Medi-Cal Managed Care Advisory Committee
Meeting Date: October 23, 2017

Mental Health Split Benefit: Panel Questions

A. The State splits the mental health benefit by requiring Plans treat individuals with mild-to-moderate needs and County Mental Health Plan (MHP) serves those with severe mental health needs. See table.

1. What direction do the Plans provide IPAs and Providers on determining whether someone is appropriate to treat within the plan benefit?
2. Do all physicians/clinics treat members with "moderate" needs? Or, do they refer to plan MH network providers?
3. Is there a uniform definition or tool?
4. What happens when a primary care provider or County MHP disagree on where the patient should be treated? Who do they talk to? How long does this take?

B. Individuals diagnosed with a mental health condition(s) do not have a static need. Some may present with a mild/moderate need but later functioning may deteriorate and they present with a severe need. Or, some individuals with severe mental health conditions such as schizophrenia or bipolar disorder may no longer need County MHP services.

1. What is the process to transition a client in an urgent situation? Contact? Timeframe?
2. What is the process to transition a client to a less intensive service such as the Plan MH benefit? Contact timeframe?

C. Care Coordination
Data informs us that having a diagnosed mental health condition is a high cost driver of physical health care costs. Co-morbidity is a health disparity. Those with a serious mental health condition do not have the same life expectancy as those without a serious mental health condition.

1. Do providers (physical health / County MHP) share information about diagnosis and treatment in order to coordinate care and optimize treatment?
2. Sometimes there are numerous individuals involved in coordinating care. Who is responsible (within the Plan? County MHP?)

D. Utilization data appears low for mental health services in comparison to expected need.

1. How are members educated about the split benefit (initial, upon need)?
2. How can we obtain better data?
3. How do we overcome the technical hurdles?

E. The Advocate Perspective was presented at the August meeting. Respond to the suggestions / issues raised.

1. Providers should not tell clients to call the Plan or County to access MH services. It is necessary to ensure the connection to Behavioral Health.
2. Clients have trouble finding BH providers. They get a list of providers, but when they start calling, they find the provider is not accepting new patients, a referral is needed, etc. Would it be possible for member services to get the client connected with the BH provider or with Case Management?
3. How do you define "moderate" vs. "severe," and how can you prevent members from being passed back and forth?

F. Committee Discussion

1. Questions & Answers
2. Next steps

Facilitation / Questions – DHHS Primary Health Services

Panel Members – Health Plans, County Mental Health Plan, Advocate