

California Mental Health Planning Council

Healthcare Integration Committee

Thursday June 18, 2015

Crowne Plaza

Bayside Room

1177 Airport Blvd.

Burlingame, CA 94010

8:30 a.m. to 12:00 p.m.

Time	Topic	Presenter or Facilitator	Tab
8:30 a.m.	Planning Council Member Issue Requests		
8:35 a.m.	Welcome and Introductions	Steven Grolnic-McClurg, LCSW, Chairperson	
8:40 a.m.	Review and Approve January Meeting Highlights		
8:45 a.m.	Brief Recap		
9:10 a.m.	Presentation: Beacon Health Strategies LLC	Sarah Arnquist, Assistant Director of Program Development at Beacon Health Strategies LLC	A
10:10 a.m.	Questions/Comments		
10:40 a.m.	Break		
10:55 a.m.	Work Plan Review and Update		B
11:25 a.m.	Committee Discussion		
11:40 a.m.	Public Comment		
11:50 a.m.	Next Steps/Develop Agenda for Next Meeting	Steven Grolnic-McClurg, LCSW, Chairperson	
11:55 a.m.	Wrap up: Report Out/ Evaluate Meeting	Steven Grolnic-McClurg, LCSW, Chairperson	
12:00 p.m.	Adjourn Committee		

The scheduled times on the agenda are estimates and subject to change.

Committee Members:

Chair: Steven-Grolnic McClurg

Chair-Elect:
Terry Lewis

Members:
Dale Mueller
Joseph Robinson
Robbie Powelson

Josephine Black
Deborah Pitts
Cheryl Treadwell
Melen Vue

Cindy Clafin
Jeff Riel
Daphyne Watson

Staff: Tracy Thompson

HEALTHCARE INTEGRATION COMMITTEE CHARTER

ADOPTED 10/17/12

OVERVIEW

The California Mental Health Planning Council (CMHPC) is mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to provide oversight and accountability for the public mental health system, and to advise the Governor and the Legislature on priority issues and participate in statewide planning.

PURPOSE

The purpose of the Healthcare Integration Committee (HCI) is to develop a framework for tracking, addressing, and responding to the multitude of issues resulting from Federal Healthcare Reform that impacts California's mental health system.

The HCI promotes the inclusion of five core elements from the Mental Health Services Act to guide all mental health work:

- Promoting Consumer and Family oriented services at all Levels
- Ensuring Cultural Competence
- Increasing Community Collaboration
- Promoting Recovery/wellness/resilience orientation
- Providing Integrated service experiences for clients and families

MEMBERSHIP

The Committee membership is listed below.

The Chairperson and Vice-Chair will be appointed by the CMHPC Leadership. In the Chairperson's absence the Vice Chair will serve as the Chairperson. Terms will begin with the first meeting of the calendar year, and end with the last meeting of the calendar year.

MEETING TIMES

The Committee meets four times a year, rotating locations in conjunction with the standing meeting times of the plenary and other committees. The Committee meets on Thursday from 8:30 AM to 12:00 PM.

Regular attendance of committee members is expected in order for the Committee to function effectively. If a committee has difficulty achieving a quorum due to the continued absence of a committee member, the committee chairperson will discuss with the member the reasons for his or her absence. If the problem persists, the committee chair can request that the Executive Committee remove the member from the committee.

The Chair and Vice Chair hold meetings as needed to plan for the full Committee meetings.

ROLES AND RESPONSIBILITIES

Members are expected to serve as advocates for the Committee's charge, and as such, could include, but are not limited to:

- Attend meetings. Speaking on behalf as requested.
- Speak at relevant conferences and summits when requested by the Committee leadership
- Develop products such as white papers, opinion papers, and other documents
- Distribute the Committee's white papers and opinion papers to their represented communities and organizations
- Assist in identifying speakers for presentations

Materials will be distributed as far in advance as possible in order to allow time for review before the meetings. Members are expected to come prepared in order to ensure effective meeting outcomes.

GENERAL PRINCIPLES OF COLLABORATION

The following general operating principles are proposed to guide the Committee's deliberations:

- The Committee's mission will be best achieved by relationships among the members characterized by mutual trust, responsiveness, flexibility, and open communication.
- It is the responsibility of all members to work toward the Committee's common goals.
- To that end, members will:
 - Commit to expending the time, energy and organizational resources necessary to carry out the Committee's mission
 - Be prepared to listen intently to the concerns of others and identify the interests represented
 - Ask questions and seek clarification to ensure they fully understand other's interests, concerns and comments
 - Regard disagreements as problems to be solved rather than battles to be won
 - Be prepared to "think outside the box" and develop creative solutions to address the many interests that will be raised throughout the Committee's deliberations

MEETING PROTOCOLS

The Committee’s decisions and activities will be captured in a highlights document, briefly summarizing the discussion and outlining key outcomes during the meeting. The meeting highlights will be distributed to the Committee within one month following the meeting. Members will review and approve the previous meeting’s highlights via email.

DECISION-MAKING

Council and non-council members of the Committee will work to find common ground on issues and strive to seek consensus on all key issues. Every effort will be made to reach consensus, and opposing views will be explained. In situations where there are strongly divergent views, members may choose to present multiple recommendations on the same topic. If the Committee is unable to reach consensus on key issues, decisions will be made by majority vote using the gradients of agreement. Minority views will be included in the meeting highlights.

MEDIA INQUIRIES

In the event the Committee is contacted by the press, the Chairperson will refer the request to the CMHPC’s Executive Officer.

SUPPORT

Tracy Thompson, Associate Governmental Program Analyst, tracy.thompson@cmhpc.ca.gov

Healthcare Integration Committee Membership

NAME
Steven Grolnic-McClurg, LCSW, Chairperson
Josephine Black
Cindy Clafin
Dale Mueller , EdD, RN
Terry Lewis
Deborah B. Pitts, PhD
Robbie Powelson
Jeff Riel
Joseph Robinson, LCSW, CADC II
Cheryl Treadwell
Daphyne Watson
Melen Vue

Updated: 03/23/15

California Mental Health Planning Council
HEALTHCARE INTEGRATION COMMITTEE
External Roster

HCI Chair and Chair-Elect

<p>Steven Grolnic-McClurg, LCSW, Chair E-mail: SGrolnic-McClurg@ci.berkeley.ca.us P: 510-898-1624</p>	<p>Terry Lewis E-mail: tlewis@dmh.lacounty.gov P: 818-425-8021</p>
--	---

Committee Members:

<p>Josephine Black E-mail: jblack32@cox.net P: 805-684-4934 C: 805-895-3108</p>	<p>Cindy Claflin E-mail: cclaflin@uacf4hope.org P: 916-203-3449 C: 916-230-3449</p>
<p>Deborah B. Pitts, PhD, OTR/L, BCMH, CPRP Email: pittsd@usc.edu P: 626-799-9734</p>	<p>Dale Mueller E-mail: dmueller@earthlink.net P: 909-920-5854</p>
<p>Robert Powelson E-mail: robbiepowelson@gmail.com P: 415-924-2826</p>	<p>Joseph Robinson E-mail: joseph@casra.org P: 415-572-5173 C: 925-229-2300</p>
<p>Cheryl Treadwell E-mail: cheryl.treadwell@dss.ca.gov P: 916-651-6020</p>	<p>Jeff Riel E-Mail: JRiel@DOR.ca.gov P: 916-558-5421</p>
<p>Daphyne Watson E-mail: dwatson@mhasd.org P: 619-942-6588</p>	<p>Melen Vue melen@namica.org P: 916- 862-2078</p>

Staff

Tracy Thompson
MS 2706 P.O Box 997413
Sacramento, CA 95899-7413
tracy.thompson@cmhpc.ca

Health Care Integration Committee

Health Plan Members with board meeting information:

1. Aetna Health of California, Inc.
2. Alameda Alliance for Health- They typically have Board Meetings on the 4th Friday of the Month, but not every month. Here is where they post agendas: <https://www.alamedaalliance.org/about-us/board-meetings>
3. Anthem Blue Cross
4. Blue Shield of California
5. California Health and Wellness- They meet behind closed doors
6. Cal Optima- Next Board Meeting is December 4, 2PM, in Orange. Here is the calendar for the rest of the fiscal year: https://www.caloptima.org/en/AboutUs/~/_media/Files/CalOptimaOrg/508/AboutUs/FY1415_BODandCommitteeMeetingSchedule_508.ashx
7. CalViva Health- There will be no meeting in December. Next year's meetings will be posted here: <http://www.calvivahealth.org/commissioners/meetings>
8. Care 1st Health Plan
9. CenCal Health- January 21, 6:00 PM, 801 S. Broadway, Santa Maria is the next Board Meeting. For latest updates, see drop down menu on this page: http://www.cencalhealth.org/about_sbrha/index.html
10. Central California Alliance for Health- December 3rd, 4:00PM-6:00PM at 1600 Green Hills Rd., Scotts Valley, is the next meeting. No schedule has been posted for 2015, but there is a tentative date for the first meeting in 2015. Meetings are open to the public. Meetings are often scheduled on the fourth Wednesday of the month from 4:00 pm to 6:00 pm. Next meeting might be February 25th. To confirm meeting dates and locations, contact the Clerk of the Board at (831) 430-5500 ext. 2547
11. Central Health Medicare of California, Inc.
12. Chinese Community Health Plan
13. CIGNA Healthcare of California, Inc.
14. Community Health Group
15. Contra Costa Health Plan- This is the county's health plan. There are various committees that may be of interest, like the Mental Health Commission and the Managed Care Commission. See the link for more information: <http://cchealth.org/groups/advisory/>
16. Easy Choice Health Plan, A WellCare Company
17. GEMCare Health Plan, Inc.- Purchased by Blue Shield of California
18. Health Net of California

