BILL NUMBER: SB 946 AMENDED
BILL TEXT

AMENDED IN ASSEMBLY SEPTEMBER 9, 2011
AMENDED IN ASSEMBLY SEPTEMBER 6, 2011
AMENDED IN ASSEMBLY SEPTEMBER 2, 2011
AMENDED IN SENATE MAY 10, 2011

INTRODUCED BY Senators Steinberg and Evans
(Principal coauthor: Senator Alquist)
(Principal coauthor: Assembly Member Beall)
(Coauthors: Senators Corbett, DeSaulnier, Leno, Lieu, Liu, Padilla, Pavley, and Wolk)
(Coauthors: Assembly Members Ammiano, Butler, Dickinson, Eng, Fong, Mitchell, Portantino, Williams, and Yamada)

MARCH 31, 2011

An act to amend Section 121022 of, to add Section 1374.74 to, and to add and repeal Section 1374.73 of, the Health and Safety Code, to add and repeal Sections 10144.51 and 10144.52 of the Insurance Code, and to amend Sections 5705, 5708, 5710, 5716, 5724, and 5750.1 of the Welfare and Institutions Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

SB 946, as amended, Steinberg. Health care coverage: mental illness: pervasive developmental disorder or autism: public health.

Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. A willful violation of these provisions is a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies to provide benefits for specified conditions, including certain mental health conditions.

This bill, effective July 1, 2012, would require those health care service plan contracts and health insurance policies, except as specified, to provide coverage for behavioral health treatment, as defined, for pervasive developmental disorder or autism. The bill would provide, however, that no benefits are required to be provided that exceed the essential health benefits that will be required under specified federal law. Because a violation of these provisions with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

These provisions would be inoperative July 1, 2014, and repealed on January 1, 2015.

The bill would require the Department of Managed Health Care, in conjunction with the Department of Insurance, to convene an Autism Advisory Task Force by February 1, 2012, to provide assistance to the department on topics related to behavioral health treatment and to develop recommendations relating to the education, training, and experience requirements to secure licensure from the state. The bill would require the department to submit a report of the Task Force to the Governor and specified members of the Legislature by December 31, 2012.

Existing law establishes various communicable disease prevention and control programs. Existing law requires the State Department of Public Health to establish a list of reportable diseases and conditions and requires health care providers and laboratories to report cases of HIV infection to the local health officer using patient names and sets guidelines regarding these reports. Existing law requires the local health officers to report unduplicated HIV cases by name to the department.

This bill would authorize the department to revise the HIV reporting form without the adoption of a regulation, as specified.

Under the Bronzan-McCorquodale Act, the State Department of Mental Health administers the provision of funds to counties for community mental health services programs. Existing law also permits counties to receive, under certain circumstances, Medi-Cal reimbursement for mental health services. Under existing law, negotiated net amounts or rates are used as the cost of services in contracts between the state and the county and between the county and a subprovider of services. Existing law establishes the method for computing negotiated rates. Existing law prohibits the charges for the care and treatment of each patient receiving service from a county mental health program from exceeding the actual or negotiated cost of the services.

This bill would only allow the use of negotiated net amounts as

the cost of services in a contract between the state and a county and the county and a subprovider of services, and would eliminate the use of negotiated rates. The bill would also specify that the charges for the care and treatment of each patient receiving a service from a county mental health program shall not exceed the actual cost of the service.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Under existing law, the State Department of Health Care Services promulgates regulations for determining reimbursement of Short-Doyle mental health services allowable under the Medi-Cal program. Existing law requires the State Department of Mental Health and the State Department of Health Care Services to jointly develop a ratesetting methodology for use in the Short-Doyle Medi-Cal system that maximizes federal funding and utilizes, as much as practicable, federal Medicare reimbursement principles. Existing law requires that this ratesetting methodology contain incentives relating to economy and efficiency.

The bill would delete the requirement that the ratesetting methodology in the Short-Doyle Medi-Cal system include incentives relating to economy and efficiency.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. Section 1374.73 is added to the Health and Safety Code, to read:

1374.73. (a) (1) Every health care service plan contract ~~issued, amended, or renewed on or after July 1, 2012, that provides hospital, medical, or surgical coverage shall provide coverage for~~ *that provides hospital, medical, or surgical coverage shall also provide coverage for* behavioral health treatment for pervasive developmental disorder or autism *no later than July 1, 2012* . The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 1374.72.

