal identifiers. That information is confidential and subject to Section 5328 and any other state and federal laws regarding confidential client information.

(4) Personal client identifiers reported to the department shall be protected to ensure confidentiality during transmission and storage through encryption and other appropriate means.

(5) Information reported to the department may be shared with local public mental health agencies submitting records for the same person and that information is subject to Section 5328.

(e) All client information reported to the department pursuant to Chapter 2 (commencing with Section 4030) of Part 1 of Division 4 and Sections 5328 to 5772.5, inclusive, Chapter 8.9 (commencing with Section 14700), and any other state and federal laws regarding reporting requirements, consistent with Section 5328, shall not be used for purposes other than those purposes expressly stated in the reporting requirements referred to in this subdivision.

(f) The department may adopt emergency regulations to implement this section in accordance with 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 adoption of emergency regulations to implement this section that are filed with the Office of Administrative Law within one year of the date on which the act that added this subdivision took effect shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare and shall remain in effect for no more than 180 days.

**SEC. 7.** Section 5614.5 of the Welfare and Institutions Code is amended to read:

**5614.5.** (a) The department, in consultation with the Quality Improvement Committee which shall include representatives of the California Behavioral Health Planning Council, local mental health departments, consumers and families of consumers, and other stakeholders, shall establish and measure indicators of access and quality to provide the information needed to continuously improve the care provided in California's public mental health system.

(b) The department in consultation with the Quality Improvement Committee shall include specific indicators in all of the following areas:

(1) Structure.

(2) Process, including access to care, appropriateness of care, and the cost effectiveness of care.

(3) Outcomes.

(c) Protocols for both compliance with law and regulations and for quality indicators shall include standards and formal decision rules for establishing when technical assistance, and enforcement in the case of compliance, will occur. These standards and decision rules shall be established through the consensual stakeholder process established by the department.

(d) The department shall report to the legislative budget committees on the status of the efforts in Section 5614 and this section by March 1, 2001. The report shall include presentation of the protocols and indicators developed pursuant to this section or barriers encountered in their development.

**SEC. 8.** Section 5664 of the Welfare and Institutions Code is amended to read:

**5664.** In consultation with the County Behavioral Health Directors Association of California, the State Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, the California Behavioral Health Planning Council, and the California Health and Human Services Agency, county behavioral health systems shall provide reports and data to meet the information needs of the state, as necessary.

**SEC. 9.** Section 5701.1 of the Welfare and Institutions Code is amended to read:

**5701.1.** Notwithstanding Section 5701, the State Department of Health Care Services, in consultation with the County Behavioral Health Directors Association of California and the California Behavioral Health Planning Council, may utilize funding from the Substance Abuse and Mental Health Services Administration Block Grant, awarded to the State Department of Health Care Services, above the funding level provided in federal fiscal year 1998, for the development of innovative programs for identified target populations, upon appropriation by the Legislature.

**SEC. 10.** Section 5750 of the Welfare and Institutions Code is amended to read:

**5750.** The State Department of Health Care Services shall administer this part and shall adopt standards for the approval of mental health services, and rules and regulations necessary thereto. However, these standards, rules, and regulations shall be adopted only after consultation with the County Behavioral Health Directors Association of California and the California Behavioral Health Planning Council.

**SEC. 11.** Section 5771 of the Welfare and Institutions Code is amended to read:

**5771.** (a) Pursuant to Public Law 102-321, there is the California Behavioral Health Planning Council. The purpose of the planning council shall be to fulfill those mental health planning requirements mandated by federal law.

(b) (1) The planning council shall have 40 members, to be comprised of members appointed from both the local and state levels in order to ensure a balance of state and local concerns relative to planning.

(2) As required by federal law, eight members of the planning council shall represent various state departments.

(3) Members of the planning council shall be appointed in a manner that will ensure that at least one-half are adults with serious mental illness, including persons who are dually diagnosed with serious mental illness and substance use disorders, family members of persons with serious mental illness, including adults who are dually diagnosed with serious mental illness and substance use disorders, family members of children with emotional disturbance, and representatives of organizations advocating on behalf of persons with mental illness, including persons who are dually diagnosed with mental illness and substance use disorders. Persons with serious mental illness, including persons who are dually diagnosed with serious mental illness and substance use disorders, and family members shall be represented in equal numbers.

(4) The Director of Health Care Services shall make appointments from among nominees from various constituency organizations for mental health or mental health and substance use disorders, which shall include representatives of consumer-related advocacy organizations, representatives of professional and provider organizations for mental health or mental health and substance use disorders, and representatives who are direct service providers from both the public and private sectors. The director shall also appoint one representative of the California Coalition on Mental Health.

(c) Members should be balanced according to demography, geography, gender, and ethnicity. Members should include representatives with interest in all target populations, including, but not limited to, children and youth, adults, and older adults.

(d) The planning council shall annually elect a chairperson and a chair-elect.

(e) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(f) In the event of changes in the federal requirements regarding the structure and function of the planning council, or the discontinuation of federal funding, the State Department of Health Care Services shall, with input from state-level advocacy groups, consumers, family members and providers, and other stakeholders, propose to the Legislature modifications in the structure of the planning council that the department deems appropriate.

**SEC. 12.** Section 5771.1 of the Welfare and Institutions Code is amended to read:

**5771.1.** The members of the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845 are members of the California Behavioral Health Planning Council. They serve in an ex officio capacity when the council is performing its statutory duties pursuant to Section 5772. This membership does not affect the composition requirements for the council specified in Section 5771.

**SEC. 13.** Section 5771.3 of the Welfare and Institutions Code is amended to read:

**5771.3.** The California Behavioral Health Planning Council may utilize staff of the State Department of Health Care Services, to the extent they are available, and the staff of any other public or private agencies that have an interest in the mental health or substance use disorders, or both, of the public and that are able and willing to provide those services.

**SEC. 14.** Section 5771.5 of the Welfare and Institutions Code is amended to read:

**5771.5.** (a) (1) The Chairperson of the California Behavioral Health Planning Council, with the concurrence of a majority of the members of the California Behavioral Health Planning Council, shall appoint an executive officer who shall have those powers delegated to him or her by the council in accordance with this chapter.

(2) The executive officer shall be exempt from civil service.

(b) Within the limit of funds allotted for these purposes, the California Behavioral Health Planning Council may appoint other staff it may require according to the rules and procedures of the civil service system.

**SEC. 15.** Section 5772 of the Welfare and Institutions Code is amended to read:

**5772.** The California Behavioral Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

(a) To advocate for effective, quality mental health and substance use disorder programs.

(b) To review, assess, and make recommendations regarding all components of California's mental health and substance use disorder systems, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs.

(c) To review program performance in delivering mental health and substance use disorder services by annually reviewing performance outcome data as follows:

(1) To review and approve the performance outcome measures.

(2) To review the performance of mental health and substance use disorder programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources.

(3) To report findings and recommendations on the performance of programs annually to the Legislature, the State Department of Health Care Services, and the local boards, and to post those findings and recommendations annually on its Internet Web site.

(4) To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties.

(d) When appropriate, make a finding pursuant to Section 5655 that a county's performance in delivering mental health services is failing in a substantive manner. The State Department of Health Care Services shall investigate and review the finding, and report the action taken to the Legislature.

(e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health and substance use disorder issues and the policies and priorities that this state should be pursuing in developing its mental health and substance use disorder health systems.

(f) To periodically review the state's data systems and paperwork requirements to ensure that they are reasonable and in compliance with state and federal law.

(g) To make recommendations to the State Department of Health Care Services on the award of grants to county programs to reward and stimulate innovation in providing mental health and substance use disorder services.