19. Health Plan of San Joaquin- 4th Wednesday of each month at 5:30 PM, 7751 S. Manthey Road, French Camp, CA 95231. Contact: Penny Schenken (209) 461-2257
20. Health Plan of San Mateo- 2nd Wednesday of each month, Health Plan of San Mateo, 4th Floor, 701 Gateway Blvd., South San Francisco, CA 94080. Clerk for Commission# (650) 616-0050. See site for more details: <http://www.hpsm.org/abouthpsm/governance.aspx>
21. Heritage Provider Network
22. Humana
23. Inland Empire Health Plan- Next meeting is on December 8th at 9:00 AM, County Government Board Chambers, 1st Floor, 385 North Arrowhead Avenue, San Bernardino, CA 92415. See website later for 2015 Meetings: <https://ww3.iehp.org/en/about-iehp/leadership-team/governing-board/>
24. Inter Valley Health Plan
25. Kaiser Permanente
26. Kern Family Health Care- There are no meetings posted for the rest of the year. See: <http://www.kernfamilyhealthcare.com/section.asp/csasp/DepartmentID.1478/cs/SectionID.2967/csasp.html>
27. LA Care Health Plan- 1st Thursday of most months at 2:00 PM (Dec. 4th), 10th Floor of LA Care Health Plan's HQ 1055 W. 7th St., Los Angeles, CA 90017. There is no meeting in January. See site for agenda: <http://www.lacare.org/about-us/board-of-governors/board-meetings>
28. Molina Healthcare of California
29. Monarch Health Plan
30. Partnership Health Plan of California- 4th Wednesday of every month, except for December (12/3/14), from 10:00 AM- 2:00 PM. Board Clerk is Cynthia McCamey at (707) 863-4241. See website for agendas and meeting places: http://www.partnershiphp.org/Board/Board_Updates.htm
31. San Francisco Health Plan- 1st Wednesday in January, March, May, September, and November, with a late June meeting to approve the budget. They are from 12:00 PM- 2:00 PM at 201 Third Street, 7th Floor, San Francisco. See website for agenda: <http://www.sfhp.org/us/governing-board/>
32. Santa Clara Family Health Plan- 2nd Thursdays, December 11th is the next meeting. The agenda has yet to be posted, but it will likely be held at 210 E. Hacienda Ave, Campbell, CA 95008. Times vary, so please check website for specifics: <http://www.scfhp.com/about-us/meetings-and-agendas>
33. SCAN Health Plan
34. Seaside Health Plan

35. Sharp Health Plan
36. Sestemos Medicos Nacionales, SA de CV
37. Sutter Health Plus
38. UnitedHealthcare of California
39. Valley Health Plan
40. Ventura County Health Care Plan
41. Western Health Advantage



March 9, 2015

Larry Gasco, PhD, LCSW
2557 Palos Verdes Dr.
W Palos Verdes Estates, CA 90274

Dear Dr. Gasco,

CHAIRPERSON
Cindy Claffin

EXECUTIVE OFFICER
Jane Adcock

We are writing from the Health Care Integration Committee of the California Mental Health Planning Council (CMHPC). As you know, the CMHPC is mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to review and report for the public mental health system, and to advise the Administration and the Legislature on priority issues and participate in statewide planning.

- **Advocacy**
- **Evaluation**
- **Inclusion**

The Health Care Integration Committee's overall focus is healthcare integration. A specific area of focus for us, brought about by national healthcare reform, has been the services now available to some Medi-Cal beneficiaries and the new providers of those services. Pursuant to Information Notice 14-020, issued to County Mental Health Directors, effective January 1, 2014, Medi-Cal Managed Care Plans (MCPs) are now responsible for the delivery of certain mental health services through the MCP provider network to Medi-Cal beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning. This change has significant implications to our entire system of care including the relationship between the health plans and the mental health plans (MHPs). Existing Title 9, California Code of Regulations (CCR), Chapter 11 regulations and the DHCS/MHP contract require MHPs to enter into a Memorandum of Understanding (MOU) with any MCP that enrolls beneficiaries covered by the MHP. The HCI Committee has heard from multiple counties that have implemented this differently.

The HCI Committee would like to share with the CALMHB/C what we have learned with regards to health plans, including how we can collaborate with this new significant partner in the provision of mental health services. To that end, is it possible for a member of our HCI Committee to join a meeting with CALMHB/C on Friday afternoon, April 17, 2015, to present this information?

Please contact us if you have any questions or need additional information.
tracy.thompson#cmhpc.ca.gov (916) 552-8665

MS 2706
PO Box 997413
Sacramento, CA 95899-7413
916.323.4501
fax 916.319.8030

Sincerely,

Cindy Claflin, CMHPC Chair
Steven Grolnic-McClurg, HCI Chair

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL

Healthcare Integration Committee

Meeting Highlights

April 16, 2015

Double Tree

2800 Via Cabrillo Marina

San Pedro, CA 90731

8:30 A.M. to 12:00 P.M.

Committee Members Present:

Steven Grolnic-McClurg, Chair

Cindy Claflin, Vice-Chair

Terry Lewis

Deborah Pitts, PhD

Joseph Robinson

Jeff Riel

Cheryl Treadwell

Daphyne Watson

Robbie Powelson

Dale Mueller

Melen Vue

Staff Present

Tracy Thompson

Others Present

Catherine Teare, Associate Director, California Health Care Foundation

Welcome and Introductions

The CHCF is a group that does a lot in supporting better health care. Our goal is to see if we can explore developing a partnership in working towards helping the health plans in moving into their new responsibilities.

Review and Approve January Meeting Highlights

A motion by Joseph Robinson and seconded by Cindy Claflin: January 2015 minutes approved as written.

Presentation: California Health Care Foundation

Catherine Teare, Associate Director, California Health Care Foundation, provided a presentation on what the California Health Care Foundation with regards their role in capacity development within the system. Ms. Teare also asked for the committee's input on integration and posed the question:

Questions/Comments

What types of things hang up integration?

- Steven Grolnic-McClurg: The committee has looked at medical homes that are located in primary care and how mental health care can be integrated into those primary clinics. We have looked at behavioral health homes as well and how physical health care can be integrated into existing mental health settings. We have also looked at pilot projects around integrated care teams and integrated care planning: this is where there is a health clinic at one place and mental health care in another, place but there are designated people working together to make sure that the treatment is shared. The committee has been focusing heavily on the low to moderate benefit and how it is being implemented in the county managed medi-Cal health plan partnership. One of the ways that we have been thinking that would support that partnership is supporting some transparency in the project.
- Each county has a separate MOU with the one or two plans, usually that are in their county, about how that is going to go and then each managed medi-Cal health plan is making choices around how they are going to provide that mental health care. Sometimes it is by directly contracting (carving it in), sometimes it is by contracting it out to someone like Beacon (carving out), and sometimes it is contracting back to the mental health plan. There also may be some combination of those models as well. We have been thinking about part of our work plan and trying to compile that information because there has been a lot of feeling that this project has been off to a rough start. It has not led to better health care for existing individuals who have Medi-Cal, much less

the vast number of new Medi-Cal recipients. If we are looking at a pathway towards integration this is the beginning of that pathway.

We would like a move toward some transparency.

- We would like to know if all these MOUs are public documents and can everyone see them? There are also potentially variations from county to county and health plan to county on how they are defining moderate to severe versus mild to moderate. There isn't clarity around what happens with someone who is moderate. There is this middle ground. And secondly some clarity around what is managed medi-cal health plan doing? Are they carving in or carving out? If they are carving out whom are they carving out too? This would make this info clear and in one place. We are about to embark on this- from your perspective is anyone else working on this?
- Catherine Teare: This may exist somewhere but I am not certain how available it is or if it exists at all. There is work that needs to be done. One of the issues with the MOU's is that they aren't different enough and are more boilerplate – they may not have the detail that people need. This is a project that the CHCF could assist on- we could work with you on what a document like this would look like and who would be good at pulling this information together. What data do we have at this point? Sarah Brooks at the DHCS recently did a presentation on statewide data. By the time we are able to put something out there we would be close to two years in this new system. This lines up very nicely with what the CHCF is doing.
- Grolnic-McClurg: Highlighting successes and best practices. What is going well and supporting the health plans. This is a clear area we can focus on now.
- Grolnic-McClurg: This group is mostly made up of advocates, not county representatives. One of the things I am aware of is that those in physical health care often talk a very different language than those in mental health care. As we move towards integration, the largest barrier is that we do not speak the same language or

understand each other at all. How do we foster more conversation so that we can learn each other's language?

