# MEDI-CAL MANAGED CARE PLAN MENTAL HEALTH SERVICES

## An Unfulfilled Promise for Communities of Color

September 2021

## Table of Contents


Acknowledgements 3

Introduction 3

Background 3

Medi-Cal Mental Health Services 4

Disparities in Access to Medi-Cal Managed Care Plan Mental Health Services 6

Methods 9

Primary Care Physician Interview Findings 10

Member Website Testing Findings 14

Recommendations 16

Conclusion 21

Appendices 22



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## About CPEHN

The California Pan-Ethnic Health Network (CPEHN) is a multicultural health policy organization dedicated to improving the health of communities of color in California. CPEHN's mission is to advance health equity by advocating for public policies and sufficient resources to address the health needs of the state's new majority. We gather the strength of communities of color to build a united and powerful voice in health advocacy. More about CPEHN can be found here: www.cpehn.org


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## Introduction

The COVID-19 pandemic has devastated low-income Black, Indigenous, and People of Color (BIPOC) communities, and is expected to leave a lasting impact on the mental health and wellbeing of many Californians. Latinx and Black people are nearly three times as likely to be hospitalized for COVID-19 [i] and over twice as likely to die from COVID-19 as White people.[ii] American Indian or Alaska Natives are over three times as likely to be hospitalized and over twice as likely to die.[iii] Moreover, Black adults (48%) and Latinx adults (46%) are more likely to report symptoms of anxiety and/or depression during the pandemic than White adults are (41%).[iv] The pandemic has also been devastating to Lesbian, Gay, Bisexual, Transgender, Queer, and Plus (LGBTQ+) communities: 70% of LGBTQ+ youth stated that their mental health was "poor" most of the time or always during COVID-19.[v]

The impacts of grief and loss on the mental health of BIPOC and LGBTQ+ communities as a result of COVID-19 should not be understated. Sonya Young Aadam, CEO of the California Black Women's Health Project, a statewide non-profit committed to improving the health of California's 1.2 million Black women and girls, coined the term "post-COVID stress disorder" to refer to the impending tsunami of mental health need. While the chasm between mental health need and mental health access is not new, it is incumbent upon us to take this opportunity to reflect on how to build a more equitable mental health system post-COVID.

## Background

In 2014, California's Medi-Cal program significantly strengthened access to mental health services. As a result of the Affordable Care Act, eligibility for Medi-Cal was expanded to adults in families with incomes below 138% of the federal poverty limit. By 2016, over 13 million Californians were enrolled in Medi-Cal. Along with the coverage expansion, California expanded the scope of its Medi-Cal mental health coverage to include a more comprehensive spectrum of services. Newly eligible adults, a majority of whom were people of color, often had significant unaddressed mental health needs due to years of lack of access to health care coupled with living in or near poverty. As a result of the expansion, Californians with low incomes were more likely than before to have coverage for mental health services

through Medi-Cal.[vi]

Despite these gains, access to mental health services in Medi-Cal still remains out of reach for many. This report analyzes the extent to which people of color access non-specialty Medi-Cal mental health services, why gaps remain, and what can be done to fulfill the promise of comprehensive mental health care for all Californians. This report focuses on understanding the barriers to care for adults. Children in the Medi-Cal program also face significant unmet mental health needs. Additional research and policy work is necessary to reckon with and address the gaps specific to children.

## Medi-Cal Mental Health Services

California has 58 county-run mental health plans, which are responsible for providing Medi-Cal specialty mental health services to adults enrolled in Medi-Cal who live with a serious mental illness. Specialty mental health services include, but are not limited to, mental health treatment, crisis intervention, targeted case management, intensive care coordination, outpatient residential treatment, and inpatient services. Counties provide additional mental health services, including prevention and early intervention, through the Mental Health Services Act as well as other locally funded programs. Individuals must meet specific diagnostic criteria in order to qualify for specialty mental health services. This is often referred to as "medical necessity."

Prior to 2014, adult Medi-Cal members with mental health conditions who did not meet the medical necessity criteria for county specialty mental health services had only limited access to outpatient mental health services. These services were delivered by Primary Care Physicians (PCPs) or by referral to Medi-Cal fee-for-service mental health providers.

In 2014, California implemented portions of the Affordable Care Act that expanded the range of mental health services available to adult Medi-Cal members. This expanded the scope of non-specialty mental health benefits for people who experience "mild-to-moderate" impairment of mental, emotional, or behavioral functioning, intermittent challenges or mental health conditions with less impact on individual functioning.  Medi-Cal managed care plans, or MCPs, became responsible for providing this expanded set of non-specialty mental health services, while counties maintained their responsibility to deliver specialty mental health services.

As a result, the Medi-Cal mental health benefit is now delivered through two separate systems. Counties retain responsibility for providing Medi-Cal specialty mental health services, while managed care plans (MCPs), which provide physical health care services to over 80% of members enrolled in Medi-Cal, also have responsibility for arranging and providing non-specialty mental health services for members with mild-to-moderate conditions. As part of their responsibility, MCPs are also responsible for ensuring an adequate network of mental health providers and for educating members about their right to and availability of these services. Members enrolled in fee-for-service Medi-Cal are entitled to the same scope of services. While not specifically addressed in this report, it is important to note that the Medi-Cal mental health system is somewhat different for children up to age 21.

There is some overlap between the two systems: some members receive services through both types of plans, and others move back and forth between them.[vii] In theory, the services for each member are coordinated and transitions are managed smoothly between systems. Because members move across the continuum of care, it is important for there to be strong service coordination and referral between these two systems of care so care is seamless for the member.

## Continuum of Mental Health Services: Non-Specialty and Specialty Mental Health

**Medi-Cal Managed Care Plans (MCPs)**

- 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
- Outpatient laboratory, drugs, supplies, and supplements (excluding certain medications)
- Psychiatric consultation[viii]

**County Mental Health Plan (MHP)**

- Adult crisis residential services*
- Adult residential treatment services*
- Crisis intervention
- Crisis stabilization
- Day rehabilitation
- Day treatment intensive
- Intensive care coordination**
- Intensive home-based services**
- Medication support
- Psychiatric health facility services (inpatient)
- Psychiatric inpatient hospital services
- Psychiatrist services
- Psychologist services
- Targeted case management
- Therapeutic behavioral services**
- Therapeutic foster care**
- Therapy and other service activities

* Available to adults age 18 and older.

