§ 1374.723. Requirements pursuant to CARE agreement or CARE plan

(a) A health care service plan contract issued, amended, renewed, or delivered on or after July 1, 2023, that covers hospital, medical, or surgical expenses shall cover the cost of developing an evaluation pursuant to Section 5977.1 of the Welfare and Institutions Code and the provision of all health care

services for an enrollee when required or recommended for the enrollee pursuant to a CARE agreement or a CARE plan approved by a court in accordance with the court's authority under Sections 5977.1, 5977.2, 5977.3, and 5982 of the Welfare and Institutions Code, regardless of whether the service is provided by an in-network or out-of-network provider.

(b)(1) A health care service plan shall not require prior authorization for services, other than prescription drugs, provided pursuant to a CARE agreement or CARE plan approved by a court pursuant to Part 8 (commencing with Section 5970) of Division 5 of the Welfare and Institutions Code.

(2) A health care service plan may conduct a postclaim review to determine appropriate payment of a claim. Payment for services subject to this section may be denied only if the health care service plan reasonably determines the enrollee was not enrolled with the plan at the time the services were rendered, the services were never performed, or the services were not provided by a health care provider appropriately licensed or authorized to provide the services.

(3) Notwithstanding paragraph (1), a health care service plan may require prior authorization for services as permitted by the department pursuant to subdivision (e).

(c)(1) A health care service plan shall provide for reimbursement of services provided to an enrollee pursuant to this section, other than prescription drugs, at the greater of either of the following amounts:

(A) The health plan's contracted rate with the provider.

(B) The fee-for-service or case reimbursement rate paid in the Medi-Cal program for the same or similar services as identified by the State Department of Health Care Services.

(2) A health care service plan shall provide for reimbursement of prescription drugs provided to an enrollee pursuant to this section at the health care service plan's contracted rate.

(3) A health care service plan shall provide reimbursement for services provided pursuant to this section in compliance with the requirements for timely payment of claims, as required by this chapter.

(d) Services provided to an enrollee pursuant to a CARE agreement or CARE plan, excluding prescription drugs, shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. An individual or entity shall not bill the enrollee or subscriber, nor seek reimbursement from the enrollee or subscriber, for services provided pursuant to a CARE agreement or CARE plan, regardless of whether the service is delivered by an in-network or out-of-network provider.

(e) No later than July 1, 2023, the department may issue guidance to health care service plans regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Guidance issued pursuant to this subdivision shall be effective only until the department adopts regulations pursuant to the Administrative Procedure Act.

(f) This section does not excuse a health care service plan from complying with Section 1374.72.

(g) This section does not apply to Medi-Cal managed care contracts entered pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commenc-

ing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(h) This section shall become operative on July 1, 2023.

HISTORY:
Added Stats 2022 ch 319 § 2 (SB 1338), effective January 1, 2023, operative July 1, 2023.

§ 1374.724. Mental health and substance use disorder treatment pro- vided by 988 center, mobile crisis team or other behavioral health crisis services provider

(a) Coverage of mental health and substance use disorder treatment pursuant to Section 1374.72 includes behavioral health crisis services that are provided to an enrollee by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, as set forth in Chapter 1 (commencing with Section 53000) of Part 1 of Division 2 of Title 5 of the Government Code, regardless of whether the service is provided by an in-network or out-of-network provider or facility. With respect to behavioral health crisis services provided to an enrollee by a 988 center or mobile crisis team, a health care service plan shall cover, at a minimum, all items and services that are eligible for coverage under the Medi-Cal program.

(b)(1) A health care service plan shall not require prior authorization for behavioral health crisis stabilization services and care provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services to an enrollee pursuant to Chapter 1 (commencing with Section 53000) of Part 1 of Division 2 of Title 5 of the Government Code.

(2) Notwithstanding any other law, payment for behavioral health crisis stabilization services and care pursuant to this section shall not be denied unless the health care service plan, or its contracting medical provider, reasonably determines that the services were never performed.

(3) If its prior authorization requirements comply with Section 1374.721, a health care service plan may require prior authorization as a prerequisite for payment for medically necessary mental health or substance use disorder services following stabilization from a behavioral health crisis addressed by services provided through the 988 system. If there is a disagreement between the health care service plan and the behavioral health crisis service provider or facility regarding the need for medically necessary mental health or substance use disorder services following stabilization of the enrollee, the plan shall assume responsibility for the care of the enrollee by arranging for services for the enrollee pursuant to Section 1374.72 at a level of care consistent with utilization review criteria pursuant to Section 1374.721.