- Teare: Blue Shield of California Foundation is working on a project in ten communities where they try to bring groups together to solve some of these data and integration issues. Each community is doing something different and were able to say: these are the issues we want to focus on. They may have some ideas on this subject.
- Grolnic-McClurg: The Planning Council is focusing on alternatives to locked facilities and we are contemplating what the HCI committee can do to support this effort. There is data from the EQRO report from the mental health plans about psychiatric hospitalizations and re-hospitalizations. The committee would like to pull together or link to data from the health plans about what their rates of psychiatric hospitalizations are or what specific diversion programs have they funded to put in place. Even if what came out of this was a recommendation that this data be collected.
- Teare: The DHCS, which manages Medi-Cal, has some interest in what is going on with those who have come into Medi-Cal within the last year and a half and their use of behavioral health services. I will inquire about this.
- Grolnic-McClurg: So what are the things that hang up integration? Part of it is that we speak different languages and part of it is that we live in separate worlds and don't attend the same meetings. Primary care providers are very uncomfortable talking about mental health issues. Even in a system that wants to move in that way there is a lot of push back from primary care providers.
- Teare: It would be good to know if we have a best practice in which a Medi-Cal health plan is giving their providers some sort of advice on how to deal with this.
- Dale Mueller: With regards to initial provider contact, primary care visits, and increased access- what are some models that plans are using for nurse run clinics? *Answer:* This is definitely something worth looking into.

- Deborah Pitts: There is not equity in payment rates between Medicare and Medicaid. We need to advocate that payments rates are the same.
- Building relationships is the key to the success of integration.
- Joseph Robinson: CCMH is having a meeting to discuss engaging the health plans and to discuss a coalition for whole health – this will be chaired by Richard Van Horn.
- Grolnic-McClurg: Is there any way that the CMHPC can be of assistance to the CHCF during this process? *Answer:* Communication is the first step. It will be very helpful to have access to your knowledge and expertise and having the CMHPC at the table. It would be wonderful if a few members were willing to be a part of an advisory committee that can help shape these kinds of things.
- Grolnic-McClurg: I think it would be helpful to connect you with our Executive Officer and to see what the mechanism for this may be.
- Grolnic-McClurg: With regards to the project we talked about before (Moving towards some transparency. Looking into the MOUs and some clarity around what are the managed medi-cal health plans doing? Are they carving in or carving out? If they are carving out whom are they carving out too?) *Answer:* Teare advised that she will brainstorm with her colleagues about what the size and shape of a project like this would be. Teare will be in contact with staff regarding this project.
- Dale Mueller advised that she will be a mentor for Melen Vue.

Work Plan Review and Update

- Goal #4 added to the work plan: Create a comprehensive list of health plans that are “carving in” and those “carving out”? This will enable local advocates to understand the layout.
- Potential goal for a future work plan: A survey of providers on what they see as opportunities and threats as far as integration.

- When the ACA and Medi-cal expansion came along there was some guidance from Feds and DHCS to the specialty mental care system that county mental health plans will only provide care for moderate to serious mental health issues. That is what is in the waiver. Health plans are now responsible for providing mild to moderate mental health care for all their Medi-Cal beneficiaries. As part of that guidance the health plan and the county mental health plan were instructed to put in place an MOU that says how they decide who goes where and what the mechanism will be for deciding that. Also, how will they resolve disputes? If the county says this is the health plan responsibility and the health plan says no this is county responsibility, how will you resolve that? This is basis of the MOU. This is helpful information for the mental health boards.
- Volunteers for subgroup to commit to a call with CHCF and to assist in this project: Robbie Powelson, Steven Grolnic-McClurg, Daphyne Watson, Jeff Riel, Deborah Pitts.
- Terry Lewis and Joseph Robinson will be speaking with Dr. Larry Gasco to follow up on the letter that the HCI Committee sent to the CALMHB/C regarding the MOU's and the HCI sharing information on health plans.
- Deborah Pitts and Jane Adcock will discuss next steps on goal #2 (Advocate to position Occupational Therapists under Licensed Mental Health Professionals)
- Joseph Robinson: The broader issue may be the employment gaps – this could be an overarching goal: workforce needs for being able to have integrated care. This can be a future work plan item.
- Grolnic-McClurg: Looking at goal #3: What is the psychiatric hospitalization rate for these managed medi-cal health plans? Is that data available and in existence? If it is not available the HCI could advocate for this. Another option is to survey the managed medical health plans on what kinds of diversion programs they have. The timeline would be July 2016.

- Robinson: Prior to committing to a work plan product I would like to see what the other committees are doing. This could offer a chance to partner and not have overlap. Answer: Adcock advised that the Advocacy committee is doing a project around IMD's and the CSI committee is focusing on at risk youth.
- Pitts: The increase in nursing homes is a large issue. Answer: This focus is for locked facilities specifically. This could be a future project.
- Grolnic-McClurg: IMD's are a potential topic and we want to think how we can work this into the health plan piece. IMD's in terms of placements from the managed medical health plans to IMD's is a topic we could survey on. My preference is to start with the hospitalization piece but I am not sure that data is available.
- The HCI committee agreed on two possible projects: survey the managed Medi-Cal health plans on what kinds of diversion programs they have **or** work to find what the existing data is around the psychiatric hospitalization rates for members of the managed Medi-Cal health plans. The HCI will lock in this goal at the June meeting.

Public Comment

No Public Comment

Future Work plan ideas

- How are nursing homes used throughout an integrated care system?
- SB 82 is a set of dollars aimed at serving universal populations in terms of preventing folks in crisis and assist them in doing better. The larger topic is how do the broad array of payers, the mental health plans, the managed medical health plans, and the private health plans, all play a piece in supporting universal mental health programs being implemented by either of those three players? How do we leverage those dollars? For the SB 82 programs the mental health plan is billing medical for the folks who are eligible for medical to leverage those SB 82 dollars. As we move to a more integrated system how we partner around the payer option?

- What are the workforce needs around integrated care?
- A survey of providers on what they see as opportunities and threats as far as integration

Next Steps/Develop Agenda for Next Meeting

- Invite Beacon to speak with the committee about how things are rolling out.
- A second option is to invite the mental health director from San Mateo to discuss how the partnership is going in San Mateo.
- An idea for a future meeting: Blue Shield of California to talk about the work they have been doing in local planning processes in integration

Wrap up: Report Out/ Evaluate Meeting

- Committee members would like to continue with one presenter per meeting to allow time for conversation.
- When the CMHPC goes to a county it would be helpful to send a notice to the county mental health director for distribution to interested constituents.
- Members would prefer to have a brief conversation prior to having a presenter.
- The Department of Managed Health Care is charged with dealing with complaints. The committee has heard from them but may want to invite them again. Inviting the DHCS would also be helpful.

Adjourn Committee

x INFORMATION

TAB SECTION A

 ACTION REQUIRED

DATE OF MEETING 04/16/15

MATERIAL
PREPARED BY: Tracy Thompson

DATE MATERIAL
PREPARED 03/9/15

AGENDA ITEM:	Presentation: Beacon Health Strategies LLC
ENCLOSURES:	
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

The HCI Committee has been focusing on issues around integration and the responsibility of the Medi-Cal Managed Care Plans (MCPs) for the delivery of certain mental health services through the MCP provider network to Medi-Cal beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning. This change has significant implications to our entire system of care including the relationship between the health plans and the mental health plans (MHPs). Thus far, the HCI Committee has heard presentations from Abbie Totten from the California Association of Health Plans, Dr. Peter Currie from Inland Empire integration, and Catherine Teare, Associate Director, from the California HealthCare Foundation. Sarah Arnquist, Assistant Director of Program Development at Beacon Health Strategies LLC, will provide a presentation on Beacon's role in the system including issues such as wellness and recovery, cultural competence, and early indicators or data around successes.

_____ INFORMATION

TAB SECTION B

___x___ ACTION REQUIRED

DATE OF MEETING 06/18/15

MATERIAL
PREPARED BY: Tracy Thompson

DATE MATERIAL
PREPARED 05/15/15

AGENDA ITEM:	Work Plan Review and Update
ENCLOSURES:	<ul style="list-style-type: none">• Health Care Integration Work Plan• All Plan Letter 13-018• All Plan Letter 13-021
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

At the April 2015 meeting, HCI committee members spent time updating the work plan and narrowing down goals.

The HCI committee agreed on two possible projects as goal #3 that would fall under the CMHPC's theme: alternatives to locked facilities.