(h) To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.

- (i) In conjunction with other statewide and local mental health and substance use disorder organizations, assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.
- (j) To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.
- (k) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health and substance use disorder systems, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.
- (l) To suggest rules, regulations, and standards for the administration of this division.
- (m) When requested, to mediate disputes between counties and the state arising under this part.
- (n) To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.
- (o) To accept any federal fund granted, by act of Congress or by executive order, for purposes within the purview of the California Behavioral Health Planning Council, subject to the approval of the Department of Finance.
- (p) To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purposes within the purview of the California Behavioral Health Planning Council, subject to the approval of the Department of Finance.
- (q) Notwithstanding subdivisions (a), (c), (e), (g), and (i), in the event that the State Department of Health Care Services determines that California's Community Mental Health Services Block Grant funding pursuant to Section 300x et seq. of Title 42 of the United States Code is in jeopardy due to the California Behavioral Health Planning Council's noncompliance with the requirements specified in Public Law 102-321, the State Department of Health Care Services shall notify and consult with the California Behavioral Health Planning Council, and the California Behavioral Health Planning Council shall make the changes necessary to comply with federal law.
- (r) The Legislature finds and declares that the amendments made to subdivisions (a), (b), (c), (e), (g), (i), and (k) by the act that added this subdivision are consistent with Section 5892.

**SEC. 16.** Section 5814 of the Welfare and Institutions Code is amended to read:

**5814.** (a) (1) This part shall be implemented only to the extent that funds are appropriated for purposes of this part. To the extent that funds are made available, the first priority shall go to maintain funding for the existing programs that meet adult system of care contract goals. The next priority for funding shall be given to counties with a high incidence of persons who are severely mentally ill and homeless or at risk of homelessness, and meet the criteria developed pursuant to paragraphs (3) and (4).

(2) The Director of Health Care Services shall establish a methodology for awarding grants under this part consistent with the legislative intent expressed in Section 5802, and in consultation with the advisory committee established in this subdivision.

(3) (A) The Director of Health Care Services shall establish an advisory committee for the purpose of providing advice regarding the development of criteria for the award of grants, and the identification of specific performance measures for evaluating the effectiveness of grants. The committee shall review evaluation reports and make findings on evidence-based best practices and recommendations for grant conditions. At not less than one meeting annually, the advisory committee shall provide to the director written comments on the performance of each of the county programs. Upon request by the department, each participating county that is the subject of a comment shall provide a written response to the comment. The department shall comment on each of these responses at a subsequent meeting.

(B) The committee shall include, but not be limited to, representatives from state, county, and community veterans' services and disabled veterans outreach programs, supportive housing and other housing assistance programs, law enforcement, county mental health and private providers of local mental health services and mental health outreach services, the Department of Corrections and Rehabilitation, local substance abuse services providers, the Department of Rehabilitation, providers of local employment services, the State Department of Social Services, the Department of Housing and Community Development, a service provider to transition youth, the United Advocates for Children of California, the California Mental Health Advocates for Children and Youth, the Mental Health Association of California, the California Alliance for the Mentally Ill, the California Network of Mental Health Clients, the California Behavioral Health Planning Council, the Mental Health Services Oversight and Accountability Commission, and other appropriate entities.

(4) The criteria for the award of grants shall include, but not be limited to, all of the following:



(A) A description of a comprehensive strategic plan for providing outreach, prevention, intervention, and evaluation in a cost appropriate manner corresponding to the criteria specified in subdivision (c).

(B) A description of the local population to be served, ability to administer an effective service program, and the degree to which local agencies and advocates will support and collaborate with program efforts.

(C) A description of efforts to maximize the use of other state, federal, and local funds or services that can support and enhance the effectiveness of these programs.

(5) In order to reduce the cost of providing supportive housing for clients, counties that receive a grant pursuant to this part after January 1, 2004, shall enter into contracts with sponsors of supportive housing projects to the greatest extent possible. Participating counties are encouraged to commit a portion of their grants to rental assistance for a specified number of housing units in exchange for the counties' clients having the right of first refusal to rent the assisted units.

(b) In each year in which additional funding is provided by the annual Budget Act the State Department of Health Care Services shall establish programs that offer individual counties sufficient funds to comprehensively serve severely mentally ill adults who are homeless, recently released from a county jail or the state prison, or others who are untreated, unstable, and at significant risk of incarceration or homelessness unless treatment is provided to them and who are severely mentally ill adults. For purposes of this subdivision, "severely mentally ill adults" are those individuals described in subdivision (b) of Section 5600.3. In consultation with the advisory committee established pursuant to paragraph (3) of subdivision (a), the department shall report to the Legislature on or before May 1 of each year in which additional funding is provided, and shall evaluate, at a minimum, the effectiveness of the strategies in providing successful outreach and reducing homelessness, involvement with local law enforcement, and other measures identified by the department. The evaluation shall include for each program funded in the current fiscal year as much of the following as available information permits:

(1) The number of persons served, and of those, the number who receive extensive community mental health services.

(2) The number of persons who are able to maintain housing, including the type of housing and whether it is emergency, transitional, or permanent housing, as defined by the department.

(3) (A) The amount of grant funding spent on each type of housing.

(B) Other local, state, or federal funds or programs used to house clients.

(4) The number of persons with contacts with local law enforcement and the extent to which local and state incarceration has been reduced or avoided.

(5) The number of persons participating in employment service programs including competitive employment.

(6) The number of persons contacted in outreach efforts who appear to be severely mentally ill, as described in Section 5600.3, who have refused treatment after completion of all applicable outreach measures.

(7) The amount of hospitalization that has been reduced or avoided.

(8) The extent to which veterans identified through these programs' outreach are receiving federally funded veterans' services for which they are eligible.

(9) The extent to which programs funded for three or more years are making a measurable and significant difference on the street, in hospitals, and in jails, as compared to other counties or as compared to those counties in previous years.

(10) For those who have been enrolled in this program for at least two years and who were enrolled in Medi-Cal prior to, and at the time they were enrolled in, this program, a comparison of their Medi-Cal hospitalizations and other Medi-Cal costs for the two years prior to enrollment and the two years after enrollment in this program.

(11) The number of persons served who were and were not receiving Medi-Cal benefits in the 12-month period prior to enrollment and, to the extent possible, the number of emergency room visits and other medical costs for those not enrolled in Medi-Cal in the prior 12-month period.

(c) To the extent that state savings associated with providing integrated services for the mentally ill are quantified, it is the intent of the Legislature to capture those savings in order to provide integrated services to additional adults.

(d) Each project shall include outreach and service grants in accordance with a contract between the state and approved counties that reflects the number of anticipated contacts with people who are homeless or at risk of homelessness, and the number of those who are severely mentally ill and who are likely to be successfully referred for treatment and will remain in treatment as necessary.

(e) All counties that receive funding shall be subject to specific terms and conditions of oversight and training, which shall be developed by the department, in consultation with the advisory committee.

(f) (1) As used in this part, "receiving extensive mental health services" means having a personal services coordinator, as described in subdivision (b) of Section 5806, and having an individual personal service plan, as described in subdivision (c) of Section 5806.

(2) The funding provided pursuant to this part shall be sufficient to provide mental health services, medically necessary medications to treat severe mental illnesses, alcohol and drug services, transportation, supportive housing and other housing assistance, vocational rehabilitation and supported employment services, money management assistance for accessing other health care and obtaining federal income and housing support, accessing veterans' services, stipends, and other incentives to attract and retain sufficient numbers of qualified professionals as necessary to provide the necessary levels of these services. These grants shall, however, pay for only that portion of the costs of those services not otherwise provided by federal funds or other state funds.