(4) A health care service plan shall not require, under any circumstances, a behavioral health crisis services provider or facility to discharge or transfer an enrollee before stabilization has occurred or before utilization review consistent with Section 1374.721.

(c)(1) A health care service plan that is contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services shall, within 30 minutes of the time the provider makes the initial telephone call

requesting information, either authorize poststabilization care or inform the provider that it will arrange for the prompt transfer of the enrollee's care to another provider.

(2) A health care service plan that is contacted by a 988 center, mobile crisis team, or other provider of behavioral health crisis services shall reimburse the provider for poststabilization care rendered to the enrollee if any of the following occur:

(A) The health care service plan authorized the 988 center, mobile crisis team, or other provider of behavioral health crisis services to provide poststabilization care.

(B) The health care service plan did not respond to the provider's initial contact or did not make a decision regarding whether to authorize poststabilization care or to promptly transfer the enrollee's care within the timeframe set forth in paragraph (1).

(C) There is an unreasonable delay in the transfer of the enrollee's care to another provider, and the provider determines that the enrollee requires poststabilization care.

(3) A health care service plan shall prominently display on its internet website the specific telephone number for noncontracting providers to obtain prompt authorization for the transfer of a stabilized enrollee's care to another provider or authorization to provide poststabilization care. The health care service plan shall ensure the telephone number published on its internet website is the correct telephone number for purposes of this paragraph. The health care service plan shall update the telephone number on the plan's internet website within one business day if the telephone number changes. A health care service plan shall provide the telephone number to the department, and the department shall post the telephone number on its internet website.

(4) To the extent permissible under federal law, a health care service plan shall not require a 988 center, mobile crisis team, or other provider of behavioral health crisis services to make more than one telephone call to the number provided in advance by the health care service plan. The representative of the 988 center, mobile crisis team, or other provider of behavioral health crisis services that makes the telephone call may be, but is not required to be, a physician or surgeon.

(5) A 988 center, mobile crisis team, or other provider of behavioral health crisis services shall not bill a patient who is an enrollee of a health care service plan for poststabilization care, except for the in-network cost-sharing amount as defined in paragraph (2) of subdivision (d). An enrollee who is billed in violation of this section may report receipt of the bill to the health care service plan and the department. The department shall forward that report to the State Department of Public Health.

(d)(1) Notwithstanding subdivision (f) of Section 1371.4, a health care service plan shall reimburse a 988 center, mobile crisis team, or other provider of behavioral health crisis services for emergency and nonemergency behavioral health crisis services and care pursuant to this section, consistent with the requirements of Section 1371.4 and any other applicable requirement of this chapter.

(2) If an enrollee receives services and care pursuant to this section from a 988 center, mobile crisis team, or other provider of behavioral health crisis

services outside the plan network, the enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same services received from an in-network provider. This amount shall be referred to as the "in-network cost-sharing amount." An out-of-network 988 center, mobile crisis team, or other provider of behavioral health crisis services shall not bill or collect an amount from the enrollee for services subject to this section except for the in-network cost-sharing amount.

(e) For purposes of this section:

(1) "Behavioral health crisis services" has the same meaning as set forth in Section 53123.1.5 of the Government Code.

(2) "Behavioral health crisis stabilization services" means the services necessary to determine if a behavioral health crisis exists and, if a behavioral health crisis does exist, the care and treatment that is necessary to stabilize the behavioral health crisis within the capability of the 988 center, mobile crisis team, or other provider of behavioral health crisis services.

(3) "Poststabilization care" means medically necessary care provided after a behavioral health crisis has been stabilized.

(4) An enrollee is "stabilized" or "stabilization" has occurred when, in the opinion of the treating provider or facility, the enrollee's condition is such that, within reasonable medical probability, both of the following criteria are satisfied:

(A) Material deterioration of the enrollee's condition is unlikely to result from, or occur during, the discharge or transfer of the enrollee to the care of another provider.

(B) The enrollee is able to safely travel from the site of care using nonmedical transportation or nonemergency medical transportation. The health care service plan shall continue to cover all services and care as behavioral health crisis stabilization services and care until the enrollee is discharged or transferred.

(f) This section does not excuse a health care service plan from complying with Section 1374.72 or any other requirement of this chapter.

(g) This section does not apply to Medi-Cal managed care contracts entered pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

HISTORY:

Added Stats 2022 ch 747 § 3 (AB 988), effective September 29, 2022. Amended Stats 2023 ch 42 § 17 (AB 118), effective July 10, 2023.