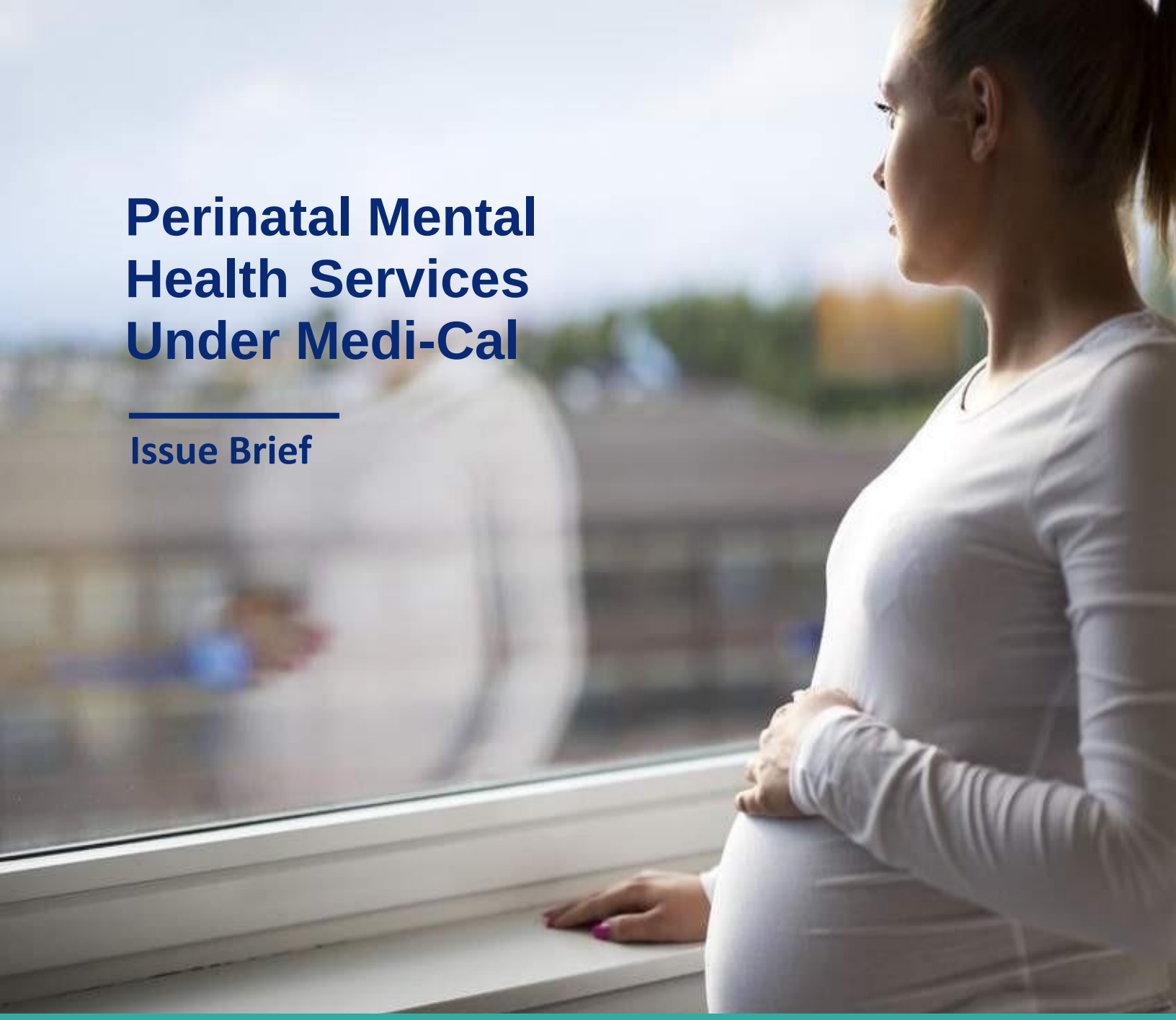

Perinatal Mental Health Services Under Medi-Cal

Issue Brief

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Maternal and Child Health Access

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Perinatal Mental Health Services Under Medi-Cal

According to the California Department of Public Health (CDPH), **depression during pregnancy is likely to lead to depression after the baby is born** and is associated with various other types of serious risks to the mother and infant.[1] One in five California women who recently gave birth experience symptoms of depression during or after pregnancy, with two groups being at heightened risk: low-income Black or Latina women and women who have experienced hardships during childhood or pregnancy. Though not all women with symptoms of depression will be diagnosed with clinical depression, screening and appropriate care should be provided during prenatal care, according to CDPH.

In this Issue Brief, we summarize the role that Medi-Cal plays in addressing perinatal mental health issues for low-income women and identify efforts to improve access and quality of care.

Medi-Cal for pregnant women

- Medi-Cal covers about 243,000 births a year,[2] which is a little less than half of California's annual births.
- Of the Medi-Cal-covered births, 157,000 are expected to be for women in fee-for-service ("regular" Medi-Cal) from July 1, 2018 to June 30, 2019, with the remainder in health plans.[3]
- As explained below, women in fee-for-service have eligibility under pregnancy-related Medi-Cal, while women in health plans have eligibility under full-scope Medi-Cal.

Pregnancy-related Medi-Cal must cover the same full-scope of benefits as Medi-Cal provides other adults.