**Available to children and youth under age 21

Many MCPs have little experience in delivering non-specialty mental health services and have limited mental health provider networks. As a result, most contract with another managed care entity, often referred to as a Managed Behavioral Health Organization (MBHO) to provide non-specialty mental health services. MBHOs develop and operate networks of mental health providers on behalf of MCPs. However, MCPs retain ultimate responsibility for ensuring appropriate access to these non-specialty mental health services for their members.[ix]

Federal law requires health insurance plans that offer coverage for both behavioral and physical health benefits to provide a similar level of benefits (also known as parity) for mental health and substance use disorder services (behavioral health services) as for physical health services. Among other things, parity is supposed to make sure it is not harder to get behavioral health services than to get physical health services.[x] In 2016, the Centers for Medicare and Medicaid Services (CMS) issued the final Medicaid Mental Health Parity Rule, providing additional guidance to state Medicaid programs on how to apply federal parity requirements. As a result, California removed certain restrictions on accessing mental health services in Medi-Cal and made clear that members may directly access mental health providers and services without prior authorization from the health plan or a referral from a Primary Care Physician (PCP).[xi] In addition, standards for timely access were applied to mental health services in the same manner as physical health services. Members must receive a mental health appointment for an urgent need within two business days and an appointment for a non-urgent need within 10 business days with a non-physician mental health provider or within 15 business days with a psychiatrist.[xii]

Since non-specialty mental health services are newer to the delivery system than specialty services, there is little available research on the implementation of this expanded benefit and recommendations for improvement. Yet, access to non-specialty mental health services is critical for the approximately one in five Medi-Cal members who may encounter mental health symptoms in any given year, the majority of whom will experience mild to moderate symptoms. For these reasons, this report focuses on examining the extent to which Medi-Cal members can access non-specialty mental health services through MCPs. CPEHN recognizes that significant challenges also exist in the specialty system and must be addressed.

## Disparities in Access to Medi-Cal Managed Care Plan Mental Health Services

Data collection and reporting on access to mental health care and mental health outcomes has historically been limited. As a result, disparities have been masked and accountability has been weak.

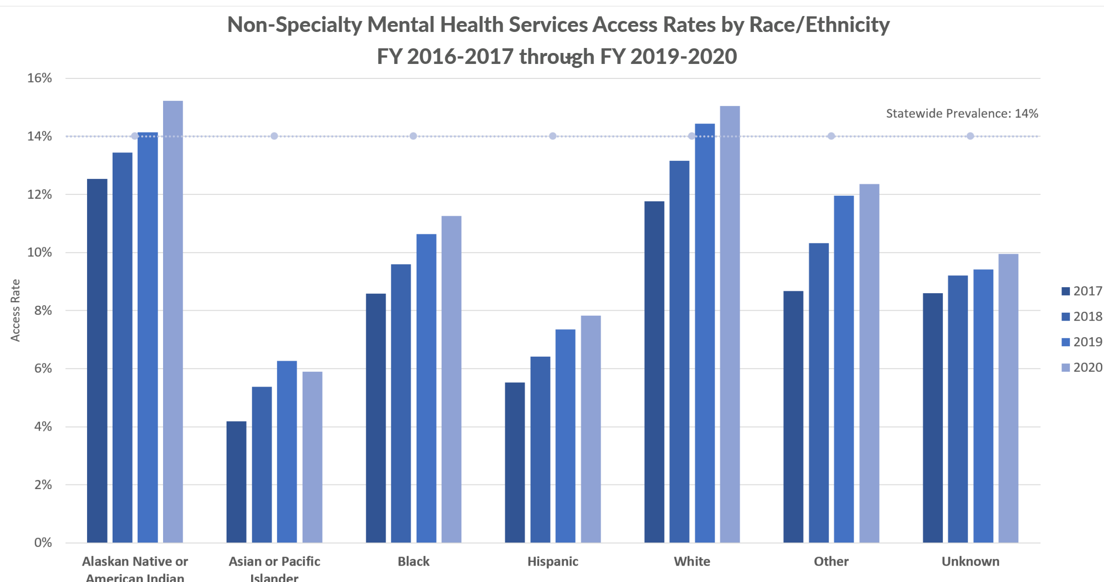
In 2017, Governor Jerry Brown signed CPEHN's sponsored legislation AB 470 (Arambula, Chapter 550) into law. It requires robust tracking and evaluation measures for mental health services in Medi-Cal, both those non-specialty mental health services provided by MCPs and those specialty mental health services provided by counties for children and adults. The goal is to ensure that Medi-Cal members receive timely access to quality mental health services, reducing mental health disparities. Medi-Cal data published in July of 2021, and released as required by AB 470, demonstrate non-specialty mental health access disparities for adults in Medi-Cal. The following brief analysis of access and engagement data is a snapshot of what is publicly available. CPEHN has analyzed these data sets and more in the "Mental Health Disparities by Race and Ethnicity for Adults in Medi-Cal" report published by the California Health Care Foundation.[1]

[1]FY 2019-2020 data has only recently been disseminated. CPEHN will be updating the "Mental Health Disparities by Race and Ethnicity for Adults in Medi-Cal" report to reflect the updated figures reflected in the following charts. In addition, in July of 2021 DHCS made retroactive changes to reporting methodology which are reflected in this report, but have yet to to be updated in the "Mental Health Disparities by Race and Ethnicity for Adults in Medi-Cal" report.