(3) Methods used by counties to contract for services pursuant to paragraph (2) shall promote prompt and flexible use of funds, consistent with the scope of services for which the county has contracted with each provider.

(g) Contracts awarded pursuant to this part shall be exempt from the Public Contract Code and the state administrative manual and shall not be subject to the approval of the Department of General Services.

(h) Notwithstanding any other provision of law, funds awarded to counties pursuant to this part and Part 4 (commencing with Section 5850) shall not require a local match in funds.

**SEC. 17.** Section 5820 of the Welfare and Institutions Code is amended to read:

**5820.** (a) It is the intent of this part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

(b) Each county mental health program shall submit to the Office of Statewide Health Planning and Development a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. For purposes of this part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.

(c) The Office of Statewide Health Planning and Development, in coordination with the California Behavioral Health Planning Council, shall identify the total statewide needs for each professional and other occupational category utilizing county needs assessment information and develop a five-year education and training development plan.

(d) Development of the first five-year plan shall commence upon enactment of the initiative. Subsequent plans shall be adopted every five years, with the next five-year plan due as of April 1, 2014.

(e) Each five-year plan shall be reviewed and approved by the California Behavioral Health Planning Council.

**SEC. 18.** Section 5821 of the Welfare and Institutions Code is amended to read:

**5821.** (a) The California Behavioral Health Planning Council shall advise the Office of Statewide Health Planning and Development on education and training policy development and provide oversight for education and training plan development.

(b) The Office of Statewide Health Planning and Development shall work with the California Behavioral Health Planning Council and the State Department of Health Care Services so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

**SEC. 19.** Section 5845 of the Welfare and Institutions Code is amended to read:

**5845.** (a) The Mental Health Services Oversight and Accountability Commission is hereby established to oversee Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act; Part 3.1 (commencing with Section 5820), Human Resources, Education, and Training Programs; Part 3.2 (commencing with Section 5830), Innovative Programs; Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs; and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act. The commission shall replace the advisory committee established pursuant to Section 5814. The commission shall consist of 16 voting members as follows:

(1) The Attorney General or his or her designee.

(2) The Superintendent of Public Instruction or his or her designee.

(3) The Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate.

(4) The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly.

(5) Two persons with a severe mental illness, a family member of an adult or senior with a severe mental illness, a family member of a child who has or has had a severe mental illness, a physician specializing in alcohol and drug treatment, a mental health professional, a county sheriff, a superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees and a representative of an employer with more than 500 employees, and a representative of a health care services plan or insurer, all appointed by the Governor. In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness. At least one of the persons appointed pursuant to this paragraph shall have a background in auditing.

(b) Members shall serve without compensation, but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

(c) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(d) In carrying out its duties and responsibilities, the commission may do all of the following:

(1) Meet at least once each quarter at any time and location convenient to the public as it may deem appropriate. All meetings of the commission shall be open to the public.

(2) Within the limit of funds allocated for these purposes, pursuant to the laws and regulations governing state civil service, employ staff, including any clerical, legal, and technical assistance as may appear necessary. The commission shall administer its operations separate and apart from the State Department of Health Care Services and the California Health and Human Services Agency.

(3) Establish technical advisory committees such as a committee of consumers and family members.

(4) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding any authority expressly granted to any officer or employee of state government.

(5) Enter into contracts.

(6) Obtain data and information from the State Department of Health Care Services, the Office of Statewide Health Planning and Development, or other state or local entities that receive Mental Health Services Act funds, for the commission to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity regarding projects and programs supported with Mental Health Services Act funds.

(7) Participate in the joint state-county decisionmaking process, as contained in Section 4061, for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.

(8) Develop strategies to overcome stigma and discrimination, and accomplish all other objectives of Part 3.2 (commencing with Section 5830), 3.6 (commencing with Section 5840), and the other provisions of the act establishing this commission.

(9) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.

(10) If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the State Department of Health Care Services pursuant to Section 5655.

(11) Assist in providing technical assistance to accomplish the purposes of the Mental Health Services Act, Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) in collaboration with the State Department of Health Care Services and in consultation with the California Mental Health Directors Association.

(12) Work in collaboration with the State Department of Health Care Services and the California Behavioral Health Planning Council, and in consultation with the California Mental Health Directors Association, in designing a comprehensive joint plan for

a coordinated evaluation of client outcomes in the community-based mental health system, including, but not limited to, parts listed in subdivision (a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.

**SEC. 19.5.** Section 5845 of the Welfare and Institutions Code is amended to read:

**5845.** (a) The Mental Health Services Oversight and Accountability Commission is hereby established to oversee Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act; Part 3.1 (commencing with Section 5820), Human Resources, Education, and Training Programs; Part 3.2 (commencing with Section 5830), Innovative Programs; Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs; and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act. The commission shall replace the advisory committee established pursuant to Section 5814. The commission shall consist of 17 voting members as follows:

(1) The Attorney General or his or her designee.

(2) The Superintendent of Public Instruction or his or her designee.

(3) The Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate.

(4) The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly.

(5) Two persons with a severe mental illness, a family member of an adult or senior with a severe mental illness, a family member of a child who has or has had a severe mental illness, a physician specializing in alcohol and drug treatment, a mental health professional, a county sheriff, a superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees and a representative of an employer with more than 500 employees, a person with knowledge and experience in reducing mental health disparities, especially for racial and ethnic communities, and a representative of a health care services plan or insurer, all appointed by the Governor. In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness. At least one of the persons appointed pursuant to this paragraph shall have a background in auditing.

(b) Members shall serve without compensation, but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

(c) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(d) In carrying out its duties and responsibilities, the commission may do all of the following:

(1) Meet at least once each quarter at any time and location convenient to the public as it may deem appropriate. All meetings of the commission shall be open to the public.

(2) Within the limit of funds allocated for these purposes, pursuant to the laws and regulations governing state civil service, employ staff, including any clerical, legal, and technical assistance as may appear necessary. The commission shall administer its operations separate and apart from the State Department of Health Care Services and the California Health and Human Services Agency.

(3) Establish technical advisory committees such as a committee of consumers and family members.

(4) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding any authority expressly granted to any officer or employee of state government.

(5) Enter into contracts.

(6) Obtain data and information from the State Department of Health Care Services, the Office of Statewide Health Planning and Development, or other state or local entities that receive Mental Health Services Act funds, for the commission to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity regarding projects and programs supported with Mental Health Services Act funds.

(7) Participate in the joint state-county decisionmaking process, as contained in Section 4061, for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.

(8) Develop strategies to overcome stigma and discrimination, and accomplish all other objectives of Part 3.2 (commencing with Section 5830), 3.6 (commencing with Section 5840), and the other provisions of the act establishing this commission.

(9) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.

(10) If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the State Department of Health Care Services pursuant to Section 5655.

(11) Assist in providing technical assistance to accomplish the purposes of the Mental Health Services Act, Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) in collaboration with the State Department of Health Care Services and in consultation with the County Behavioral Health Directors Association of California.

(12) Work in collaboration with the State Department of Health Care Services and the California Behavioral Health Planning Council, and in consultation with the County Behavioral Health Directors Association of California, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including, but not limited to, parts listed in subdivision (a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.

**SEC. 20.** Section 5848 of the Welfare and Institutions Code is amended to read:

**5848.** (a) Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.

(c) The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) funded by the Mental Health Services Fund and established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the County Behavioral Health Directors Association of California.

(d) Mental health services provided pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) shall be included in the review of program performance by the California Behavioral Health Planning Council required by paragraph (2) of subdivision (c) of Section 5772 and in the local mental health board's review and comment on the performance outcome data required by paragraph (7) of subdivision (a) of Section 5604.2.