(2) Notwithstanding paragraph (1), as of the date that proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health plans will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(3) This section shall not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(4) This section shall not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individualized service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400, et seq.) and its implementing regulations.

(b) Every health care service plan subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise and employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. Nothing shall prevent a health care service plan from selectively contracting with providers within these requirements.

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

(1) "Behavioral health treatment" means professional services and treatment programs, including applied behavior analysis and ~~other~~ *evidence-based* behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following criteria:

(A) The treatment is prescribed by a physician and surgeon

licensed pursuant to Chapter 5 (commencing with Section 2000) of, or *is developed by* a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.

(B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:

(i) A qualified autism service provider.

(ii) A qualified autism service professional supervised and employed by the qualified autism service provider.

(iii) A qualified autism service paraprofessional supervised and employed by a qualified autism service provider.

(C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

(i) Describes the patient's behavioral health impairments to be treated.

(ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.

(iii) Provides intervention plans that ~~reflect~~ *utilize* evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.

(iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not ~~prescribed~~ *used* for purposes of providing *or for the reimbursement of* respite, day care, or ~~school~~ *educational* services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care service plan upon request.

(2) "Pervasive developmental disorder or autism" shall have the same meaning and interpretation as used in Section 1374.72.

(3) "Qualified autism service provider" means either of the following:

(A) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.

(B) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

(4) "Qualified autism service professional" means an individual who meets all of the following criteria:

(A) Provides behavioral health treatment.

(B) Is employed and supervised by a qualified autism service provider.

(C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.

(D) Is a behavioral service provider approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations.

(E) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(5) "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:

(A) Is employed and supervised by a qualified autism service provider.

(B) Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.

(C) Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.

(D) Has adequate education, training, and experience, as certified by a qualified autism service provider.

(d) This section shall not apply to the following:

(1) A specialized health care service plan that does not deliver mental health or behavioral health services to enrollees.

(2) A health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(3) A health care service plan contract in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code).

(4) A health care benefit plan or contract entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code).

(e) Nothing in this section shall be construed to limit the obligation to provide services under Section 1374.72.

(f) ~~Notwithstanding any other provision of law~~ *As provided in Section 1374.72 and in paragraph (1) of subdivision (a)* , in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

(g) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2015, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. Section 1374.74 is added to the Health and Safety Code, to read:

1374.74. (a) The department, in consultation with the Department of Insurance, shall convene an Autism Advisory Task Force by February 1, 2012, in collaboration with other agencies, departments, advocates, autism experts, health plan and health insurer representatives, and other entities and stakeholders that it deems appropriate. The Autism Advisory Task Force shall develop recommendations regarding behavioral health treatment that is medically necessary for the treatment of individuals with autism or pervasive developmental disorder. The Autism Advisory Task Force shall address at the following:

(1) Interventions that have been scientifically validated and have demonstrated clinical efficacy.

(2) Interventions that have measurable treatment outcomes.

(3) Patient selection, monitoring, and duration of therapy.

(4) Qualifications, training, and supervision of providers.

(5) Adequate networks of providers.

(b) The Autism Advisory Task Force shall also develop recommendations regarding the education, training, and experience requirements that unlicensed individuals providing autism services shall meet in order to secure a license from the state.

(c) The department shall submit a report of the Autism Advisory Task Force to the Governor, the President pro Tem of the Senate, the Speaker of the Assembly, and the Senate and Assembly Committees on Health by December 31, 2012, on which date the task force shall cease to exist.

SEC. 3. Section 121022 of the Health and Safety Code is amended to read:

121022. (a) To ensure knowledge of current trends in the HIV epidemic and to ensure that California remains competitive for federal HIV and AIDS funding, health care providers and laboratories shall report cases of HIV infection to the local health officer using patient names on a form developed by the department. Local health officers shall report unduplicated HIV cases by name to the department on a form developed by the department.

(b) (1) Health care providers and local health officers shall submit cases of HIV infection pursuant to subdivision (a) by courier service, United States Postal Service express mail or registered mail, other traceable mail, person-to-person transfer, facsimile, or electronically by a secure and confidential electronic reporting system established by the department.

(2) This subdivision shall be implemented using the existing resources of the department.

(c) The department and local health officers shall ensure continued reasonable access to anonymous HIV testing through alternative testing sites, as established by Section 120890, and in consultation with HIV planning groups and affected stakeholders,

including representatives of persons living with HIV and health officers.