## Differences in Access Rates

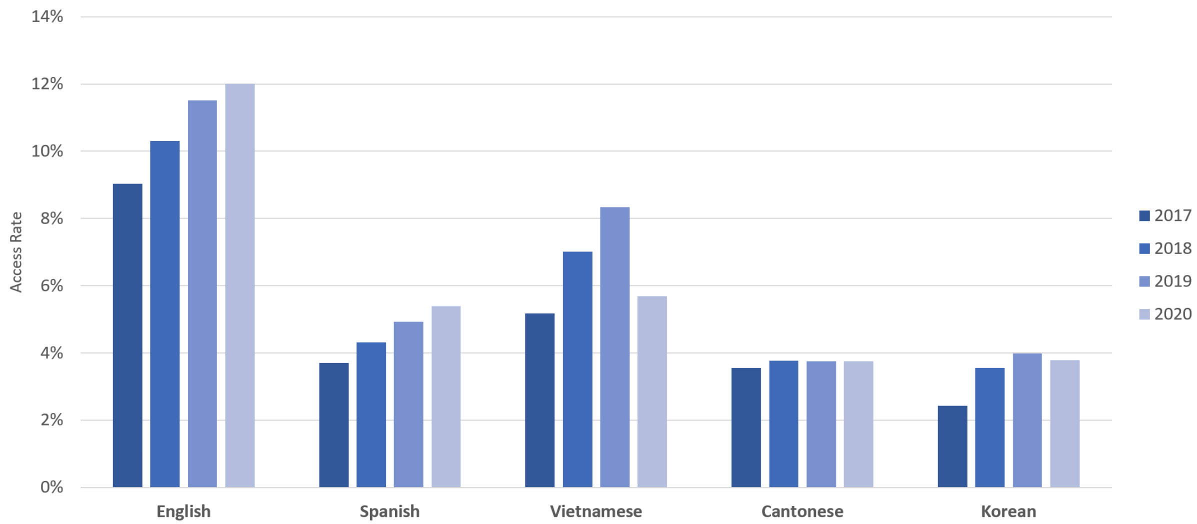
Access is defined in the AB 470 data as any contact with the mental health system, which may include an assessment, a single treatment visit, or an involuntary service. Most BIPOC communities have low access rates for non-specialty mental health services. Black Medi-Cal members use non-specialty mental health services at a much lower rate than White members. Latinx and Asian and Pacific Islander Medi-Cal members access non-specialty mental health services at the lowest rates of all racial and ethnic groups in managed care. Access in Lesbian, Gay, Bisexual, Transgender, Queer, and Plus (LGBTQ+) communities is so low that publicly available data shows no stratification by Sexual Orientation and Gender Identity (SOGI).

To draw a comparison between the need in services statewide and access to care, the statewide mental health prevalence rate has been added as a dashed line. The prevalence estimate used here is taken from the National Survey on Drug Use and Health, which estimates that 14% of California adults have any mental illness.




## Differences by Preferred Written Language

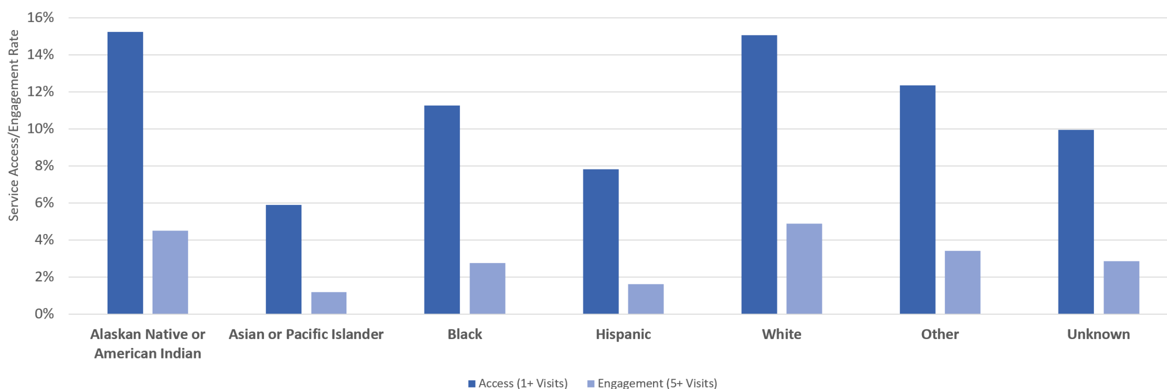
Medi-Cal members whose preferred written language is not English are less likely to receive non-specialty Medi-Cal mental health services than those whose preferred written language is English. This chart shows the five most commonly preferred written languages among adult Medi-Cal members and the mental health access rates for each of these groups. For 2019-2020, members who preferred Spanish, Vietnamese, and Cantonese had access rates less than half that of members whose preferred written language is English.




## Differences in Engagement

Research has shown that, for depression, 6-8 sessions offer more benefit than 1-5, whereas for anxiety, treatment appears to reduce symptoms with each additional session on a continual basis.[xiv] Though the optimal number of sessions needed to effectively treat depression and anxiety look different, both greatly benefit from more than five sessions.

This graph shows that even when members access non-specialty mental health care, many do not receive ongoing care (defined as five visits, and or more). This is even more true for people from BIPOC communities. Asian and Pacific Islander and Latinx members are the least likely to receive five or more non-specialty mental health services from their MCP.



Current AB 470 data sets focus on process measures such as visit types and service counts, which provide important measures of how the system is performing. The data can also highlight inequities in member access and movement through the mental health system. However, the data does not answer questions about potential inequities in care quality and outcomes, nor does it capture whether mental health providers treat members respectfully and equitably during treatment or a member's experience of care. The data is also not broken down by detailed sub-categories, making it impossible to understand the unique needs of racial, ethnic and gender diverse communities.

The Department of Health Care Services (DHCS) now requires Medi-Cal health managed care plans (MCPs) to meet the national Medicaid 50th percentile minimum performance level (MPL) for a number of measures.[xv] In mental health, MCPs are required to report their data on screenings for depression and follow-up care, but they are not held to a minimum performance level, despite the clear need to improve access. Currently, only 9.72 percent of members ages 18-64 in Medi-Cal managed care health plans (MCPs) are receiving a screening for depression, and if positive, a follow up plan.[xvi] The Department of Health Care Services (DHCS) has noted that MCP reporting on the depression screening and follow-up metric is incomplete and unreliable.[xvii] There is currently no established data stream for collecting depression screening results.[xviii]

## Methods

To better understand the barriers to accessing non-specialty, or mild to moderate, mental health services, CPEHN examined two key avenues that exist for members to learn about how and where to get help for mental health care: Primary Care Physicians (PCPs) and Medi-Cal managed care health plan (MCPs) websites.