(e) The department shall annually post on its Internet Web site a summary of the performance outcomes reports submitted by counties if clearly and separately identified by counties as the achievement of performance outcomes pursuant to subdivision (c).

**SEC. 21.** Section 5892 of the Welfare and Institutions Code, as amended by Section 13 of Chapter 38 of the Statutes of 2017, is amended to read:

**5892.** (a) In order to promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services Fund as follows:

(1) In 2005–06, 2006–07, and in 2007–08, 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.

(2) In 2005–06, 2006–07, and in 2007–08, 10 percent for capital facilities and technological needs distributed to counties in accordance with a formula developed in consultation with the County Behavioral Health Directors Association of California to implement plans developed pursuant to Section 5847.

(3) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840) of this division.

(4) The expenditure for prevention and early intervention may be increased in any county in which the department determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care.

(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division, shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.

(b) In any year after 2007–08, programs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division.

(d) Prior to making the allocations pursuant to subdivisions (a), (b), and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. The amount of funds available for the purposes of this subdivision in any fiscal year shall be subject to appropriation in the annual Budget Act.

(e) In 2004–05, funds shall be allocated as follows:

- (1) Forty-five percent for education and training pursuant to Part 3.1 (commencing with Section 5820) of this division.
- (2) Forty-five percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).
- (3) Five percent for local planning in the manner specified in subdivision (c).
- (4) Five percent for state implementation in the manner specified in subdivision (d).

(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) (1) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county that have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years, provided however, that funds for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the fund.

- (2) If a county receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) until three years after the date of the approval.

(3) Notwithstanding paragraph (1), any funds allocated to a county with a population of less than 200,000 that have not been spent for their authorized purpose within five years shall revert to the state as described in paragraph (1).

(4) Notwithstanding paragraphs (1) and (2), if a county with a population of less than 200,000 receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) until five years after the date of the approval.

(i) If there are still additional revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the commission's adopted plan that furthers the purposes of this act.

(j) For the 2011–12 fiscal year, General Fund revenues will be insufficient to fully fund many existing mental health programs, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and mental health services provided for special education pupils. In order to adequately fund those programs for the 2011–12 fiscal year and avoid deeper reductions in programs that serve individuals with severe mental illness and the most vulnerable, medically needy citizens of the state, prior to distribution of funds under paragraphs (1) to (6), inclusive, of subdivision (a), effective July 1, 2011, moneys shall be allocated from the Mental Health Services Fund to the counties as follows:

(1) Commencing July 1, 2011, one hundred eighty-three million six hundred thousand dollars (\$183,600,000) of the funds available as of July 1, 2011, in the Mental Health Services Fund, shall be allocated in a manner consistent with subdivision (c) of Section 5778 and based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California to meet the fiscal year 2011–12 General Fund obligation for Medi-Cal Specialty Mental Health Managed Care.

(2) Upon completion of the allocation in paragraph (1), the Controller shall distribute to counties ninety-eight million five hundred eighty-six thousand dollars (\$98,586,000) from the Mental Health Services Fund for mental health services for special education pupils based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California.

(3) Upon completion of the allocation in paragraph (2), the Controller shall distribute to counties 50 percent of their 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, not to exceed four hundred eighty-eight million dollars (\$488,000,000). This allocation shall commence beginning August 1, 2011.

(4) Upon completion of the allocation in paragraph (3), and as revenues are deposited into the Mental Health Services Fund, the Controller shall distribute five hundred seventy-nine million dollars (\$579,000,000) from the Mental Health Services Fund to counties to meet the General Fund obligation for EPSDT for the 2011–12 fiscal year. These revenues shall be distributed to counties on a quarterly basis and based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California. These funds shall not be subject to reconciliation or cost settlement.

(5) The Controller shall distribute to counties the remaining 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, beginning no later than April 30, 2012. These remaining allocations shall be made on a monthly basis.

(6) The total one-time allocation from the Mental Health Services Fund for EPSDT, Medi-Cal Specialty Mental Health Managed Care, and mental health services provided to special education pupils as referenced shall not exceed eight hundred sixty-two million dollars (\$862,000,000). Any revenues deposited in the Mental Health Services Fund in the 2011–12 fiscal year that exceed this obligation shall be distributed to counties for remaining fiscal year 2011–12 Mental Health Services Act component allocations, consistent with Sections 5847 and 5891.

(k) Subdivision (j) shall not be subject to repayment.

(l) Subdivision (j) shall become inoperative on July 1, 2012.

**SEC. 21.5.** Section 5892 of the Welfare and Institutions Code is amended to read:

**5892.** (a) In order to promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services Fund as follows:

(1) In 2005–06, 2006–07, and in 2007–08, 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.

(2) In 2005–06, 2006–07, and in 2007–08, 10 percent for capital facilities and technological needs distributed to counties in accordance with a formula developed in consultation with the County Behavioral Health Directors Association of California to implement plans developed pursuant to Section 5847.

(3) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840) of this division.

(4) The expenditure for prevention and early intervention may be increased in any county in which the department determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division, shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.

(b) In any year after 2007–08, programs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division.

(d) Prior to making the allocations pursuant to subdivisions (a), (b), and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. The amount of funds available for the purposes of this subdivision in any fiscal year shall be subject to appropriation in the annual Budget Act.

(e) In 2004–05, funds shall be allocated as follows:

(1) Forty-five percent for education and training pursuant to Part 3.1 (commencing with Section 5820) of this division.

(2) Forty-five percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).

(3) Five percent for local planning in the manner specified in subdivision (c).

(4) Five percent for state implementation in the manner specified in subdivision (d).

(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.



(h) (1) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county that have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years, provided however, that funds for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the fund.

(2) If a county receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) until three years after the date of the approval.

(3) Notwithstanding paragraph (1), any funds allocated to a county with a population of less than 200,000 that have not been spent for their authorized purpose within five years shall revert to the state as described in paragraph (1).

(4) Notwithstanding paragraphs (1) and (2), if a county with a population of less than 200,000 receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) until five years after the date of the approval.

(i) If there are still additional revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the commission's adopted plan that furthers the purposes of this act.

(j) For the 2011–12 fiscal year, General Fund revenues will be insufficient to fully fund many existing mental health programs, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and mental health services provided for special education pupils. In order to adequately fund those programs for the 2011–12 fiscal year and avoid deeper reductions in programs that serve individuals with severe mental illness and the most vulnerable, medically needy citizens of the state, prior to distribution of funds under paragraphs (1) to (6), inclusive, of subdivision (a), effective July 1, 2011, moneys shall be allocated from the Mental Health Services Fund to the counties as follows:

(1) Commencing July 1, 2011, one hundred eighty-three million six hundred thousand dollars (\$183,600,000) of the funds available as of July 1, 2011, in the Mental Health Services Fund, shall be allocated in a manner consistent with subdivision (c) of Section 5778 and based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California to meet the fiscal year 2011–12 General Fund obligation for Medi-Cal Specialty Mental Health Managed Care.

(2) Upon completion of the allocation in paragraph (1), the Controller shall distribute to counties ninety-eight million five hundred eighty-six thousand dollars (\$98,586,000) from the Mental Health Services Fund for mental health services for special education pupils based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California.

(3) Upon completion of the allocation in paragraph (2), the Controller shall distribute to counties 50 percent of their 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, not to exceed four hundred eighty-eight million dollars (\$488,000,000). This allocation shall commence beginning August 1, 2011.