1. Survey the managed Medi-Cal health plans on what kinds of diversion programs they have or
2. Work to find what the existing data is around the psychiatric hospitalization rates for members of the managed Medi-Cal health plans. The HCI will lock in this goal at the June meeting

Committee members will review the work plan and make a decision on which project they would like for goal #3. I have included All County Letters 13-018 and 13-021 as informational material regarding the new mild to moderate responsibilities of the Medi-Cal managed care health plans (MCPs) and the Memoranda of Understanding (MOU) with the county Mental Health Plans (MHPs) for coordination of Medi-Cal mental health services

CMHPC

Healthcare Integration Committee

Draft Work Plan 2015-2016

<p>Goal 1: Explore Best Practices for the Delivery of Mild to Moderate level of Services.</p>	<p>Rationale: <i>MCPs are responsible for the delivery of certain mental health services through the MCP provider network to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder as defined by the current DSM, that are outside of the PCP's scope of practice</i></p> <p><i>(ACL 13-021)</i></p>	<p>Measure of Success:</p> <p>Written Report</p>	<p>Target Audience:</p> <p>Counties, Public, Legislature</p>
<p>Objectives</p>	<p>Action Steps</p>	<p>Timeline</p>	<p>Leads</p>
<ul style="list-style-type: none"> • To find and highlight different ways mental health services are being delivered for mild to moderate levels. 	<ul style="list-style-type: none"> • Ongoing Presentations at Meetings. • Literature Review • Possible Telephone Interviews. 	<p>January 2015-October 2015</p>	<p>Staff</p> <p>?</p>

CMHPC

Healthcare Integration Committee

<p>Goal 2: Advocate to position Occupational Therapists under Licensed Mental Health Professionals</p>	<p>Rationale: Increase workforce and access to care</p>	<p>Measure of Success: Occupational Therapists are moved to the Mental Health Professional Category</p>	<p>Target Audience: TBD</p>
<p align="center">Objectives</p>	<p align="center">Action Steps</p>	<p align="center">Timeline</p>	<p align="center">Leads</p>
<p>TBD</p>	<p>Deborah and Jane to discuss with lobbyist action steps for this Goal.</p> <ul style="list-style-type: none"> • Broker a meeting with CBHDA to get support • Broker a meet with DHCS to get them to do a State Plan Amendment • Talk to OSHPD 	<p>April 2015- December 2015</p>	<p>TBD</p>

CMHPC

Healthcare Integration Committee

<ul style="list-style-type: none"> Goal 3: Decide on one of two projects: <i>survey the managed Medi-Cal health plans on what kinds of diversion programs they have <u>or</u> work to find what the existing data is around the psychiatric hospitalization rates for members of the managed Medi-Cal health plans. The HCI will lock in this goal at the June meeting.</i> 	<p>Rationale: This project will fall under the full council's theme: <i>alternatives to locked facilities.</i></p>	<p>Measure of Success: TBD</p>	<p>Target Audience: TBD</p>
Objectives	Action Steps	Timeline	Leads
TBD	TBD	TBD	TBD

CMHPC

Healthcare Integration Committee

<p>Goal 4: Create a comprehensive list of health plans that are “carving in” and those “carving out”?</p>	<p>Rationale: TBD</p>	<p>Measure of Success: TBD</p>	<p>Target Audience: TBD</p>
<p align="center">Objectives</p>	<p align="center">Action Steps</p>	<p align="center">Timeline</p>	<p align="center">Leads</p>
<ul style="list-style-type: none"> • Highlight some successes • Link to all of the MOU’s between the counties and the Managed Medi-Cal Health Plans • Training/Presentation to the CALMHB/C regarding MOU’s (Health plans and mental health plans) 	<ul style="list-style-type: none"> • Work with CHCF (Catherine Teare) 	<p>TBD</p>	<p>TBD</p>



TOBY DOUGLAS
Director

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
Governor

DATE: November 27, 2013

ALL PLAN LETTER 13-018

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEMORANDUM OF UNDERSTANDING REQUIREMENTS FOR
MEDI-CAL MANAGED CARE PLANS

PURPOSE:

The purpose of this All Plan Letter (APL) is to describe the responsibilities of Medi-Cal managed care health plans (MCPs) for amending or replacing Memoranda of Understanding (MOU) with the county Mental Health Plans (MHPs) for coordination of Medi-Cal mental health services. These requirements are in addition to existing MOU requirements for specialty mental health services provided by MHPs as outlined in Title 9, Chapter 11 — Medi-Cal Specialty Mental Health Services Regulations (Attachment 1) and Exhibits 11 and 12 of the current MCP contracts.

BACKGROUND:

Pursuant to Senate Bill X1 1 (Hernandez, Chapter 4, Statutes of 2013), effective January 1, 2014, mental health services included in the essential health benefits package adopted by the State, pursuant to Health and Safety Code Section 1367.005 and the Insurance Code Section 10112.27, and approved by the United States Secretary of Health and Human Services under Title 42, Section 18022 of the United States Code, shall be covered Medi-Cal benefits. MCPs shall provide mental health benefits covered in the state plan, excluding those benefits provided by the county MHPs under the Specialty Mental Health Services Waiver. Specialty mental health services, which are county-administered, will not be included in the capitation rate for MCPs.

Starting on January 1, 2014, the Department of Health Care Services (DHCS) will expand the array of Medi-Cal mental health services available to Medi-Cal beneficiaries. The following outpatient mental health benefits will be available through MCPs for beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from any mental health condition defined by the current Diagnostic and Statistical Manual:

- Individual and group mental health evaluation and treatment (psychotherapy);

- Psychological testing, when clinically indicated to evaluate a mental health condition;
- Outpatient services for the purposes of monitoring drug therapy;
- Psychiatric consultation; and,
- Outpatient laboratory, drugs, supplies and supplements (excluding medications as described in forthcoming “Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services and Coordination with County Mental Health Plans” APL).

Medi-Cal specialty mental health services currently provided by the MHPs will continue to be provided by the MHPs for Medi-Cal beneficiaries that meet the medical necessity criteria pursuant to Title 9, California Code of Regulations (CCR), Chapter 11, Sections 1820.205, 1830.205, and 1830.210.

DHCS will provide separate MOU requirements for MCPs and counties participating in the Drug Medi-Cal program for the coordination of substance use benefits.

POLICY:

MCPs are responsible for updating, amending, or replacing existing MOUs with MHPs to account for the above mentioned mental health services that will be provided by the MCPs. The existing MOUs between the MHPs and the MCPs are required based on specialty mental health services regulation and existing MCP contracts.

Pursuant to Welfare and Institutions Code Section 14681, DHCS shall ensure that all contracts with MCPs include a process for screening, referral, and coordination with MHPs.

For MHPs, Title 9, CCR, Chapter 11, Medi-Cal Specialty Mental Health Services Regulations (Attachment 1) outlines MOU requirements, as follows:

- Section 1810.370, MOUs with Medi-Cal Managed Care Plans.
- Section 1810.415, Coordination of Physical and Mental Health Care.
- Section 1850.505, Request for Resolution.
- Section 1850.515, Departments’ Responsibility for Review of Disputes.
- Section 1850.525, Provision of Medically Necessary Services Pending Resolution of Dispute.

For MCPs, the existing DHCS contracts outline MOU requirements as follows:

- Exhibit A, Attachment 11, Case Management and Care Coordination, Local Mental Health Plan Coordination.
- Exhibit A, Attachment 12, Local Health Department Coordination, Local Mental Health Plan Coordination.

The MOU shall include the following elements, which are described in greater detail in the MOU Template (Attachment 2), "Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Mental Health Plans:"

- Basic Requirements;
- Covered Services and Populations;
- Oversight Responsibilities of the MCP and MHP;
- Screening, Assessment, and Referral;
- Care Coordination;
- Information Exchange;
- Reporting and Quality Improvement Requirements;
- Dispute Resolution;
- After-Hours Policies and Procedures; and,
- Member and Provider Education.

The MOU should be the primary vehicle for ensuring beneficiary access to necessary and appropriate mental health services. The MOU shall address policies and procedures for management of the beneficiary's care, including but not limited to: screening, assessment and referral, medical necessity determination, care coordination, and exchange of medical information. MOU elements should promote local flexibility and acknowledge the unique relationships and resources that exist at the county level. Responsibility for specific covered services may be addressed by referencing the matrix developed by DHCS which will be included in a forthcoming APL titled, "Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services and Coordination with County Mental Health Plans."

Each MCP is obligated to conduct a mental health assessment for beneficiaries with a potential mental health condition using a tool mutually agreed upon with the MHP to determine the appropriate care needed. The MOU should include a process for resolving clinical and administrative differences of opinion between the MCP and MHP and comply with the dispute resolution process in accordance with Title 9, CCR, Section 1850.505.

The MOU shall include identified points of contact for each party responsible for managing the MOU, overseeing quality improvement, and resolving disputes.

The MOU shall include all of the elements described in this APL as well as those outlined in the MOU Template (Attachment 2). MCPs are advised that the MOU Template is provided as a guide for MCPs and MHPs to structure their MOUs; however, the specific format provided on the MOU Template is not required and may be modified to account for the needs of MCPs and MHPs.