While Medi-Cal members are not required to obtain a referral from primary care in order to access non-specialty mental health care, primary care is still a central point for information and access to other services. People of color often rely on Primary Care Physicians (PCPs) for mental health services.[xix] CPEHN interviewed ten PCPs about their experiences with referring Medi-Cal patients to mental health providers. The PCPs, who were recruited through partnerships that CPEHN maintains with UC primary care training programs, currently work in Sacramento, Alameda, and San Francisco counties. Several work at Federally Qualified Health Centers (FQHCs), which often have in-house mental health services, although these services are variable in both scope and availability.

For those members who do not have a usual source of care or choose not to enlist their PCP for assistance accessing non-specialty mental health services, health plan websites are a key source of information on covered services and in-network mental health providers. However, members themselves may have difficulty accessing health plan websites due to lack of broadband access, limited English proficiency, or discomfort with technology. For this reason, CPEHN worked with five community-based organizations (CBO) and eight staff to test provider search sites for accessibility and understanding. The CBOs were recruited through Having Our Say and Behavioral Health Equity Collaborative, two statewide networks of over 50 CBOs working to advance health and mental health equity.

While the data collected is only a snapshot of the many reasons diverse Medi-Cal members may not be accessing non-specialty mental health services, this paper serves as a call to action to start a more thorough review and evaluation of the role of MCPs in providing and coordinating non-specialty mental health services.

# PRIMARY CARE PHYSICIAN INTERVIEWS

## Primary Care Physician Interview Findings

The research team developed a series of interview questions for hour-long interviews with PCPs. Questions included:

- Are you aware the Medi-Cal program offers a comprehensive mental health benefit?
- On a scale of 1 to 5, how confident are you guiding patients to find an in-network mental health provider with their Medi-Cal managed care plan?
- Is there someone else in your office who coordinates care (like finding a mental health provider) for your patients?[xix]

Several themes recurred throughout the interviews: lack of knowledge about the scope of services covered by MCPs and the responsibility MCPs have in coordinating non-specialty mental health services. The terms "patient" and "member" are used interchangeably throughout the remainder of this report. Further findings from the PCP interviews are below:

1. **Poor Awareness of the Non-Specialty Mental Health Benefit among PCPs and Members.** When the physicians were asked if they were aware of this particular benefit, five out of the ten said they were completely unaware of it, mistakenly believing that only the county provides these services. It is important to note that physicians working at FQHCs may have access to non-specialty mental health services directly, including when the MCP contracts with the FQHC to be the provider of these services. However, this is not always the case and FQHCs often have limited resources even when they can provide some mental health services. Most importantly, none of the physicians interviewed felt that they had access to adequate non-specialty services for their patients. "*I think the biggest [surprise] is not knowing that it existed. Like in my mind, it was like 'it's either internal or [the county access line] and I did not know we even had this access to the managed care plan.*"

2. **Challenges Finding Available Mental Health Providers:** Searching for an accurate list of in-network mental health providers has proven very difficult for these PCPs' patients. According to the PCPs, their patients have described using the mental health professional referral site *Psychology Today* to find a provider, only to realize that the networks represented on the site are different from Medi-Cal managed care plan (MCP) networks, even when the plans have the same name. After reviewing several provider profiles, patients will call these mental health providers and are often told they cannot be seen because that particular mental health provider does not see Medi-Cal patients. According to these PCPs, the same has happened with the lists available directly from the MCP site. Again, these sites contain provider lists for all of their networks (private, Medicare, and Medi-Cal), leading patients to be confused by which provider directory to choose. If patients choose the wrong directory, the mental health providers in their search results will be unlikely to see them. One PCP who serves patients outside of large cities mentioned barriers in finding a provider due to distance.

- Of the remaining five, three said while they were aware mental health was a benefit, they did not know how to guide their patients in accessing non-specialty mental health services and could not speak on what the benefit covers (with one PCP believing there could be a copay involved). *"So I would have seemingly pretty little confidence in being able to refer them in-network, outside of our clinic. I've never seen that happen, or [I'm] not clear what that's supposed to look like."*

- All of the PCPs were aware of specialty mental health services available through the county for severe cases of mental illness. *"I have been taught always that Medi-Cal patients have to go through the county. I was not aware that you can even refer people to mental health through their managed care plan."*

- All the interviewed PCPs agreed that most patients are unaware of the non-specialty mental health benefits managed by their MCPs. *"Well, the patients understand it even less, which is really bad because the physicians don't understand it at all."*

- When the PCPs were asked how confident they were in guiding patients to find an in-network mental health provider with their Medi-Cal managed care plan, seven out of ten stated they were "not at all confident" unless the services were provided within the FQHC. "*Right, if it's within our clinic, I feel very confident. If it's outside of our clinics, I have a very limited understanding of what that workflow looks like, to be honest."*

- One PCP mentioned relying on medication management first before attempting to coordinate mental health services outside their clinic. *"I can do one piece, which is the medication, which might offer some benefit, but the crux of the solution or the large piece of the solution is to actually get into working with somebody who can help [patients]."*

3. **Challenges Finding Language Concordant Mental Health Providers And Ensuring Quality Language Access:** Even when a PCP is able to find a mental health care provider for their patient, six of the PCPs spoke about difficulty finding linguistically concordant providers. Acknowledging there are phone interpreters they can use, the PCPs we interviewed said that providing care through a phone interpreter is awkward for everyone involved and discouraging for patients seeking mental health services. For example, one PCP said that when she recommended therapy to a patient, they were very eager, but upon hearing it would be done through a phone interpreter, the patient declined treatment. It was already difficult for this patient to confide in their PCP that they struggled with managing their mental health. Having to admit this same struggle to two strangers, where one is not a mental health professional, felt like too much of an obstacle for this patient. Additionally, some patients mentioned their hesitancy in moving forward with phone interpretation because they had previously struggled to comprehend their underlying issues or treatment plan in provider appointments that utilize a phone interpreter.