(4) Upon completion of the allocation in paragraph (3), and as revenues are deposited into the Mental Health Services Fund, the Controller shall distribute five hundred seventy-nine million dollars (\$579,000,000) from the Mental Health Services Fund to counties to meet the General Fund obligation for EPSDT for the 2011–12 fiscal year. These revenues shall be distributed to counties on a quarterly basis and based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California. These funds shall not be subject to reconciliation or cost settlement.

(5) The Controller shall distribute to counties the remaining 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, beginning no later than April 30, 2012. These remaining allocations shall be made on a monthly basis.

(6) The total one-time allocation from the Mental Health Services Fund for EPSDT, Medi-Cal Specialty Mental Health Managed Care, and mental health services provided to special education pupils as referenced shall not exceed eight hundred sixty-two million dollars (\$862,000,000). Any revenues deposited in the Mental Health Services Fund in the 2011–12 fiscal year that exceed this obligation shall be distributed to counties for remaining fiscal year 2011–12 Mental Health Services Act component allocations, consistent with Sections 5847 and 5891.

(k) Subdivision (j) shall not be subject to repayment.

(l) Subdivision (j) shall become inoperative on July 1, 2012.

**SEC. 22.** Section 5897 of the Welfare and Institutions Code is amended to read:

**5897.** (a) Notwithstanding any other state law, the State Department of Health Care Services shall implement the mental health services provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. For purposes of this section, a county mental health program includes a city receiving funds pursuant to Section 5701.5.

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of those mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) through the annual county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2.

(d) The department shall conduct program reviews of performance contracts to determine compliance. Each county performance contract shall be reviewed at least once every three years, subject to available funding for this purpose.

(e) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific timeline to achieve improvements. The department shall post on its Internet Web site any plans of correction requested and the related findings.

(f) Contracts awarded by the State Department of Health Care Services, the State Department of Public Health, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with Section 5800), Part 3.1 (commencing with Section 5820), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and Part 4.5 (commencing with Section 5890), may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to those contracts.

(g) For purposes of Section 14712, the allocation of funds pursuant to Section 5892 which are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the State Department of Health Care Services of the anticipated county matching funds needed for community mental health programs.

**SEC. 23.** Section 14094.18 of the Welfare and Institutions Code is amended to read:

**14094.18.** (a) (1) The department shall contract with an independent entity that has experience in performing robust program evaluations to conduct an evaluation to assess Medi-Cal managed care plan performance and the outcomes and the experience of CCS-eligible children and youth participating in the Whole Child Model program, including access to primary and specialty care, and youth transitions from Whole Child Model program to adult Medi-Cal coverage.

(2) The department shall provide a report on the results of this evaluation required pursuant to this section to the Legislature by January 1, 2021, or three years from the date when all counties described in Section 14094.5 are fully operational under the Whole Child Model program pursuant to this article, whichever is later. A report submitted to the Legislature pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(b) The evaluation required by this section, at a minimum, shall evaluate the performance of the plans participating in the Whole Child Model program as compared to the performance of the CCS program prior to the implementation of the Whole Child Model program in those same counties. The evaluation shall evaluate whether the inclusion of CCS services in a managed care delivery system improves access to care, quality of care, and the patient experience by analyzing all of the following, and when possible, disaggregating the results, based on the child's or youth's race, ethnicity, and primary language spoken at home:

(1) Access to specialty and primary care, and in particular, utilization of CCS-paneled providers.

(2) The type and location of CCS services and the extent to which CCS services are provided in-network compared to out of network.

(3) Utilization rates of inpatient admissions, outpatient services, durable medical equipment, behavioral health services, home health, pharmacy, and other ancillary services.

(4) Patient and family satisfaction.

(5) Appeals and grievances, including the number of petitions to the plan to extend the continuity of care period for durable medical equipment and CCS providers, the results of those appeals, whether any subsequent appeals were made to the department, and the results of those appeals to the department.

(6) Authorization of CCS-eligible services.

(7) Network and provider participation, including participation of pediatricians, pediatric specialists, and pediatric subspecialists, by specialty and subspecialty.

(8) The ability of a child or youth who ages out of CCS and remains in the same Medi-Cal managed care plan to retain his or her existing providers, to the extent possible or known.

(c) The evaluation required by this section shall also evaluate managed care plans participating in the Whole Child Model program as compared to the CCS program in counties where CCS services are not incorporated into managed care, and collect appropriate data to evaluate all of the following:

(1) The rate of new CCS enrollment in each county.

(2) The percentage of CCS-eligible children and youth with a diagnosis requiring a referral to a CCS special care center who have been seen by a CCS special care center.

(3) The percentage of CCS children and youth discharged from a hospital who had at least one followup contact or visit within 28 days after discharge.

(4) Appeals and grievances.

(d) The department shall consult with stakeholders, including, but not limited to, the Whole Child Model program stakeholder advisory group, regarding the scope and structure of the review.

**SEC. 24.** Section 14102.5 of the Welfare and Institutions Code is amended to read:

**14102.5.** (a) The department shall, in collaboration with the Exchange, the counties, consumer advocates, and the Statewide Automated Welfare System consortia, develop and prepare one or more reports that shall be issued on at least a biannual basis and shall be made publicly available within 90 days following the end of each reporting period, for the purpose of informing the California Health and Human Services Agency, the Exchange, the Legislature, and the public about the enrollment process for all insurance affordability programs. The data within the reports shall be aggregated and calculated on at least a quarterly basis. The reports shall comply with federal reporting requirements and shall, at a minimum, include the following information, to be derived from, as appropriate depending on the data element, CalHEERS, MEDS, or the Statewide Automated Welfare System:

(1) For applications received for insurance affordability programs through any venue, all of the following:

(A) The number of applications received through each venue.

(B) The number of applicants included on those applications.

(C) Applicant demographics, including, but not limited to, gender, age, race, ethnicity, and primary language.

(D) The disposition of applications, including all of the following:

(i) The number of eligibility determinations that resulted in an approval for coverage.

(ii) The program or programs for which the individuals in clause (i) were determined eligible.

(iii) The number of applications that were denied for any coverage and the reason or reasons for the denials.

(E) The number of days for eligibility determinations to be completed.

(2) With regard to health plan selection, all of the following:

(A) The health plans that are selected by applicants enrolled in an insurance affordability program, reported by the program.

(B) The number of Medi-Cal enrollees who do not select a health plan but are defaulted into a plan.

(3) For annual redeterminations conducted for beneficiaries, all of the following:

(A) The number of redeterminations processed.

(B) The number of redeterminations that resulted in continued eligibility for the same insurance affordability program.

(C) The number of redeterminations that resulted in a change in eligibility to a different insurance affordability program.

(D) The number of redeterminations that resulted in a finding of ineligibility for any program and the reason or reasons for the findings of ineligibility.

(E) The number of days for redeterminations to be completed.

(4) With regard to disenrollments not related to a redetermination of eligibility, all of the following:

(A) The number of beneficiary disenrollments.

(B) The reasons for the disenrollments.

(C) The number of disenrollments that are caused by an individual disenrolling from one insurance affordability program and enrolling into another.

(5) The number of applications for insurance affordability programs that were filed with the help of an assister or navigator.

(6) The total number of grievances and appeals filed by applicants and enrollees regarding eligibility for insurance affordability programs, the basis for the grievance, and the outcomes of the appeals.

(b) The department shall collect the information necessary for these reports and develop these reports using data obtained from the Statewide Automated Welfare System, CalHEERS, MEDS, and any other appropriate state information management systems.

(c) For purposes of this section, the following definitions shall apply:

(1) "CalHEERS" means the California Healthcare Eligibility, Enrollment, and Retention System developed under Section 15926.

(2) "Exchange" means the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(3) "Statewide Automated Welfare System" means the system developed pursuant to Section 10823.