If you have any questions regarding this APL, please contact Sarah Royce, Medical Policy Section Chief, at (916) 650-0113 or sarah.royce@dhcs.ca.gov.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar, Assistant Deputy Director
Health Care Delivery Systems

**Title 9 – Rehabilitative and Developmental Services
Chapter 11 – Medi-Cal Specialty Mental Health Services**

§ 1810.370. MOUs with Medi-Cal Managed Care Plans.

(a) The MHP shall enter into an MOU with any Medi-Cal Managed Care Plan that enrolls beneficiaries covered by the MHP. The MOU shall, at a minimum, address the following:

(1) Referral protocols between plans, including:

(A) How the MHP will provide a referral to the Medi-Cal managed care plan when the MHP determines that the beneficiary's mental illness would be responsive to physical health care based treatment and

(B) How the Medi-Cal managed care plan will provide a referral when the Medi-Cal managed care plan determines specialty mental health services covered by the MHP may be required.

(2) The availability of clinical consultation, including consultation on medications, to the Medi-Cal managed care plan for beneficiaries whose mental illness is being treated by the Medi-Cal managed care plan.

(3) Management of a beneficiary's care, including procedures for the exchange of medical information. The procedures shall ensure that the confidentiality of medical records is maintained in accordance with State and federal laws and regulations governing the confidentiality of personal or medical information, including mental health information, relating to beneficiaries.

(4) Procedures for providing beneficiaries with services necessary to the treatment of mental illnesses covered by the MHP when those necessary services are covered by the Medi-Cal managed care plan. The procedures shall address, but are not limited to:

(A) Prescription drugs and laboratory services covered by the Medi-Cal managed care plan and prescribed through the MHP. Prescription drug and laboratory service procedures shall include:

1. The MHP's obligation to provide the names and qualifications of the MHP's prescribing physicians to the Medi-Cal managed care plan, if the Medi-Cal managed care plan covers prescription drugs.

2. The Medi-Cal managed care plan's obligation to provide the Medi-Cal managed care plan's procedures for obtaining authorization of prescribed drugs and laboratory services and a list of available pharmacies and laboratories to the MHP, if the Medi-Cal managed care plan covers these services.

3. The MHP's obligation to designate a process or entity to receive notices of actions, denials, or deferrals from the Medi-Cal managed care plan and to provide any additional information requested in the deferral notice as necessary for a medical necessity determination by the Medi-Cal managed care plan.

4. The MHP's obligation to respond by the close of the business day following the day the deferral notice is received by the MHP.

(B) Emergency room facility and related services other than specialty mental health services, home health agency services as described in Title 22, Section 51337, non-emergency medical transportation, and services to treat the physical health care needs of beneficiaries who are receiving psychiatric inpatient hospital services, including the history and physical required upon admission.

(C) Direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address a beneficiary's medical problems based on changes in the beneficiary' mental health or medical condition.

(5) A process for resolving disputes between the MHP and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services, including specialty mental health services and prescription drugs, while the dispute is being resolved. When the dispute involves the Medi-Cal managed care plan continuing to provide services to a beneficiary the Medi-Cal managed care plan believes requires specialty mental health services from the MHP, the MHP shall identify and provide the Medi-Cal managed care plan with the name and telephone number of a psychiatrist or other qualified licensed mental health professional available to provide clinical consultation, including consultation on medications to the Medi-Cal managed care plan provider responsible for the beneficiary's care.

(b) If the MHP does not enter into an MOU with the Medi-Cal managed care plan, the MHP shall not be out of compliance with this Section provided the MHP establishes to the satisfaction of the Department that it has made good faith efforts to enter into an MOU.

§ 1810.415. Coordination of Physical and Mental Health Care.

(a) The MHP shall make clinical consultation and training, including consultation and training on medications, available to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by the MHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving specialty mental health services from the MHP.

(b) The MHP shall arrange appropriate management of a beneficiary's care, including the exchange of medical information, with a beneficiary's other health care providers or providers of specialty mental health services. The MHP shall maintain the confidentiality of medical records in accordance with State and federal laws and regulations governing the confidentiality of personal or medical information, including mental health information, relating to beneficiaries.

(c) The MHP shall coordinate with pharmacies and Medi-Cal managed care plans as appropriate to assist beneficiaries to receive prescription drugs and laboratory services prescribed through the MHP, including ensuring that any medical justification of the services required for approval of payment to the pharmacy or laboratory is provided to the authorizing entity in accordance with the authorizing entity's procedures.

(d) When the MHP determines that the beneficiary's diagnosis is not included in Section 1830.205(b)(1) or is included but would be responsive to physical health care based treatment, the MHP of the beneficiary shall refer the beneficiary to:

(1) A provider outside the MHP, which may include:

(A) Whenever possible, a provider with whom the beneficiary already has a patient-provider relationship;

(B) The Medi-Cal managed care plan in which the beneficiary is enrolled;

(C) A provider in the area who has indicated to the MHP a willingness to accept MHP referrals, including federally qualified health centers, rural health clinics, and Indian health clinics; or

(2) An entity that provides assistance in identifying providers willing to accept Medi-Cal beneficiaries, which may include, where appropriate:

(A) The health care options program described in Section 14016.5 of the Welfare and Institutions Code;

(B) The local Child Health and Disability Prevention program as described in Title 17, Section 6800 et seq.;

(C) Provider organizations;

(D) Other community resources available in the county of the MHP.

The MHP of the beneficiary shall not be required to ensure the beneficiary's access to physical health care based treatment or to ensure the beneficiary's access to treatment from licensed mental health professionals for diagnoses not covered in Section 1830.205(b)(1). When the situation generating a referral under this Subsection meets the criteria established in Section 1850.210(i), a notice of action will be provided in accordance with that Section.

§ 1850.505. Requests for Resolution.

(a) Except as provided in Subsection (c), when an MHP has a dispute with a Medi-Cal Managed Care Plan that cannot be resolved to the satisfaction of the MHP concerning the obligations of the MHP or the Medi-Cal Managed Care Plan under their respective contracts with the State, State Medi-Cal laws and regulations, or an MOU as described in Section 1810.370, the MHP may submit a request for resolution to the Department.

(b) Except as provided in Subsection (c), when a Medi-Cal Managed Care plan has a dispute with an MHP that cannot be resolved to the satisfaction of the Medi-Cal Managed Care Plan concerning the obligations of the MHP or the Medi-Cal Managed Care Plan under their respective contracts with the State, State Medi-Cal laws and regulations, or an MOU as described in Section 1810.370, the Medi-Cal Managed Care Plan may submit a request for resolution to the State Department of Health Services.

(c) If the MHP and the Medi-Cal managed care plan have agreed in the MOU entered into pursuant to Section 1810.370 to binding arbitration as the means for resolving disputes, the MHP and the Medi-Cal managed care plan may not request resolution of the dispute under this Section.

(d) If the MHP and the Medi-Cal Managed Care Plan have an MOU pursuant to Section 1810.370, a request for resolution by either department shall be submitted to the respective

department within 15 calendar days of the completion of the dispute resolution process between the parties as provided in the MOU. If there is no MOU, a request for resolution shall be submitted to the respective department within 30 calendar days after the event giving rise to the dispute. The request for resolution shall contain the following information:

- (1) A summary of the issue and a statement of the desired remedy, including any disputed services that have been or are expected to be delivered to the beneficiary and the expected rate of payment for each type of service.
 - (2) History of attempts to resolve the issue.
 - (3) Justification for the desired remedy.
 - (4) Documentation regarding the issue.
- (e) Upon receipt of a request for resolution, the department receiving the request shall notify the other department and the other party within seven calendar days. The notice to the other party shall include a copy of the request and will ask for a statement of the party's position on the dispute, any relevant documentation supporting its position, and any dispute of the rate of payment for services included by the other party in its request.
- (f) The other party shall submit the requested documentation within 21 calendar days from notification of the party from whom documentation is being requested by the party that received the initial request for resolution or the departments shall decide the dispute based solely on the documentation filed by the initiating party.

§ 1850.515. Departments' Responsibility for Review of Disputes.

- (a) The two departments shall each designate at least one and no more than two individuals to review the dispute and make a joint recommendation to directors of the departments or their designees.
- (b) The recommendation shall be based on a review of the submitted documentation in relation to the statutory, regulatory and contractual obligations of the MHP and the Medi-Cal Managed Care Plan.
- (c) The individuals reviewing the dispute may, at their discretion, allow representatives of both the MHP and the Medi-Cal Managed Care Plan an opportunity to present oral argument.

§ 1850.525. Provision of Medically Necessary Services Pending Resolution of Dispute.

A dispute between an MHP and a Medi-Cal Managed Care Plan shall not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries. Until the dispute is resolved, the following shall apply:

- (a) The parties may agree to an arrangement satisfactory to both parties regarding how the services under dispute will be provided; or
- (b) When the dispute concerns the Medi-Cal Managed Care Plan's contention that the MHP is required to deliver specialty mental health services to a beneficiary either because the

beneficiary's condition would not be responsive to physical health care based treatment or because the MHP has incorrectly determined the beneficiary's diagnosis to be a diagnosis not covered by the MHP, the Medi-Cal Managed Care Plan shall manage the care of the beneficiary under the terms of its contract with the State until the dispute is resolved. The MHP shall identify and provide the Medi-Cal managed care plan with the name and telephone number of a psychiatrist or other qualified licensed mental health professional available to provide clinical consultation, including consultation on medications to the Medi-Cal managed care plan provider responsible for the beneficiary's care.