4. **Finding Mental Health Providers with Cultural Concordance:** Additionally, there are cultural barriers that interpretation services alone cannot overcome. Large populations of undocumented people and immigrants who have had traumatic experiences are driven to leave their home country, with some having the added stress of living in a precarious position. For example, one PCP mentioned the challenges of serving patients in Sacramento who speak Dari, an Afghan dialect of Farsi, and have specific cultural, sociopolitical, and generational concerns that a non-Afghan mental health provider may find difficult to support. There also continues to be a lack of mental health providers who specialize or have training and experiences on Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+) issues.[xxi]

## Having Our Say Coalition

The Having Our Say (HOS) Coalition was founded in 2007 to raise the voices of communities of color in the health reform debate and the fight for access to quality health care. Since the passage of the Patient Protection and Affordable Care Act in 2010, the coalition is focused on ensuring health reform implementation in California reflects the voices and needs of our diverse communities. The coalition has brought together more than 35 member organizations, including grassroots community organizations, health care clinics, providers, and advocates, to fight for health equity and racial justice

## Behavioral Health Equity Collaborative

CPEHN launched the Behavioral Health Equity Collaborative (BHEC) in 2016 with a mission to advance mental health equity in California by bringing voices of diverse communities to state policymaking. The collaborative brings together state and local organizations representing different communities of color—BIPOC, immigrant, refugee, youth, and LGBTQ+ communities—and mobilizes them to advocate for increased investments in quality mental health services collectively. BHEC engages in policy advocacy and mental health systems change through policy research and development, advocacy with state agencies and state legislature, and capacity building of BIPOC-led and serving community organizations.

# WEBSITE TESTING

CPEHN heard from both Medi-Cal Members and PCPs that one of the most confusing parts of finding a non-specialty mental health provider is navigating the corresponding Medi-Cal managed care website. Therefore, CPEHN recruited Behavioral Health Equity Collaborative (BHEC) and Having Our Say (HOS) partners to navigate these sites using particular scenarios and answer a series of questions.[xxii] The purpose of this testing was to compile a list of areas where MCPs could change or modify their sites to improve mental health search outcomes for members. To better gauge the member experience, CPEHN engaged five CBO partners who tested the provider search sites for the two Medi-Cal managed care plans in their county to evaluate their degree of accessibility. The CBO staff tested the Medi-Cal health plan websites in the four counties they serve, Los Angeles, San Joaquin, Fresno, and Alameda.[xxiii] The findings of these tests are below.

1. **Long and Difficult Searches Requiring Multiple Clicks:** The diverse group of testers averaged 45 minutes searching on an MCP site to find a language concordant mental health provider. In navigating the main MCP sites, the testers reported between four and eight mouse clicks to reach a mental health provider search site. Testers with five or more clicks reported being taken to external webpages that differed from the initial MCP site they started on. These external pages were often delegate plan provider search websites (MHN, for example). The testers did not come across a webpage explaining why they were being taken to an external site.

   Some testers were prompted to input the "specialty provider" they were looking for in these provider searches. Some terms the testers used were "therapist," "mental health," and "behavioral health." One tester was uncertain of the correct term to use for a mental health provider, so they left the search bar blank, leading to a listing of hundreds of PCPs.

   These searches also often included terminology the testers felt their community members would not be able to understand. For example, a tester's search results had several Licensed Clinical Social Workers (LCSWs) listed in their results. However, this tester felt members of their community would not understand the distinction between an LCSW and a psychologist. Moreover, the term "social worker" is synonymous with the Eligibility Workers many Medi-Cal members interact with through the Department of Public Social Services. Because of this experience, the tester felt members might believe an LCSW is not a licensed mental health professional but rather a public benefits worker.

2. **Confusion over the Appropriate "Product" to Choose:** Testers who navigated MCP websites, where the MCP offers various health plan products through Medicare, Medi-Cal, Medicaid, Covered California, ACA Marketplaces, and private insurance found these sites to be challenging to navigate. A common theme was the use of the words "Medical," "Medicare," "Medicaid," and "Medi-Cal" in the titles of some of these products. Many testers were confused over which option applied to their case. When testers were asked to submit their final search results, 50% of the results were inaccurate after testers chose the wrong product line (Medicare instead of Medi-Cal, for instance). When the inaccurate results were cross-referenced with accurate results, few mental health providers overlapped, meaning that if a Medi-Cal patient were to seek out non-specialty mental health services from that inaccurate list, most of the mental health providers would have been unable to see the patient.

3. **Limited Language Access on the MCP Sites and in the Mental Health Provider Listings:** The testers represent communities with limited English proficiency (LEP). Therefore, testing the sites' approach to language access was a main priority for testers. None of the sites tested were available in a language other than English. One site offered interpreter services to navigate the site, but the offer was written in English. One tester said, *"I believe I was able to explore and identify some mental health providers due to being somewhat knowledgeable on exploring the internet and speaking the English language. I can only imagine what individuals who do not speak English have to experience in trying to find a mental health provider. It would be extremely hard.""*

   Additionally, some mental health provider search pages did not have the option to filter the results by preferred language, making it difficult to confirm whether a mental health provider could adequately provide for a patient's needs. Though interpreter services are available to all Medi-Cal members, this policy was not explicitly stated on these provider search pages leading testers to believe LEP Medi-Cal patients could not access mental health care.

# RECOMMENDATIONS

## Recommendations

1. **Integrate Mental Health Referrals into Electronic Medical Records (EMRs).** Several PCPs identified being unable to immediately refer patients to a mental health provider during an appointment as a barrier. They noted for other referrals to other specialists, they enter the corresponding referral code into their EMR and the referral is made. Ideally, the EMR system would allow PCPs to refer patients to a mental health provider, in addition to incorporating several markers like gender, language, and therapy modalities. This referral system would be integrated with the current referral system providers use, making it easier to refer quickly. *"I'll type in a referral for endocrinology, and that will pop up, and then it'll say 'what is your consult question,' and that's where I type in [the referral]…and then I press send, and it goes off to our referrals office. Depending on the managed care plan, we will send it out to the [corresponding] managed care plan [authorization unit], and the managed care plan will then approve or deny the referral. And then, if they approve it, they send it out to their network and call the patient to schedule. Ideally, that would be a much a nicer way for it to work with mental health."*

   Through this integrated EMR system, the PCPs felt non-specialty mental health referrals would be treated with the same urgency as specialty care referrals. However, current law makes it clear that members may directly access mental health providers and non-specialty mental health services without prior authorization from the health plan or a referral from a PCP. This means that if non-specialty mental health referrals were integrated into the EMR, Medi-Cal managed care health plans would still need to comply with current law and could not add a requirement of prior authorization, so specific workflows would need to be designed carefully.