(4) "MEDS" means the Medi-Cal Eligibility Data System that is maintained by the department.

**SEC. 25.** Section 14124.1 of the Welfare and Institutions Code is amended to read:

**14124.1.** Each provider, as defined in Section 14043.1, of health care services rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, shall keep and maintain records of each service rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, the beneficiary or person to whom rendered, the date the service was rendered, and any additional information as the department may by regulation require. Records required to be kept and maintained under this section shall be retained by the provider for a period of 10 years from the final date of the contract period between the plan and the provider, from the date of completion of any audit, or from the date the service was rendered, whichever is later, in accordance with Section 438.3(u) of Title 42 of the Code of Federal Regulations.

**SEC. 26.** Section 14133.5 of the Welfare and Institutions Code is repealed.

**SEC. 27.** Section 14133.51 of the Welfare and Institutions Code is repealed.

**SEC. 28.** Section 14149.8 of the Welfare and Institutions Code is amended to read:

**14149.8.** (a) The department shall expedite the enrollment of Medi-Cal dental providers by streamlining the Medi-Cal provider enrollment process. The department shall pursue and implement all of the following activities, to the extent permitted by federal law:

(1) Create a dental-specific enrollment form.

(2) Pursue an alternative automatic enrollment process for a provider already commercially credentialed by either a dental fee-for-service contractor or an administrative services contractor for the purpose of providing services as a commercial provider.

(3) Discontinue requiring providers to resubmit an enrollment application that has been deemed incomplete if the missing information is available elsewhere within the application packet.

(4) To the extent that the department expedites the enrollment of Medi-Cal dental providers by streamlining the Medi-Cal provider enrollment process, the department shall publish the criteria for those processes in applicable provider bulletins and

manuals.

- (b) (1) The department shall maintain the provider network on a monthly basis by deactivating a billing provider who has not, over a continuous 12-month period, submitted a claim for reimbursement for services rendered.
- (2) Prior to deactivating a provider described in paragraph (1), the department shall send a notice to the provider informing the provider that the provider shall be deactivated from the dental program unless the provider requests reactivation within six months after the date of the notice. The department shall not disenroll a provider until six months after the date of that notice. This paragraph shall not be implemented until the date the department implements and programs the necessary system changes to the California Dental Medicaid Management Information Systems to implement this paragraph, or no sooner than July 1, 2017, whichever is later.
- (3) In order to improve the quality of the dental provider network, the department also shall exercise additional measures as appropriate and permitted by law, including, but not limited to, temporary suspensions. The parameters and criteria developed by the department for additional measures for deactivations and disenrollments shall be published in applicable provider bulletins and manuals.
- (c) (1) The department shall monitor access and utilization of Medi-Cal dental services in the fee-for-service and managed care delivery systems to assess opportunities to improve access and utilization, including an annual review of the treatment authorization review process.
- (2) The department shall assess opportunities to develop and implement innovative payment reform proposals within the Medi-Cal dental programs.
- (d) The department shall explore additional opportunities to improve the Medi-Cal Dental Program, in consultation with stakeholders and as deemed appropriate by the department and to the extent permitted by federal law, including, but not limited to, the following:
- (1) Aligning the provision of dental anesthesia services with that of medical anesthesia services, including the ability to bill for applicable facility fees and ancillary services.
- (2) Adjusting other utilization controls for specialty services, as appropriate, to promote access to care while still protecting program integrity.
- (3) Expanding the scope of beneficiary outreach activities required by an entity that is contracted with the department to more broadly address underutilization throughout the state.
- (e) Prior to implementing an action pursuant to subdivision (d), the department shall post the proposed action on its Internet Web site at least 30 days before implementation.
- (f) The department shall work with dental managed care plans that contract with the department for the purposes of implementing the Medi-Cal Dental Program, which includes, but is not limited to, contracts authorized pursuant to Sections 14087.46, 14089, and 14104.3, to provide beneficiaries with access to dental plan liaisons to assist in the coordination of care for enrolled members.
- (g) A Medi-Cal managed care health plan shall do all of the following:
- (1) Provide dental screenings for every eligible beneficiary as a part of the beneficiary's initial health assessment.
- (2) Ensure that an eligible beneficiary is referred to an appropriate Medi-Cal dental provider.
- (3) Identify plan liaisons available to dental managed care contractors and dental fee-for-service contractors to assist with referrals to health plan covered services.
- (h) In accordance with Section 438.230(c)(3) of Title 42 of the Code of Federal Regulations, effective for the rating period for contracts with dental managed care plans beginning on or after July 1, 2017, the department shall require that the dental managed care plans provide that the department, the federal Centers for Medicare and Medicaid Services, the federal Office of the Inspector General, the federal Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the managed care entity, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this subdivision exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- (i) In accordance with Section 438.230(c)(3) of Title 42 of Code of Federal Regulations, effective for the rating period for contracts with dental managed care plans beginning on or after July 1, 2017, the department shall require that the dental managed care

plan contractors retain, and require its subcontractors to retain, as applicable, all of the following information for a period of no less than 10 years:

(1) Enrollee grievance and appeal records.

(2) Base data.

(3) Medical loss ratio reports.

(4) The data, information, and documentation specified in federal Medicaid regulations, including Sections 438.604, 438.606, 438.608, and 438.610 of Title 42 of the Code of Federal Regulations.

(j) (1) To increase the efficiency and timeliness of changes, any contract amendment, modification, or change order to any contract entered into by the department for the purposes of implementing the state Medi-Cal Dental Program shall be exempt, except as provided in paragraph (2), from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, as well as Sections 11545 and 11546 of the Government Code, in addition to any policies, procedures, or regulations authorized by those provisions.

(2) Paragraph (1) shall not exempt the department from establishing a competitive bid process for awarding new contracts pursuant to Section 14104.3, as well as for awarding new dental contracts pursuant to Sections 14087.46 and 14089.

(k) Prior to implementing any change pursuant to this section, the department shall consult with, and provide notification to, stakeholders, including representatives from counties, local dental societies, nonprofit entities, legal aid entities, and other interested parties.

(l) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific policies and procedures pertaining to the dental fee-for-service program and dental managed care plans, as well as applicable federal waivers and state plan amendments, including the provisions set forth in this section, by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until regulations are adopted.

(2) No later than December 31, 2018, the department shall adopt regulations 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. Beginning six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(m) This section shall be implemented only to the extent that all of the following occur:

(1) The department obtains any federal approvals necessary to implement this section.

(2) The department obtains federal matching funds to the extent permitted by federal law.

**SEC. 29.** Section 14304 of the Welfare and Institutions Code is amended to read:

**14304.** (a) The director shall terminate a contract with a prepaid health plan or a Medi-Cal managed health care plan if he or she finds that the standards prescribed in this chapter, the regulations, or the contract are not being complied with, that claims accrued or to accrue have not or will not be recompensed, or for other good cause shown. Good cause includes, but is not necessarily limited to, three repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care, as defined by the department in accordance with this section, identified in the medical audits conducted by the department. Except in the event that the director determines there is an immediate threat to the health of Medi-Cal beneficiaries enrolled in the plan, at the request of the plan, the department shall hold a public hearing to commence 30 days after notice of intent to terminate the contract has been received by the plan. The department shall present evidence at the hearing showing good cause for the termination. The department shall assign an administrative law judge who shall provide a written recommendation to the department on the termination of the contract within 30 days after conclusion of the hearing. Reasonable notice of the hearing shall be given to the plan, to Medi-Cal beneficiaries enrolled in the plan, and others who may be directly interested, including any other persons and organizations as the director may deem necessary. The notice shall state the effective date of, and the reason for, the termination.