(c) When the dispute concerns the MHP's contention that the Medi-Cal Managed Care Plan is required to deliver physical health care based treatment of a mental illness, or to deliver prescription drugs or laboratory, radiological, or radioisotope services required to diagnose or treat the mental illness, the MHP shall be responsible for providing or arranging and paying for those services to the beneficiary until the dispute is resolved.

MEMORANDUM OF UNDERSTANDING REQUIREMENTS FOR MEDI-CAL MANAGED CARE PLANS AND COUNTY MENTAL HEALTH PLANS

PURPOSE

The purpose of this document is to describe the responsibilities of Medi-Cal managed care plans (MCPs) for amending or replacing memoranda of understanding (MOU) with the county Mental Health Plans (MHPs) for coordination of Medi-Cal mental health services. These requirements are in addition to existing MOU requirements for specialty mental health services provided by the MHP as outlined in Title 9, Chapter 11 — Medi-Cal Specialty Mental Health Services Regulations (Attachment 1) and Exhibits 11 and 12 of the current MCP contracts.

On January 1, 2014, the following outpatient mental health benefits will be available through MCPs for members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from any mental health condition defined by the current *Diagnostic and Statistical Manual* that is also covered according to State regulations:

- Individual and group mental health evaluation and treatment (psychotherapy).
- Psychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for the purposes of monitoring therapy with medications.
- Psychiatric consultation.
- Outpatient laboratory, medications, supplies, and supplements (excluding medications as described in a forthcoming APL, Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services and Coordination with County Mental Health Plans).

ATTESTATION TO UPDATE MOU

The MCPs must provide an attestation by December 9, 2013 to amend or replace existing MOUs with MHPs that address the provision of all covered mental health services. The amended or new MOU must address the mental health outpatient benefits covered by the MCPs in addition to the existing requirements for specialty mental health services covered by the MHPs. Fully executed MOUs are due to the Department of Health Care Services (DHCS) by June 30, 2014, and are subject to DHCS approval.

MCPs must provide monthly updates via email or letter to DHCS on efforts to implement the MOU beginning on February 15, 2014 for the previous month and due the 15th of each month thereafter through June 30, 2014. Please send the MOUs and monthly updates to your Contract Manager.

If the MCP and MHP do not enter into a MOU, neither plan shall be out of compliance provided the MCP and the MHP establish, and can demonstrate to the satisfaction of DHCS, that they have made good faith efforts to enter into a MOU. DHCS may require subsequent efforts to implement a MOU.

MOU REQUIREMENTS

Amended or new MOUs shall include, but not be limited to, the following additional requirements for outpatient Medi-Cal mental health services covered by the MCPs:

1. Basic Requirements

The MOU shall address policies and procedures for management of the beneficiary's care, including, but not limited to, the following: screening assessment and referrals, medical necessity determination, care coordination, and exchange of medical information.

2. Covered Services and Populations

The MOU shall include the Coverage and Population Matrix developed by DHCS (forthcoming in "Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services and Coordination with County Mental Health Plans" APL). Parties may include this Matrix as an attachment to the MOU.

3. Oversight Responsibilities of the MCP and the MHP

The MOU shall include, but not be limited to, the following responsibilities:

- a. MCP organizational approach to mental health management (i.e., direct or subcontracted care management, direct or subcontracted provider network).
- b. MCP and MHP mental health Medi-Cal oversight team comprised of representatives of the MCP and MHP responsible for program oversight, quality improvement, problem and dispute resolution, and ongoing management of the MOU.
- c. MCP and MHP multidisciplinary clinical team oversight process for clinical operations: screening, assessment, referrals, care management, care coordination, and exchange of medical information. The MCP and MHP may determine the composition of the multidisciplinary teams.
- d. The MCP and the MHP oversight teams and multidisciplinary teams may be the same teams.

4. Screening, Assessment, and Referral

The MCP and MHP shall develop and agree to written policies and procedures for screening, assessment, and referral processes, including screening and assessment tools for use in determining if the MCP or MHP will provide mental health services. The screening, assessment, and referral must be completed within a reasonable period that ensures timely access to services for all beneficiaries. The policies and procedures must include, but not be limited to, the following requirements:

- a. Each MCP is obligated to conduct a mental health assessment for members with a potential mental health condition using a tool mutually agreed upon with the MHP to determine the appropriate care needed.
- b. MHP accepts referrals from MCP staff, providers, and members' self-referrals for determination of medical necessity for specialty mental health services. The MCP primary care provider refers the member to the MCP mental health network provider for initial assessment and treatment (except in emergency situations or in cases when the beneficiary clearly has a significant impairment that the member can be referred directly to the MHP). If it is determined by the MCP mental health provider that the member may meet specialty mental health services medical necessity criteria, the MCP mental health network provider refers the member to the MHP for further assessment and treatment.

- c. MCP accepts referrals from MHP staff, providers, and members' self-referral for assessment, makes a determination of medical necessity for outpatient services, and provides referrals within the MCP mental health provider network. The MHP refers to the MCP when the service needed is one provided by the MCP and not the MHP, and when it has been determined by the MHP that the beneficiary does not meet the specialty mental health medical necessity criteria.

5. Care Coordination

The MCP and MHP will develop and agree to policies and procedures for coordinating inpatient and outpatient medical and mental health care for beneficiaries enrolled in the MCP and receiving Medi-Cal specialty mental health services through the MHP. The MCP and MHP shall have policies and procedures that address, but are not limited to, the following:

- a. An identified point of contact from each party who will initiate, provide, and maintain ongoing care coordination as mutually agreed upon in MCP and MHP protocols.
- b. Coordination of care for inpatient mental health treatment provided by the MHP, including a notification process between the MHP and the MCP within 24 hours of admission and discharge to arrange for appropriate follow-up services. A process for reviewing and updating the care plan of beneficiaries, as clinically indicated (i.e., following crisis intervention or hospitalization). The process must include triggers for updating care plans and coordinating with outpatient mental health providers.
- c. Transition of care for members transitioning to or from MCP or MHP services.
- d. Regular meetings to review referral, care coordination, and information exchange protocols and processes.

6. Information Exchange

The MCP and MHP shall have policies and procedures that ensure timely sharing of information. The policies and procedures shall describe agreed upon roles and responsibilities for sharing protected health information (PHI) for the purposes of medical and behavioral health care coordination pursuant to Title 9, CCR, Section 1810.370(a)(3), and in compliance with HIPAA and other State and federal privacy laws. Such information may include, but is not limited to, beneficiary demographic information, diagnosis, treatment plan, medications prescribed, laboratory results, referrals/discharges to/from inpatient and crisis services, and known changes in condition that may adversely impact the beneficiary's health and/or welfare.

7. Reporting and Quality Improvement Requirements

The MOU shall specify policies, procedures, and reports to address quality improvement requirements for mental health services including, but not limited to:

- a. Regular meetings, as agreed upon by the MCP and MHP, to review the referral and care coordination process and to monitor member engagement and utilization.
- b. No less than a semi-annual calendar year review of referral and care coordination processes to improve quality of care; and at least semi-annual reports summarizing quality findings, as determined in collaboration with DHCS. Reports summarizing findings of the review must address the systemic strengths and barriers to effective collaboration between the MCP and MHP.
- c. Reports that track cross-system referrals, beneficiary engagement, and service utilization to be determined in collaboration with DHCS, including, but not limited to, the number of disputes between the MCP and MHP, the dispositions/outcomes of those disputes, the number of grievances related to referrals and network access,

- and the dispositions/outcomes of those grievances. Reports shall also address utilization of mental health services by members receiving such services from the MCP and the MHP, as well as quality strategies to address duplication of services.
- d. Performance measures and quality improvement initiatives to be determined in collaboration with DHCS.

8. Dispute Resolution

The MOU must describe a mutually agreed upon review process to facilitate timely resolution of clinical and administrative disputes, including differences of opinion about whether the MCP or MHP should provide mental health services. The review process may not result in delays in member access to services while the decision from the formal dispute resolution process is pending. The MCP and MHP must also agree to follow the resolution of dispute process in accordance with Title 9, Section 1850.505.¹

9. After-Hours Policies and Procedures

The MOU shall specify access during non-business hours:

- a. Access for members and providers after hours.
- b. 24/7 emergency access.

10. Member and Provider Education

The MCP and MHP shall determine requirements for coordination of member and provider information about access to MCP and MHP covered mental health services. For example, the MCP and MHP may develop “Frequently Asked Questions” on their respective websites about mutually agreed upon screening and referral protocols.

DEFINITIONS

California Department of Health Care Services (DHCS) means the single State department responsible for administration of the federal Medicaid program (referred to as Medi-Cal in California), California Children Services, Genetically Handicapped Persons Program, Child Health and Disabilities Prevention, and other health related programs. DHCS provides State oversight of the MCPs and the MHPs.