   Viewing mental health care as requiring the same level of attention and parity to physical medical care, the PCPs believe this integrated EMR system would reduce the priority hierarchy found in healthcare. *"I think that's the hesitancy [in referring] is the uncertainty and the lack of clarity of the process. Even for me to like tell my patients, 'These are the things that are going to happen following this.' Compared to like a specialty referral like 'okay, I'm going to put in this referral, it's going to get reviewed by your insurance and be authorized… So there is a process that I can counsel them on. And I don't know what happens after I put in these [mental health] referrals."*

   Additionally, some PCPs identified this integrated EMR system as an opportunity to incorporate mental health data metrics. For example, suppose this system were to be standardized across all Medi-Cal managed care providers. In that case, data on mental health disparities across multiple factors like race, ethnicity, gender, sexual orientation and gender identity, and disability could be pulled at the clinic level and institutional level, making it easier to address disparities in mental health care. *"On a regular basis, I get a dashboard report [from the EMR] on the percentage of patients who are supposed to have a colon cancer screening…the percentage of people who should have pap smears done, who I'm responsible for doing those pap smears for…I don't have any data like that when it comes to mental health."*

2. **Fund Case Managers, Care Coordinators, and Navigators:** A recommendation some PCPs made was having an MCP staff available to coordinate an appointment. Though all MCPs have phone lines that patients and PCPs can call to get a list of in-network mental health providers; patients need more than that. They need someone who will help make the first appointment and follow up if the first appointment is missed or if it was not a good fit. These types of case management services are essential in ensuring members receive the care they need. California could also expand their community-based navigator program, which helps members enroll and navigate health and mental health coverage.

3. **Implement an Education and Outreach Campaign for Members and Primary Care Physicians:** All the interviewed PCPs agreed that most patients are unaware of the non-specialty mental health benefits managed by their MCPs. The few that are familiar find navigating the program complicated and frustrating. Several PCPs suggested a campaign targeted to both members and PCPs. Members currently get a quarterly mailer from the Medi-Cal program. Incorporating the non-specialty mental health benefits education material into these quarterly mailers would help patients understand their health coverage.

   All interviewed PCPs also stated they would welcome training by the Medi-Cal program on the provider search and referral process for non-specialty mental health care. Additionally, PCPs would like a bulletin that went directly to them rather than an office manager or clinic director. Understanding the benefit for themselves makes it easier to talk about it with patients. *"I don't ever receive communication from [MCPs] that I see patients from. So like, I don't know what the Anthem system is for [mental health care], and I don't know what the Molina system is for [mental health care]... if you're receiving [a newsletter] from both the plan, and it's highlighted by your medical director, that's part of how you reinforce education."*

4. **Improve MCP Provider Search Websites:** Testers with five or more clicks recommended streamlining the MCP search pages to reduce the number of clicks and external pages necessary to reach the appropriate mental health provider search page. In addition, the testers would have liked warnings or explanations as to why they were being redirected from their MCP page to a page with no sign of connection to the MCP page. Testers felt searching for a mental health provider should be easy and quick; however, as the MCP website pages currently stand, they are neither.

   **Reduce Clicks:** In regards to accessibility, two testers highlighted Cal-Viva as being easy to navigate. First, Cal-Viva had a picture of a brain with the words "mental health provider search" underneath it, making it explicitly clear that any providers stemming from this search portal would be 100% mental health providers. It also only took testers two clicks to get to this mental health provider search. Moreover, the search results for Cal-Viva did not require testers to choose or submit a specific "specialty provider." Instead, they could insert their zip code and get a listing of all mental health providers in the area. Other MCPs could take cues from Cal-Viva's approach to website navigation accessibility and reduce mouse clicks and time by making their sites clear and concise.

**Make Clear Distinctions between Products:** One of the significant difficulties for testers was choosing the appropriate "product" for their hypothetical scenario. The major MCPs like Health Net and Anthem have dozens of products to choose from in dropdown menus, making it an overwhelmingly stressful process for Medi-Cal members. For example, one recommendation by testers was to swap out the term "Medicaid" for "Medi-Cal." Our state's Medicaid program is known and most commonly referred to as Medi-Cal; using its federal name makes it unnecessarily confusing.

**Reduce Crowding of Information:** Crowding was also another issue testers identified as needing to be reviewed. The MCP websites have so much information on one page that key components like the product dropdown menus can be overwhelming. Reducing and simplifying the amount of information on these pages, plus writing them at a grade level that is accessible to all, would make navigating these sites easier. Member testing, including review of translations, should be a requirement for all member facing materials, including websites.

5. **Highlight Language Access Rights and Translate MCP Sites:** Most Medi-Cal members are not aware of their right to interpreter services. Making these rights clear on all MCP member-facing materials, including their provider search sites, and in-language, would help members see that even if their mental health provider does not speak their language, they could still be offered services through an interpreter. However, MCPs should still be striving to expand their mental health provider networks to include providers who speak all threshold languages.

   Additionally, all of the MCP provider search sites should be made available in the threshold languages. For example, the Medi-Cal Dental program recently translated its dental outreach and education site to be accessible in all the threshold languages, making it easier for members to learn about the importance of oral health and their Medi-Cal benefits. Doing the same for these MCP sites would make navigating them easier for LEP members, a population cited above as having the lowest utilization numbers in the Medi-Cal program.

6. **Incorporate Language and Cultural Competence in Mental Health Provider Recruitment:** To meet the needs of a very diverse Medi-Cal population, MCPs must recruit mental health providers with increased language capacity, and training and experience on the culture of their patients, including intersections with LGBTQ+ issues. As our findings showed, even when PCPs identify mental health providers for their patients, having to use interpreters due to language barriers has a negative impact on patient willingness to engage in services. Access numbers for BIPOC communities should not be this devastatingly low when the need is much higher. A concerted and intentional effort to recruit mental health providers with expanded language capacity and cultural competence is essential to meeting the needs of all Medi-Cal members. Scaling and integrating other types of qualified health practitioners, including those who do not have a medical or mental health license, like peer support specialists, community health workers, trained facilitators, promotoras, and traditional healers, could improve the coordination and delivery of non-specialty mental health care. MCPs could also increase access by adding community-defined evidence practices to the non-specialty mental health services available to a plan's members.