(d) The department shall promulgate emergency regulations to conform the relevant provisions of Article 3.5 (commencing with Section 2641.5) of Chapter 4 of Division 1 of Title 17 of the California Code of Regulations, consistent with this chapter, by April 17, 2007. Notwithstanding the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), if the department revises the form used for reporting pursuant to subdivision (a) after consideration of the reporting guidelines published by the federal Centers for Disease Control and Prevention, the revised form shall be implemented without being adopted as a regulation, and shall be filed with the Secretary of State and printed in Title 17 of the California Code of Regulations.

(e) Pursuant to Section 121025, reported cases of HIV infection shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding.

(f) State and local health department employees and contractors shall be required to sign confidentiality agreements developed by the department that include information related to the penalties for a breach of confidentiality and the procedures for reporting a breach of confidentiality, prior to accessing confidential HIV-related public health records. Those agreements shall be reviewed annually by either the department or the appropriate local health department.

(g) No person shall disclose identifying information reported pursuant to subdivision (a) to the federal government, including, but not limited to, any agency, employee, agent, contractor, or anyone else acting on behalf of the federal government, except as permitted under subdivision (b) of Section 121025.

(h) (1) Any potential or actual breach of confidentiality of HIV-related public health records shall be investigated by the local health officer, in coordination with the department, when appropriate. The local health officer shall immediately report any evidence of an actual breach of confidentiality of HIV-related public health records at a city or county level to the department and the appropriate law enforcement agency.

(2) The department shall investigate any potential or actual breach of confidentiality of HIV-related public health records at the state level, and shall report any evidence of such a breach of confidentiality to an appropriate law enforcement agency.

(i) Any willful, negligent, or malicious disclosure of cases of HIV infection reported pursuant to subdivision (a) shall be subject to the penalties prescribed in Section 121025.

(j) Nothing in this section shall be construed to limit other remedies and protections available under state or federal law.

SEC. 4. Section 10144.51 is added to the Insurance Code, to read:

10144.51. (a) (1) Every health insurance policy ~~issued, amended, or renewed on or after July 1, 2012, shall provide~~ *shall also provide* coverage for behavioral health treatment for pervasive developmental disorder or autism *no later than July 1, 2012* . The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 10144.5.

(2) Notwithstanding paragraph (1), as of the date that proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health insurers will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(3) This section shall not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(4) This section shall not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individualized service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400, et seq.) and its implementing regulations.

(b) Pursuant to Article 6 (commencing with Section 2240.1) of Title 10 of the California Code of Regulations, every health insurer subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise and employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. Nothing shall prevent a health insurer from selectively contracting with providers within these requirements.

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

(1) "Behavioral health treatment" means professional services and treatment programs, including applied behavior analysis and ~~other~~ *evidence-based* behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:

(A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or *is developed by* a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.

(B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:

(i) A qualified autism service provider.

(ii) A qualified autism service professional supervised and employed by the qualified autism service provider.

(iii) A qualified autism service paraprofessional supervised and employed by a qualified autism service provider.

(C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

(i) Describes the patient's behavioral health impairments to be treated.

(ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.

(iii) Provides intervention plans that ~~reflect~~ *utilize* evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.

(iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not ~~prescribed~~ *used* for purposes of providing *or for the reimbursement of* respite, day care, or ~~school~~ *educational* services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the insurer upon request.

(2) "Pervasive developmental disorder or autism" shall have the same meaning and interpretation as used in Section 10144.5.

(3) "Qualified autism service provider" means either of the following:

(A) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.

(B) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

(4) "Qualified autism service professional" means an individual who meets all of the following criteria:

(A) Provides behavioral health treatment.

(B) Is employed and supervised by a qualified autism service provider.

(C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.

(D) Is a behavioral service provider approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations.

(E) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(5) "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:

(A) Is employed and supervised by a qualified autism service provider.

(B) Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.

(C) Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.

(D) Has adequate education, training, and experience, as certified by a qualified autism service provider.

(d) This section shall not apply to the following:

(1) A specialized health insurance policy that does not cover mental health or behavioral health services or an accident only, specified disease, hospital indemnity, or Medicare supplement policy.

(2) A health insurance policy in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(3) A health insurance policy in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code).

(4) A health care benefit plan or policy entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code).

(e) Nothing in this section shall be construed to limit the obligation to provide services under Section 10144.5.