Good Faith, for the purposes of this document, means efforts by the MCP and MHP to negotiate a MOU, and determined by an independent DHCS evaluator that both parties made reasonable, but ultimately unsuccessful, efforts to come to an agreement.

Medically Necessary or **Medical Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

When determining the medical necessity of covered services for a Medi-Cal beneficiary under the age of 21, “medical necessity” is expanded to include the standards set forth in Title 22 CCR Sections 51340 and 51340.1.

Medical necessity for specialty mental health services is defined at Title 9, CCR, Sections 1820.205, 1830.205, and 1830.210.

¹ DHCS will convene a work group to further address the dispute resolution process for those instances when the MCP and MHP cannot resolve clinical differences of opinions.

Member means an eligible beneficiary who has enrolled in the MCP.

Quality Improvement means the result of an effective quality improvement system.

Quality of Care means the degree to which the MCP/MHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality, as specified by the Institute of Medicine. The six domains are as follows: efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.

Specialty Mental Health Services means the following mental health services covered by MHPs:

- Outpatient services:
 - Mental health services (assessments, plan development, therapy, rehabilitation, and collateral).
 - Medication support services.
 - Day treatment intensive services.
 - Day rehabilitation services.
 - Crisis intervention services.
 - Crisis stabilization services.
 - Targeted case management services.
 - Therapeutic behavioral services.
- Residential services:
 - Adult residential treatment services.
 - Crisis residential treatment services.
- Inpatient services:
 - Acute psychiatric inpatient hospital services.
 - Psychiatric inpatient hospital professional services.
 - Psychiatric health facility services.

Timely, for the purposes of MOU requirements outlined in this document, means a reasonable time period from the date of request for services to the date when the beneficiary receives medically necessary mental health services. Timeliness also applies to the provision of information that may positively impact the course of treatment, would not negatively impact the member's condition or delay the provision of services. All timeliness standards must be consistent with Knox-Keene access standards and the contract requirements for MCPs and MHPs.



TOBY DOUGLAS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

DATE: December 13, 2013

ALL PLAN LETTER 13-021

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE PLAN RESPONSIBILITIES FOR
OUTPATIENT MENTAL HEALTH SERVICES

PURPOSE:

The purpose of this All Plan Letter (APL) is to explain the contractual responsibilities of Medi-Cal managed care plans (MCPs) for the provision of medically necessary outpatient mental health services. MCPs must provide specified services to adults and children diagnosed with a mental health disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) that results in mild to moderate distress or impairment¹ of mental, emotional, or behavioral functioning. This APL also delineates MCP responsibilities for referring to, and coordinating with, county Mental Health Plans (MHPs) for the delivery of specialty mental health services.

This letter provides updates to the responsibilities of the MCPs for providing mental health services that were described in Policy Letter (PL) 00-001REV². Specialty mental health services (SMHS) provided by county MHPs as described in PL 00-001REV have not changed, and therefore remain the same. The Department of Health Care Services (DHCS) also issued APL 13-018 on November 27, 2013 to address the required memorandum of understanding (MOU) between each MCP and its county MHP.³

BACKGROUND:

The Section 1915(b) Freedom of Choice waiver entitled Medi-Cal Specialty Mental Health Services requires Medi-Cal beneficiaries needing specialty mental health services to access these services through MHPs. To qualify for these services, beneficiaries must meet specialty mental health services medical necessity criteria including having received a covered diagnosis, demonstrating specified impairments,

¹ DHCS recognizes that the medical necessity criteria for impairment and intervention for Medi-Cal specialty mental health services differ for children and adults. Therefore, many children with impairments that may be considered moderate meet, and will continue to meet, medical necessity criteria (Title 9, CCR, Section 1830.210) to access Medi-Cal specialty mental health services provided by MHPs.

² Policy Letters are available at <http://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx>.

³ APLs are available at <http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>.

and meeting specific intervention criteria. Medical necessity criteria differ depending on whether the determination is for:

1. Inpatient services;
2. Outpatient services; or
3. Outpatient services for beneficiaries under the age of 21.

Regulations governing medical necessity criteria may be found at Title 9, California Code of Regulations (CCR), Sections (§§) 1820.205 (inpatient),⁴ 1830.205 (outpatient), and 1830.210 (outpatient for beneficiaries under the age of 21).

1. Pursuant to Title 9, CCR §1830.205, a beneficiary must meet the following criteria to receive outpatient Medi-Cal specialty mental health services:
 - a. Diagnosis: The beneficiary has one or more diagnoses covered by Title 9, CCR §1830.205(b)(1), whether or not additional diagnoses that are not included in Title 9, CCR §1830.210(b)(1) are also present.
 - b. Impairment: The beneficiary must have at least one of the following impairments as a result of the covered mental health diagnosis (see #1.a. above):
 - i. A significant impairment in an important area of life functioning;
 - ii. A reasonable probability of significant deterioration in an important area of life functioning; or,
 - iii. Except as described in #2 below, a reasonable probability a child (e.g. a beneficiary under the age of 21) will not progress developmentally as individually appropriate.
 - c. Intervention: The proposed intervention is focused on addressing the impairment resulting from the covered diagnosis with the expectation that the proposed intervention will significantly diminish the impairment, prevent significant deterioration in an important area of life functioning, or, except as described in #2 below, allow the child to progress developmentally as individually appropriate. In addition, the beneficiary's condition would not be responsive to physical health care based treatment.
2. Pursuant to Title 9, CCR, §1830.210, for beneficiaries under the age of 21 receiving services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit who do not meet the medical necessity requirements described in #1.b and #1.c above, medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services are met when all of the following exist:
 - a. Diagnosis: The beneficiary has one or more diagnoses covered by Title 9, CCR §1830.205(b)(1), whether or not additional diagnoses that are not included in Title 9, CCR §1830.210(b)(1) are also present;

⁴ Medical necessity criteria for inpatient specialty mental health services (Title 9, CCR, §1820.205) are not described in detail in this APL, as this APL is primarily focused on outpatient mental health services.

- b. Impairment: The beneficiary has a condition that would not be responsive to physical health care-based treatment and meets the requirements of Title 22, CCR §51340(e)(3)(A) with respect to the mental illness which provides a list of criteria that apply to the provision of EPSDT supplemental services including, but not limited to, the requirement that the service provided must correct or ameliorate the mental health condition; and,
- c. Intervention: The services are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

Through December 31, 2013, MCP beneficiaries with mental health conditions that do not meet medical necessity criteria for specialty mental health services have only had access to limited outpatient mental health services delivered by primary care providers (PCPs) or were referred to Medi-Cal Fee-for-Service mental health providers. DHCS pays MCPs a capitated rate to provide mental health services that are within the PCP's scope of practice (unless otherwise excluded by contract). Effective January 1, 2014, DHCS will adjust MCP capitation payments to include the expanded outpatient mental health services described in this APL.

This letter describes the new policy regarding outpatient mental health services in accordance with sections 29 and 30 of Senate Bill X1 1 of the First Extraordinary Session (Hernandez & Steinberg, Chapter 4, Statutes of 2013), which added §§14132.03 and 14189 to the Welfare and Institutions Code.

POLICY:

Beginning January 1, 2014, MCPs are responsible for the delivery of certain mental health services through the MCP provider network to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder as defined by the current DSM, that are outside of the PCP's scope of practice. The eligibility and medical necessity criteria for Medi-Cal specialty mental health services provided by MHPs have not changed pursuant to this policy. Specialty mental health services provided by MHPs continue to be available.

MCPs continue to be responsible for the provision of mental health services within the scope of PCP practice. MCPs will also continue to be responsible for the arrangement and payment of all medically necessary Medi-Cal physical health care services, not otherwise excluded by contract, to MCP beneficiaries who require specialty mental health services.

MCP Responsibility for Outpatient Mental Health Services

Effective January 1, 2014, each MCP is obligated to cover and pay for mental health assessments of MCP beneficiaries with potential mental health disorders conducted by licensed mental health professionals as specified in the Medi-Cal Provider Manual. This new requirement is in addition to the existing requirement that PCPs offer mental health

services within their scope of practice. MCPs are also obligated to cover outpatient mental health services to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning (assessed by a licensed mental health professional through the use of a Medi-Cal-approved clinical tool or set of tools agreed upon by both the MCP and MHP), resulting from a mental health disorder, as defined in the current DSM. Conditions that the DSM identifies as relational problems (e.g. couples counseling, family counseling for relational problems) are not covered as part of the new benefit by an MCP nor by an MHP. All services must be provided in a culturally and linguistically appropriate manner.

Attachment 1 summarizes mental health services provided by MCPs and MHPs. MCPs must provide the services listed below, when medically necessary and provided by PCPs or licensed mental health professionals in the MCP provider network within the scope of their practice:

1. Individual and group mental health evaluation and treatment (psychotherapy);
2. Psychological testing, when clinically indicated to evaluate a mental health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Outpatient laboratory, drugs, supplies, and supplements (excluding medications listed in Attachment 2); and,
5. Psychiatric consultation.