(b) In lieu of contract termination specified in subdivision (a), the director shall have the power and authority to take one or more of the following sanctions against a contractor for noncompliance with the findings by the director as specified in subdivision (a):

(1) Suspend enrollment and marketing activities.

(2) Require the contractor to suspend or terminate contractor personnel or subcontractors.

(3) Impose civil penalties in accordance with Section 438.704 of Title 42 of the Code of Federal Regulations, as follows:

(A) A limit of twenty-five thousand dollars (\$25,000) for each determination of the following:

(i) The contractor fails to provide medically necessary services that the contractor is required to provide, under law or under its contract with the department, to an enrollee covered under the contract.

(ii) The contractor misrepresents or falsifies information that is furnished to an enrollee, potential enrollee, or health care provider.

(iii) The contractor distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the department or that contain false or materially misleading information.

(B) A limit of one hundred thousand dollars (\$100,000) for each determination of the following:

(i) The contractor conducts any act of discrimination against an enrollee on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

(ii) The contractor misrepresents or falsifies information that it furnishes to the federal Centers for Medicare and Medicaid Services or to the department.

(C) A limit of fifteen thousand dollars (\$15,000) for each beneficiary the department determines was not enrolled because of a discriminatory practice under clause (i) of subparagraph (B) of paragraph (3). This sanction is subject to the overall limit of one hundred thousand dollars (\$100,000) under subparagraph (B) of paragraph (3).

(4) (A) Notwithstanding the penalties assessed for the violations set forth in subparagraphs (A), (B), and (C) of paragraph (3), the director may impose civil penalties in accordance with this section, as follows:

(i) The contractor violates any federal or state statute or regulation.

(ii) The contractor violates any provision of its contract with the department.

(B) The civil penalties under this paragraph shall be assessed as follows:

(i) Five thousand dollars (\$5,000) for the first violation.

(ii) Ten thousand dollars (\$10,000) for the second violation.

(iii) Up to twenty-five thousand dollars (\$25,000) for each subsequent violation.

(5) Make one or more of the temporary suspension orders set out in subdivision (d).

(6) Take other appropriate action as determined necessary by the department.

The director shall give reasonable notice of his or her intention to apply any of the sanctions authorized by this subdivision to the plan and others who may be directly interested, including any other persons and organizations as the director may deem necessary. The notice shall include the effective date, the duration of, and the reason for each sanction proposed by the director. The penalties described in paragraphs (3) and (4) may be separately and independently assessed. Unless imposed in error, the penalties described in paragraphs (3) and (4) shall not be returned to the plan.

(c) Notwithstanding subdivision (b), the director shall terminate a contract with a prepaid health plan which the United States Secretary of Health and Human Services has determined does not meet the requirements for participation in the Medicaid program contained in Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(d) The department may make one or more of the following temporary suspension orders as an immediate sanction: temporarily suspend enrollment activities, temporarily suspend marketing activities, require the contractor temporarily to suspend specified personnel of the contractor, or require the contractor temporarily to suspend participation by a specified subcontractor. The temporary suspension orders must be effective no earlier than 20 days after the notice specified in subdivision (b).

If the department issues a temporary suspension order as an immediate sanction, it shall notify the contractor of the nature and effective date of the temporary suspension and at the same time shall serve the provider with an accusation. Upon receipt of a notice of defense filed by the contractor, the department shall within 15 days set the matter for hearing, which shall be held as soon as possible, but not later than 30 days after receipt of the notice of hearing by the contractor. The hearing may be continued at the request of the contractor if a continuance is necessary to permit presentation of an adequate defense. The temporary

suspension order shall remain in effect until the hearing is completed and the department has made a final determination on the merits. However, the temporary suspension order shall be deemed vacated if the director fails to make a final determination on the merits within 60 days after the original hearing has been completed.

(e) A contractor may request a hearing in connection with any sanctions applied pursuant to subdivision (b), other than those contained in a temporary suspension order, within 15 working days after the notice of the effective date of the sanctions has been given, by sending a letter so stating to the address specified in the notice. The department shall stay implementation of the sanction upon receipt of the request for a hearing. Implementation of the sanction shall remain stayed until the effective date of the final decision of the department.

(f) Except as otherwise provided in this section, all hearings to review the imposition of sanctions, including temporary suspension orders, shall be held pursuant to the procedures set forth in Section 100171 of the Health and Safety Code.

(g) The director may collect civil penalties by withholding the amount from capitation owed to the plan.

**SEC. 30.** Section 14459.5 of the Welfare and Institutions Code is amended to read:

**14459.5.** (a) As delegated by the federal government, the department has responsibility for monitoring the quality of all Medicaid services provided in the state. A key component of this monitoring function is the performance of annual, independent, external reviews of the quality of services furnished under each state contract with a health maintenance organization, as specified by the federal Centers for Medicare and Medicaid Services.

(b) In accordance with Section 438.332 of Title 42 of the Code of Federal Regulations, the department shall require, through its contracts, that each managed care plan inform the department whether it has been accredited by a private independent accrediting entity.

(c) In accordance with Section 438.332 of Title 42 of the Code of Federal Regulations, the department shall require, through its contracts, that each managed care plan that has received accreditation by a private independent accrediting entity shall authorize the private independent accrediting entity to provide the department a copy of its most recent accreditation review, including all of the following:

(1) Accreditation status, survey type, and level, as applicable.

(2) Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings.

(3) Expiration date of the accreditation.

(d) The Legislature finds and declares that the final report obtained from the external reviews will provide valid and reliable information regarding health care outcomes and the overall quality of care delivered by the managed care plans.

(e) The department shall make the final report of each external review available, within 30 calendar days of completion, to the fiscal and health policy committees of the Legislature.

(f) In accordance with Section 438.332 of Title 42 of the Code of Federal Regulations, the department shall make the accreditation status for each contracted entity available on its Internet Web site, including whether each entity has been accredited, and if applicable, the name of the accrediting entity, accreditation program, and accreditation level. The department shall update this information at least annually.

(g) Subdivisions (b), (c), and (f) shall be effective for the rating period for managed care plan contracts beginning on or after July 1, 2017.

**SEC. 31.** Section 14459.6 of the Welfare and Institutions Code is amended to read:

**14459.6.** (a) The department shall establish a list of performance measures to ensure dental health plans meet quality criteria required by the department. The list shall specify the benchmarks used by the department to determine whether and the extent to which a dental health plan meets each performance measure. Commencing January 1, 2013, and quarterly thereafter, the list of performance measures established by the department along with each plan's performance shall be posted on the department's Internet Web site. The Department of Managed Health Care and the advisory committee established pursuant to Section 14089.08 shall have access to all performance measures and benchmarks used by the department as described in this section.

(1) Commencing April 30, 2017, the quarterly reporting required by this subdivision shall be posted in the following manner:

(A) On or before April 30, 2017, the reporting shall be posted for the July 2016 to September 2016, inclusive, fiscal quarter.



(B) After April 30, 2017, the reporting shall be posted on a quarterly basis on or before April 30, July 31, October 31, and January 31 for the fiscal quarter ending seven months prior.

(2) The performance measures established by the department shall include, but not be limited to, all of the following: provider network adequacy, overall utilization of dental services, annual dental visits, the total number of patients seen on a per-provider basis and the total number of dental services rendered by each provider during each calendar year, use of preventive dental services, use of dental treatment services, use of examinations and oral health evaluations, sealant to restoration ratio, filling to preventive services ratio, treatment to caries prevention ratio, use of dental sealants, use of diagnostic services, and survey of member satisfaction with plans and providers.