7. **Hold Medi-Cal Managed Care Plans Accountable for Both Utilization and Quality:** Despite federal and state laws that require parity for access to mental health care, it is clear that access non-specialty mental health care continues to be extremely challenging for individuals enrolled in Medi-Cal managed care health plans. Members face obstacles such as lack of education about how to access non-specialty mental health services, health plan denials, long wait times, shortages of culturally and linguistically appropriate mental health providers, and poor quality of care. However, seven years after its implementation, the non-specialty mental health benefit should be considered mature, and health plans should be held accountable for poor performance. At a minimum, DHCS should:

    **a.** Require contracted Medi-Cal managed care plans to collect and report detailed data on utilization of non-specialty mental health care by sub-categories of racial, ethnic and gender diverse communities with a higher level of granularity than what is currently available in the AB 470 data system.

    **b.** Ensure that contracted Medi-Cal managed care plans provide Medi-Cal members with access to care that is culturally and linguistically responsive.

    **c.** Work with the Department of Managed Health Care to ensure health plans are meeting minimum quality performance standards and requirements in mental health such as network adequacy, timely access, after-hours availability of services, language access and physical accessibility standards, and explicit reduction of disparities, amongst others.

    **d.** Consider rate adjustments, penalties, corrective action plans, and claw backs. Other states across the country, for instance, claw back funds when health pans fail to achieve expected utilization of services and the same rule should apply to California Medi-Cal managed care plans. California could claw back and reinvest in community initiatives such as community-defined evidence practices instead.

    Ultimately, Medi-Cal managed care health plans that are unable to meet the access standards in law today or that fail to meet benchmarks for utilization and quality of non-specialty mental health care across multiple measures and populations should no longer be eligible to contract with DHCS to provide services to Medi-Cal members.[xxv]

## Conclusion

After identifying barriers to non-specialty mental health care, the work in addressing them can begin. The pandemic has ignited a sense of urgency among all stakeholders, and this momentum can be harnessed to enact systemic change within the Medi-Cal program. Historically, many successful expansions in coverage and eligibility in the Medi-Cal program have been rooted in community advocacy and leadership. Centering community voices and experiences in reforming access to non-specialty mental health care will result in a program that truly reflects the needs of its members. This report is one snapshot of the many issues advocates and stakeholders need to address to diminish racial and ethnic disparities in the Medi-Cal program. CPEHN is committed to seeing through the recommendations in this report and working with all stakeholders to improve mental health outcomes for communities of color.

[i] COVID-NET (March 1, 2020 through June 26, 2021). Numbers are ratios of age-adjusted rates standardized to the 2019 US standard COVID-NET catchment population.

[ii] National Center for Health Statistics (NCHS) provisional death counts (data through July 3, 2021). Numbers are ratios of age-adjusted rates standardized to the 2019 U.S. intercensal population estimate.

[iii] National Center for Health Statistics (NCHS) provisional death counts (data through July 3, 2021). Numbers are ratios of age-adjusted rates standardized to the 2019 U.S. intercensal population estimate.

[iv] Panchal, Nirmita, Rabah Kamal, Cynthia Cox, and Rachel Garfield. "The Implications of COVID-19 for Mental Health and Substance Use." Kaiser Family Foundation, February 10, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

[v] Paley, Amit. "National Survey on LGBTQ Youth Mental Health 2021." The Trevor Project. 2021. https://www.thetrevorproject.org/survey-2021/?section=Introduction.

[vi] Repealing the Affordable Care Act (ACA) What's at Stake for Californians Benefiting from Mental Health Care Services? Report. California Pan-Ethnic Health Network, 2017. https:// cpehn.org/assets/uploads/archive/resource_files/aca_repeal_mental_health_3.16.17.pdf.

[vii] Mental Health Disparities by Race and Ethnicity for Adults in Medi-Cal. Report. California Health Care Foundation, 2020. https://www.chcf.org/wp-content/uploads/2020/11/MentalHealthDisparitiesRaceEthnicityAdultsMediCal.pdf.

[viii] "Medi-Cal Managed Care Health Plan Responsibilities For Outpatient Mental Health Services." Nathan Nau to All Medi-Cal Managed Care Health Plans. Department of Health Care Services. October 27, 2017. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-018.pdf.

[ix] See Appendix A for a crosswalk of all Medi-Cal Managed Care Plans in CA regulated by the Department of Managed Care (DMHC) and their corresponding non-specialty mental health care delegate plan.

[x] Coursolle, Abbi, and Elizabeth Edwards. "Mental Health Parity in Medicaid: Overview of Requirements & the Right to Information." National Health Law Program. March 2021. https://healthlaw.org/wp-content/uploads/2021/04/2021-03-31-Medicaid-parity-laws-brochure-FINAL.pdf.

[xi] "Mental Health Parity Compliance Summary." Department of Health Care Services. May 18, 2018. https://www.dhcs.ca.gov/formsandpubs/Documents/MH-Parity-Compliance-Summary.pdf.

[xii] "Timely Access to Care." California Department of Managed Health Care. https://www.dmhc.ca.gov/healthcareincalifornia/yourhealthcarerights/timelyaccesstocare.aspx.

[xiii] "National Survey on Drug Use and Health: 4-Year RDAS (2015 to 2018)." Substance Abuse & Mental Health Data Archive. https://rdas.samhsa.gov/#/survey/NSDUH-2015-2018-RD04YR/crosstab/?column=STNAME&results_received=false&row=LMMIYRU&run_chisq=false&weight=DASWT_2.

[xiv] Forde, Frances, Marie Frame, Pauline Hanlon, Gus MacLean, Des Nolan, Polash Shajahan, and Elizabeth Troy. "Optimum Number of Sessions for Depression and Anxiety." Nursing Times 101, no. 43 (October 25-31, 2005). https://pubmed.ncbi.nlm.nih.gov/16276843/.

[xv] The complete list of measures is available online at: www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/HEDIS_Reports/Managed-Care-Accountability-Set-Reporting-Year-2021.pdf.

[xvi] Medi-Cal Managed Care External Quality Review Technical Report. Report. April 2021. https://www.dhcs.ca.gov/Documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol1-F1.pdf.

[xvii]Ibid.