Current Procedural Terminology codes that are covered can be found in the Medi-Cal Provider Manual.

Laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications. Supplies may include laboratory supplies. Supplements may include vitamins that are not specifically excluded in the Medi-Cal formulary and that are scientifically proven effective in the treatment of mental health disorders (although none are currently indicated for this purpose).

For MCP-covered services, medically necessary services are defined as reasonable and necessary services to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. These include services to:

1. Diagnose a mental health condition and determine a treatment plan;
2. Provide medically necessary treatment for mental health conditions (excluding couples and family counseling for relational problems) that result in mild or moderate impairment; and,
3. Refer adults to the county MHP for specialty mental health services when a mental health diagnosis covered by the MHP results in significant impairment; or

refer children under age 21 to the MHP for specialty mental health services when they meet the criteria for those services.

The number of visits for mental health services is not limited as long as the MCP beneficiary meets medical necessity criteria.

Each MCP is obligated to continue to ensure mental health screening of all beneficiaries by network PCPs. Beneficiaries with positive screening results may be treated by a network PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the MCP must refer the beneficiary to a mental health provider within the MCP network for a mental health assessment. The mental health provider must use a Medi-Cal-approved clinical tool or the set of tools mutually agreed upon with the MHP to assess the beneficiary's disorder, level of impairment, and appropriate care needed. This tool must be identified in the MOU between the MCP and MHP, as discussed in APL 13-018.

If an MCP beneficiary with a mental health diagnosis is not eligible for MHP services because the adult beneficiary's level of impairment is mild to moderate, or, for adults and children, the recommended treatment does not meet criteria for Medi-Cal specialty mental health services, then the MCP is required to ensure the provision of the outpatient mental health services listed or other appropriate services within the scope of the MCP's covered services.

Each MCP must ensure its network providers refer beneficiaries with significant impairment resulting from a covered mental health diagnosis to the county MHP. Also, when the MCP beneficiary has a significant impairment, but the diagnosis is uncertain, the MCP must ensure that the beneficiary is referred to the MHP for further assessment.

MCPs must also cover outpatient laboratory tests, medications (excluding those listed in Attachment 2), supplies, and supplements prescribed by the mental health providers in the MCP network, as well as by PCPs, to assess and treat mental health conditions. The MCP may require that covered services be provided through the MCP's provider network and be subject to a medical necessity determination.

The MCP may negotiate with the MHP to provide the outpatient mental health services when the MCP covers payment for these services.

MCPs continue to be required to provide medical case management and cover and pay for all medically necessary Medi-Cal-covered physical health care services for an MCP beneficiary receiving specialty mental health services. The MCP must coordinate with the MHP. The MCP is responsible for the appropriate management of a beneficiary's mental and physical health care, which includes, but is not limited to, the coordination of all medically necessary, contractually required Medi-Cal-covered services, including mental health services, both within and outside the MCP's provider network.

DHCS will monitor the implementation of this new policy and make adjustments as needed. Reporting requirements and performance metrics are being established with input from MCPs and will be communicated in a separate APL.

If you have any questions regarding this APL, please contact Sarah Royce, MD, MPH at sarah.royce@dhcs.ca.gov or Liana Lianov, MD, MPH, at liana.lianov@dhcs.ca.gov, Medi-Cal Managed Care Division.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar
Assistant Deputy Director
Health Care Delivery Systems

Attachments

**Attachment 1
Mental Health Services Description Chart for Medi-Cal Managed Care Members**

DIMENSION	Medi-Ca	PATIENT	MHP INPATIENT
<p>ELIGIBILITY</p>	<p>Mild to Moderate Impairment in Functioning</p> <p>A member is covered by the MCP for services if he or she is diagnosed with a mental health disorder as defined by the current DSM³ resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning:</p> <ul style="list-style-type: none"> • Primary care providers identify the need for a mental health screening and refer to a specialist within their network. Upon assessment, the mental health specialists can assess the mental health disorder and the level of impairment and refer members that meet medical necessity criteria to the MHP for a Specialty Mental Health Services (SMHS) assessment. • When a member's condition improves under SMHS and the mental health providers in the MCP and MHP coordinate care, the member may return to the MH provider in the MCP network. <p><i>Note: Conditions that the current DSM identifies as relational problems are not covered, i.e. couples counseling or family counseling.</i></p>	<p>Significant Impairment in Functioning</p> <p>A member is eligible for services if he or she meets all of the following medical necessity criteria:</p> <ol style="list-style-type: none"> 1. Has an included mental health diagnosis;⁴ 2. Has a significant impairment in an important area of life function, or a reasonable probability of significant deterioration in an important area of life function, or a reasonable probability of not progressing developmentally as individually appropriate; 3. The focus of the proposed treatment is to address the impairment(s) described in #2; 4. The expectation that the proposed treatment will significantly diminish the impairment, prevent significant deterioration in an important area of life function, and 5. The condition would not be responsive to physical health care-based treatment. <p><i>Note: For members under age 21 who meet criteria for EPSTD specialty mental health services, the criteria allow for a range of impairment levels⁴ and include treatment that allows the child to progress developmentally as individually appropriate.</i></p>	<p>Emergency and Inpatient</p> <p>A member is eligible for services if he or she meets the following medical necessity criteria:</p> <ol style="list-style-type: none"> 1. An included diagnosis; 2. Cannot be safely treated at a lower level of care; 3. Requires inpatient hospital services due to one of the following which is the result of an included mental disorder: <ol style="list-style-type: none"> a. Symptoms or behaviors which represent a current danger to self or others, or significant property destruction; b. Symptoms or behaviors which prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter; c. Symptoms or behaviors which present a severe risk to the beneficiary's physical health; d. Symptoms or behaviors which represent a recent, significant deterioration in ability to function; e. Psychiatric evaluation or treatment which can only be performed in an acute psychiatric inpatient setting or through urgent or emergency intervention provided in the community or clinic; and f. Serious adverse reactions to medications, procedures or therapies requiring continued hospitalization.

¹ Medi-Cal Managed Care Plan

² County Mental Health Plan Medi-Cal Specialty Mental Health Services

³ Current policy is based on DSM IV and will be updated to DSM 5 in the future

⁴ As specified in regulations Title IX, Sections 1820.205 and 1830.205 for adults and 1830.210 for those under age 21

DIMENSION	Medi-Cal ⁵	MHP ⁶ OUTPATIENT	MHP INPATIENT
SERVICES	<p>Mental health services when provided by licensed mental health care professionals (as defined in the Medi-Cal provider bulletin) acting within the scope of their license:</p> <ul style="list-style-type: none"> • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient services for the purposes of monitoring medication therapy • Outpatient laboratory, medications, supplies, and supplements • Psychiatric consultation 	<p>Medi-Cal Specialty Mental Health Services:</p> <ul style="list-style-type: none"> • Mental Health Services <ul style="list-style-type: none"> ○ Assessment ○ Plan development ○ Therapy ○ Rehabilitation ○ Collateral • Medication Support Services • Day Treatment Intensive • Day Rehabilitation • Crisis Residential • Adult Crisis Residential • Crisis Intervention • Crisis Stabilization • Targeted Case Management 	<ul style="list-style-type: none"> • Acute psychiatric inpatient hospital services • Psychiatric Health Facility Services • Psychiatric Inpatient Hospital Professional Services if the beneficiary is in fee-for-service hospital

⁵ Medi-Cal Managed Care Plan

⁶ County Mental Health Plan Medi-Cal Specialty Mental Health Services

Attachment 2

Drugs Excluded from MCP Coverage

The following psychiatric drugs are noncapitated except for HCP 170 (KP Cal, LLC)	
Amantadine HCl	Olanzapine Fluoxetine HCl
Aripiprazole	Olanzapine Pamoate Monohydrate (Zyprexa Relprevv)
Asenapine (Saphris)	
Benzotropine Mesylate	Paliperidone (Invega)
Biperiden HCl	Paliperidone Palmitate (Invega Sustenna)
Biperiden Lactate	
Chlorpromazine HCl	Perphenazine
Chlorprothixene	Phenelzine Sulfate
Clozapine	Pimozide
Fluphenazine Decanoate	Prochlorperidine HCl
Fluphenazine Enanthate	Promazine HCl
Fluphenazine HCl	Quetiapine
Haloperidol	Risperidone
Haloperidol Decanoate	Risperidone Microspheres
Haloperidol Lactate	Selegiline (transdermal only)
Iloperidone (Fanapt)	Thioridazine HCl
Isocarboxazid	Thiothixene
Lithium Carbonate	Thiothixene HCl
Lithium Citrate	Tranlycypromine Sulfate
Loxapine HCl	Trifluoperazine HCl
Loxapine Succinate	Triflupromazine HCl
Lurasidone Hydrochloride	Trihexyphenidyl
Mesoridazine Mesylate	Ziprasidone
Molindone HCl	Ziprasidone Mesylate
Olanzapine	

These drugs are listed in the Medi-Cal Provider Manual in the following link:

http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpgmc_z01.doc