(3) The survey of member satisfaction with plans and providers shall be the same dental version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as used by the Healthy Families Program.

(4) The department shall notify dental health plans at least 30 days prior to the implementation date of these performance measures.

(5) The department shall include the initial list of performance measures and benchmarks in any dental health contracts entered into between the department and a dental health plan pursuant to Section 14204.

(6) The department shall update performance measures and benchmarks and establish additional performance measures and benchmarks in accordance with all of the following:

(A) The department shall consider performance measures and benchmarks established by other states, the federal government, and national organizations developing dental program performance and quality measures.

(B) The department shall notify dental health plans at least 30 days prior to the implementation date of updates or changes to performance measures and benchmarks. The department shall also post these updates or changes on its Internet Web site at least 30 days prior to implementation in order to provide transparency to the public.

(C) To ensure that the dental health needs of Medi-Cal beneficiaries are met, the department shall, when evaluating performance measures and benchmarks for retention on, addition to, or deletion from the list, consider all of the following criteria:

(i) Monthly, quarterly, annual, and multiyear Medi-Cal dental managed care trended data.

(ii) County and statewide Medi-Cal dental fee-for-service performance and quality ratings.

(iii) Other state and national dental program performance and quality measures.

(iv) Other state and national performance ratings.

(b) In establishing and updating the performance measures and benchmarks, the department shall consult the advisory committee established pursuant to Section 14089.08, as well as dental health plan representatives and other stakeholders, including representatives from counties, local dental societies, nonprofit entities, legal aid entities, and other interested parties.

(c) In evaluating a dental health plan's ability to meet the criteria established through the performance measures and benchmarks, the department shall select specific performance measures from those established by the department in subdivision (a) as the basis for establishing financial or other incentives or disincentives, including, but not limited to, bonuses, payment withholds, and adjustments to beneficiary assignment to plan algorithms. These incentives and disincentives shall be included in the dental health plan contracts.

(d) (1) The department shall designate a qualified external quality review organization (EQRO) that shall conduct external quality reviews for any dental health plan contracting with the department pursuant to Section 14204.

(2) As determined by the department, but at least annually, dental health plans shall arrange for an external quality of care review with the EQRO designated by the department that evaluates the dental health plan's performance in meeting the performance measures established in this section. Dental health plans shall cooperate with and assist the EQRO in this review. The Department of Managed Health Care shall have direct access to all external quality of care review information upon request to the department.

(3) (A) No later than July 1, 2018, the department shall require that the dental EQRO shall have sufficient information to use in performing the review, and the department shall require the external quality review (EQR) to comply with the following requirements:

(i) The information used to carry out the review shall be obtained from the EQR-related activities in accordance with federal Medicaid regulations, including Section 438.358 of Title 42 of the Code of Federal Regulations, or, if applicable, from a Medicare or private accreditation review as authorized under Section 438.360 of Title 42 of the Code of Federal Regulations.

(ii) For each EQR-related activity, the information gathered for use in the EQR shall include the elements described in federal Medicaid regulations, including the elements described in Section 438.364(a)(2)(i) to (iv), inclusive, of Title 42 of the Code of Federal Regulations.

(iii) The information provided to the EQRO in accordance with this paragraph is obtained through methods consistent with the protocols established by the federal Secretary of Health and Human Services in accordance with federal Medicaid regulations, including Section 438.352 of Title 42 of the Code of Federal Regulations.

(iv) The results of the reviews are made available as specified in federal Medicaid regulations, including Section 438.364 of Title 42 of the Code of Federal Regulations.

(B) The qualified EQRO shall produce and submit to the department an annual EQR technical report in accordance with Section 438.364(a) of Title 42 of the Code of Federal Regulations. The department shall finalize the annual technical report by April 30 of each year.

(C) Once the annual technical report is finalized, the department shall post by April 30 of each year the most recent copy of the annual EQR technical report on the Internet Web site required under Section 438.10(c)(3) of Title 42 of the Code of Federal Regulations.

(D) An external quality of care review shall include, but not be limited to, all of the following: performance on the selected performance measures and benchmarks established and updated by the department, the CAHPS member or consumer satisfaction survey referenced in paragraph (2) of subdivision (a), reporting systems, and methodologies for calculating performance measures. An external quality of care review that includes all of the above components shall be paid for by the dental health plan and posted online annually, or at any other frequency specified by the department, on the department's Internet Web site. The department shall provide printed or electronic copies of the information specified under Section 438.364(a) of Title 42 of the Code of Federal Regulations, upon request, to interested parties, such as participating health care providers, enrollees and potential enrollees of the managed care plan entity, beneficiary advocacy groups, and members of the general public.

(E) The department shall make the information specified in Section 438.364(a) of Title 42 of the Code of Federal Regulations available in alternative formats for persons with disabilities, when requested.

(e) All marketing methods and activities to be used by dental plans shall comply with subdivision (b) of Section 10850, Sections 14407.1, 14408, 14409, 14410, and 14411, and Title 22 of the California Code of Regulations, including Sections 53880 and 53881 of Title 22 of the California Code of Regulations. Each dental plan shall submit its marketing plan to the department for review and approval.

(f) Each dental plan shall submit its member services procedures, beneficiary informational materials, and any updates to those procedures or materials to the department for review and approval. The department shall ensure that member services procedures and beneficiary informational materials are clear and provide timely and fair processes for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits.

(g) Each dental plan shall submit its provider compensation agreements to the department for review and approval.

(h) The department shall post on its Internet Web site a copy of all final reports completed by the Department of Managed Health Care regarding dental managed care plans.

(i) The department shall ensure, to the greatest degree possible, that the categories of data and performance measures selected under this section are consistent with the categories of data and performance measures selected under Section 14132.915.

**SEC. 32.** Section 14682.1 of the Welfare and Institutions Code is amended to read:

**14682.1.** (a) The State Department of Health Care Services shall be designated as the state agency responsible for development, consistent with the requirements of Section 4060, and implementation of, mental health plans for Medi-Cal beneficiaries.

(b) The department shall convene a steering committee for the purpose of providing advice and recommendations on the transition and continuing development of the Medi-Cal mental health managed care systems pursuant to subdivision (a). The committee shall include work groups to advise the department of major issues to be addressed in the managed mental health care plan, as well as system transition and transformation issues pertaining to the delivery of mental health care services to Medi-

Cal beneficiaries, including services to children provided through the Early and Periodic Screening, Diagnosis, and Treatment Program.

(c) The committee shall consist of diverse representatives of concerned and involved communities, including, but not limited to, beneficiaries, their families, providers, mental health professionals, substance use disorder treatment professionals, statewide representatives of health care service plans, representatives of the California Behavioral Health Planning Council, public and private organizations, county behavioral health directors, and others as determined by the department. The department has the authority to structure this steering committee process in a manner that is conducive for addressing issues effectively, and for providing a transparent, collaborative, meaningful process to ensure a more diverse and representative approach to problem-solving and dissemination of information.

**SEC. 33.** (a) Section 19.5 of this bill incorporates amendments to Section 5845 of the Welfare and Institutions Code proposed by both this bill and Assembly Bill 850. That section shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2018, (2) each bill amends Section 5845 of the Welfare and Institutions Code, and (3) this bill is enacted after Assembly Bill 850, in which case Section 19 of this bill shall not become operative.

(b) Section 21.5 of this bill incorporates amendments to Section 5892 of the Welfare and Institutions Code proposed by both this bill and Assembly Bill 727. That section shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2018, (2) each bill amends Section 5892 of the Welfare and Institutions Code, and (3) this bill is enacted after Assembly Bill 727, in which case Section 21 of this bill shall not become operative.