[xviii]"2023-2025 Attachment 7 Refresh Workgroup " (Presentation, Covered California, June 3, 2021). https://hbex.coveredca.com/stakeholders/plan-management/PDFs/Plan-Management-Advisory-Group-Presentation-June-3.pdf

[xix]Thompson, Tommy G., Joseph H. Autry III, Bernard S. Arons, and David Undefined Satcher. Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Report. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2001. Center for Mental Health Services.

[xx]see Appendix B for the full list of interview questions for Primary Care Physicians.

[xxi]LGBTQ Experiences Accessing Health Care. Report. California Pan-Ethnic Health Network, 2020.

[xxii]See Appendix C for the full list of community review questions

[xxiii]CalViva and Anthem Blue Cross Partnership Plan serve Fresno; Alameda Alliance for Health and Anthem Blue Cross Partnership serve Alameda; Health Net Community Solutions, Inc. and L.A. Care Health Plan serve Los Angeles; Health Plan of San Joaquin and Health Net Community Solutions, Inc serve San Joaquin. It should be noted that Health Net Community Solutions, Inc. serves San Joaquin and Los Angeles County, while Anthem Blue Cross Partnership serves Fresno and Alameda County.

[xxiv]"Medi-Cal Health Enrollment Navigators Project." Department of Health Care Services. July 29, 2021. https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/NavigatorsProject.aspx.

[xxv]Centering Equity in Health Care Delivery and Payment Reform: A Guide for California Policymakers. Report. California Pan-Ethnic Health Network, 2020. https://cpehn.org/publications/centering-equity-in-health-care-delivery-and-payment-reform-a-guide-for-california-policymakers/.

## APPENDIX A: Crosswalk of California's Medi-Cal Managed Care Plans and Corresponding Non-Specialty Mental Health Care Delegate Plan.

| | |
|---|---|
| Aetna Better Health of California Inc. (933 0521) | Aetna Medicaid Administrator LLC. |
| AIDS Healthcare Foundation (933 0432) | Juman Affairs International (HAI) |
| Alameda Alliance For Health (933 0328) | 1. Beacon 2. College Health IPA |
| Blue Cross of California dba Anthem Blue Cross (933 0303) | |
| Blue Shield of California Promise Health Plan (933 0326) | 1. Beacon 2. College Health IPA |
| California Health & Wellness Plan (933 0493) | MHN Services, LLC |
| CHG Foundation dba Community Health Group Partnership Plan (933 0431) | |
| Contra Costa Medical Services dvba Contra Costa health Plan (933 0054) | 1. Contra Costa County Mental health Program; 2.Kaiser |
| Fresno-Kings-Madera Regional Health Authority dba CalViva Health (933 0484) | Health Net Community Solutions |
| Health Net Community Solutions, Inc. (933 0426) | Mhn Services, LLC |
| Inland Empire Health Plan dba IEHP (933 0346) | Kaiser |
| Kaiser Foundation Health Plan, Inc. (933 0055) | GMC Sacramento - 1. Beacon 2. Mindful Health Solutions dba TMS Health Solutions. GMC San Diego - Windstone Behavioral Health, Inc. |
| Kern Health Systems (933 0322) | Kaiser |
| Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan (933 0355) | 1. Beacon 2. College Health IPA |
| Molina Healthcare of California (933 0322) | |
| San Franssico Health Authority dba San Fransisco Health Plan (933 0349) | 1. Beacon 2. College Health IPA 3. Kaiser |
| San Joaquin County Health Commision dba Health Plan of San Joaquin (933 0338) | 1. Human Affairs International (HAI) 2. Kaiser |
| San Mateo health Commission dba Health of San Mateo (933 0358) | 1. Valley Health Plan 2. Kaiser |
| Santa Clara County Health Authority dba Santa Clara Family Health Plan (933 0351) | U.S. Behavioral Health Plan, California |
| UnitedHealthcare Community Plan of California, Inc. (933 0499) | |

## APPENDIX B: Interview Questions for Primary Care Physicians

1. Do you have a contract with a Medi-Cal managed care plan?

a. Yes or no

2. Are you aware the Medi-Cal program offers a comprehensive mental health benefit?

a. Yes or no

b. Are you aware that Medi-Cal managed care plans are responsible for providing outpatient mental health services to Medi-Cal members with mild to moderate mental health services?

i. Yes or no

ii. Please describe:

c. Are you aware that counties are responsible for providing specialty mental health services to Medi-Cal members with serious mental illness?

i. Yes or no.

d. How do you decide to refer a patient to the county for mental health services versus an in-network mental health provider with their Medi-Cal managed care plan?

i. Please describe:

3. On a scale of 1 to 5, how confident are you guiding patients to find an in-network mental health provider with their Medi-Cal managed care plan?

a. 1 being not confident at all and 5 certain of your confidence

i. If there is hesitancy in providing a referral, what are the reasons for the hesitancy?

1. Please describe:

ii. How do you choose a mental health provider to refer to?

1. Please describe:

4. Would you say any barriers to mental health are the same for kids as they are for adults?

a. Yes or no

5. Is there someone else in your office who coordinates care (like finding a mental health provider) for your patients?

a. Yes or no

b. If yes, who is that person?

6. Tell me about your experience helping Medi-Cal members access mental health services with their Medi-Cal managed care plan. What have been some of the successes?

a. Please describe:

b. What have been some of the challenges?

i. Please describe:

7. According to an All-Plan Letter (APL 17-018) by the of Department of Health Care Services, mental health referrals start, “At an initial health screening, [where] a PCP may identify the need for a thorough mental health assessment and refer a member to a licensed mental health provider within the MCP’s network. The mental health provider can identify the mental health disorder and determine the level of impairment.”

a. Is this how the process works or have you changed the process?

8. Are their things that Medi-Cal managed care plans could change to make it easier for you to ensure your patients get access to mental health services?

a. Please describe:

9. How do patients introduce the topic of needing a mental health referral?

a. Please describe:

10. How do you decide whether you can provide for the mental health needs of a patient vs referring them to a mental health provider?

a. Please describe:

11. Do you think patients are aware of the mental health benefits offered by their Medi-Cal managed care plans?

a. Yes or no

b. If you believe they are not, what do you think can be done to increase awareness?

12. Has anyone from the Medi-Cal program offered you training on patient referrals to mental health providers?

a. Yes or no

13. Would you like you or your staff to be trained on how to navigate the Medi-Cal mental health benefit?

a. Yes or no