(f) ~~Notwithstanding any other provision of law~~ *As provided in Section 10144.5 and in paragraph (1) of subdivision (a)* , in the provision of benefits required by this section, a health insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

(g) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2015, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 5. Section 10144.52 is added to the Insurance Code, to read:

10144.52. (a) For purposes of this part, the terms "provider," "professional provider," "network provider," "mental health provider," and "mental health professional" shall include the term "qualified autism service provider," as defined in subdivision (c) of Section 10144.51.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2015, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 6. Section 5705 of the Welfare and Institutions Code is amended to read:

5705. (a) It is the intent of the Legislature that the use of negotiated net amounts, as provided in this section, be given preference in contracts for services under this division.

(b) Negotiated net amounts may be used as the cost of services in contracts between the state and the county or contracts between the county and a subprovider of services, or both. A negotiated net amount shall be determined by calculating the total budget for services for a program or a component of a program, less the amount of projected revenue. All participating government funding sources, except for the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9), shall be bound to that amount as the cost of providing all or part of the total county mental health program as described in the county performance contract for each fiscal year, to the extent that the governmental funding source participates in funding the county mental health programs. Where the State Department of Health Care Services promulgates regulations for determining reimbursement of Short-Doyle mental health services allowable under the Medi-Cal program, those regulations shall be controlling as to the rates for reimbursement of Short-Doyle mental health services allowable under the Medi-Cal program and rendered to Medi-Cal beneficiaries. Providers under this subdivision shall report to the State Department of Mental Health and local mental health programs any information required by the State Department of Mental Health in accordance with procedures established by the Director of Mental Health.

(c) Notwithstanding any other provision of this division or Division 9 (commencing with Section 10000), absent a finding of fraud, abuse, or failure to achieve contract objectives, no restrictions, other than any contained in the contract, shall be placed upon a provider's expenditure pursuant to this section.

SEC. 7. Section 5708 of the Welfare and Institutions Code is amended to read:

5708. To maintain stability during the transition, counties that contracted with the department during the 1990-91 fiscal year on a negotiated net amount basis may continue to use the same funding mechanism.

SEC. 8. Section 5710 of the Welfare and Institutions Code is amended to read:

5710. (a) Charges for the care and treatment of each patient receiving service from a county mental health program shall not exceed the actual cost thereof as determined or approved by the Director of Mental Health in accordance with standard accounting practices. The director may include the amount of expenditures for capital outlay or the interest thereon, or both, in his or her determination of actual cost. The responsibility of a patient, his or her estate, or his or her responsible relatives to pay the charges and the powers of the director with respect thereto shall be determined in accordance with Article 4 (commencing with Section 7275) of Chapter 3 of Division 7.

(b) The Director of Mental Health may delegate to each county all or part of the responsibility for determining the financial liability of patients to whom services are rendered by a county mental health program and all or part of the responsibility for determining the ability of the responsible parties to pay for services to minor children who are referred by a county for treatment in a state hospital. Liability shall extend to the estates of patients and to responsible relatives, including the spouse of an adult patient and the parents of minor children. The Director of Mental Health may also delegate all or part of the responsibility for collecting the charges for patient fees. Counties may decline this responsibility as it pertains to state hospitals, at their discretion. If this responsibility is delegated by the director, the director shall establish and maintain the policies and procedures for making the determinations and collections. Each county to which the responsibility is delegated shall comply with the policy and procedures.

(c) The director shall prepare and adopt a uniform sliding scale patient fee schedule to be used in all mental health agencies for services rendered to each patient. In preparing the uniform patient fee schedule, the director shall take into account the existing charges for state hospital services and those for community mental health program services. If the director determines that it is not practicable to devise a single uniform patient fee schedule applicable to both state hospital services and services of other mental health agencies, the director may adopt a separate fee schedule for the state hospital services which differs from the uniform patient fee schedule applicable to other mental health agencies.

SEC. 9. Section 5716 of the Welfare and Institutions Code is amended to read:

5716. Counties may contract with providers on a negotiated net amount basis in the same manner as set forth in Section 5705.

SEC. 10. Section 5724 of the Welfare and Institutions Code is amended to read:

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

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

(c) Administrative costs shall be claimed separately and shall be limited to 15 percent of the total cost of direct client services.

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

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

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

SEC. 11. Section 5750.1 of the Welfare and Institutions Code is amended to read:

5750.1. Notwithstanding Section 5750, a standard, rule, or

policy, not directly the result of a statutory or administrative law change, adopted by the department or county during the term of an existing county performance contract shall not apply to the negotiated net amount terms of that contract under Sections 5705 and 5716, but shall only apply to contracts established after adoption of the standard, rule, or policy.

SEC. 12. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.