[1] Summer 2018 MIHA Data Brief, Symptoms of Depression During and After Pregnancy.
[2] 2013 data from the State Department of Health Care Services (DHCS).
[3] See PDF p. 434 for fiscal years 2018-19 and 2019-20 here: http://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2018_May_Estimate/M1807_Regular_PC_Tab.pdf

Three Medi-Cal programs for pregnant women

- **Full-scope Medi-Cal:** U.S. citizens and individuals with an eligible immigration status are enrolled in full-scope Medi-Cal when household income is at or below 138% of poverty. These very low-income citizens and lawfully present immigrants, including pregnant women, are enrolled in health plans.
- **Pregnancy-related Medi-Cal:** This is for women who don't qualify for full-scope Medi-Cal, either because their income is over 138% of poverty or because of immigration status. The income eligibility limit is 213%. Women in pregnancy-related Medi-Cal are primarily covered in fee-for-service.
    - Pregnancy-related Medi-Cal is often referred to as "restricted" or "limited", but that is misleading because, following the 2010 federal health care reform law ("Obamacare"), pregnancy-related Medi-Cal must cover the same full-scope of benefits as Medi-Cal provides other adults.
- **MCAP:** Women with income over 213% up to and including 322% of poverty receive full-scope Medi-Cal coverage through what's called the Medi-Cal Access Program (MCAP). MCAP is the former Access for Infants and Mothers (AIM) program. Immigration status doesn't matter for MCAP eligibility. Women approved for MCAP are enrolled into Medi-Cal health plans. About 7,200 women were in MCAP from July 2017 through June 2018.[4]

…pregnant/postpartum women are continuously eligible for Medi-Cal or MCAP with full benefits, including for mental health services…

Under all these programs**, eligibility continues for pregnant women until the end of the month following the sixtieth day postpartum,** even with increases in household income during that time.[5]

Taken altogether, these rules mean that **pregnant/postpartum women are continuously eligible for Medi-Cal or MCAP with full benefits, including for mental health services**, with income from 0% up to and including 322% of poverty, regardless of immigration status. The federal government matches California spending for pregnant women at a rate of 50% for Medi-Cal and 66% for MCAP.

Scope of Medi-Cal's mental health services and how services are delivered

As noted above, women in pregnancy-related Medi-Cal are now covered for the same scope of services as women in full-scope Medi-Cal, including mental health. For more information, see *Mental health and substance use disorder treatment services now covered under pregnancy-related Medi-Cal and MCAP*.[6]

How services are delivered and how case management is supposed to occur depend in part on whether the woman is in a Medi-Cal managed care plan or in fee-for-service. Below we discuss Medi-Cal's basic policies on these topics. Whether the state ensures that plans and providers comply so that consumers and the taxpayer get the benefit of these policies is a separate issue.

Covered services for mental health include:

- ✓ Assessment and screening
- ✓ Referral
- ✓ Treatment
- ✓ Case management

[4] Several thousand additional pregnant women with household income up to 400% of poverty deliver their babies with subsidized Covered California coverage each year. Medi-Cal's rules do not apply to these private Covered California plans.
[5] However, if an MCAP woman's income drops, she can opt to move to Medi-Cal to avoid paying MCAP's fees.
[6] http://www.mchaccess.org/pdfs/alerts/Mental%20Health%20Services%20Are%20Covered%20by%20Pregnancy-Related%20Aid%20Codes%205-11-17.pdf

Assessment and screening for mental health issues during pregnancy/postpartum

Medi-Cal managed care health plan members: The plans have been instructed to conduct an Initial health assessment within 120 days of each Medi-Cal member's enrollment and periodically after that.[7] Medi-Cal plan members can obtain additional mental health assessments from a licensed mental health provider in the plan's provider network at any time.[8] **Plans are strongly encouraged to use Medi-Cal's "Staying Healthy" assessment form** but can request approval to use an alternative. The form includes two mental health and three personal safety questions.[9] Specified age-appropriate screening and follow up must occur for young people under 21.[10]

In addition, **separate state instructions for Medi-Cal's Comprehensive Perinatal Services Program (CPSP) for women and teens require mental health assessments at the initial prenatal care visit and again during each trimester as well as the postpartum period**.[11] CPSP's Provider Handbook emphasizse assessment for perinatal mood, anxiety disorders, and other mental illness particularly during the postpartum period, using a validated screening tool, such as the PSQ-9, Edinburgh and/or GAD-7.[12] At all stages of the pregnancy/postpartum period, mental health screening is supposed to be integrated with CPSP's assessment for other social risks, such as intimate partner violence, food and housing insecurity, and transportation needs, among others.[13] These non-clinical interventions for "social determinants of health" (SDOH) are not covered by Medi-Cal for other populations without special federal permission. CPSP also covers nutrition and health education.

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[7] All Plan Letter 13-001, p. 7.
[8] All Plan Letter 17-018, p. 7.
[9] Policy Letter No. 13-001 (Revised) (*Requirements for the Staying Healthy Assessment/Individual Health Education Behavioral Assessment*), with link to forms and periodicity table at p. 8; Policy Letter No. 08-003 (*Initial Comprehensive Assessment*), pp. 3-5; *see also,* All Plan Letter No. 13-017.
[10] All Plan Letter No. 18-007 (*Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21);* Policy Letter No. 13-001, p. 8.
[11] CPSP's initial and trimester assessment forms are here: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-CombinedInitialandTrimesterAssessmentandCarePlan.pdf
The postpartum assessment form is here: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-PostpartumAssessmentandCarePlan.pdf.
[12] *CPSP Provider Handbook* (2016) p. 2-49, https://apps.cce.csus.edu/sites/CPSP/docs2016/CPSP-ProviderHandbook-Fall2016-ActiveLinks.pdf.
[13] *CPSP Provider Handbook,* pp. 2-16, 2-23-24, 2-31; *see also* CPSP Protocols, https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/Assessment-and-Care-Plan-Forms.aspx and *Steps-to-Take Manual* (2017), https://custom.cvent.com/C506006261F8428CB7CCB91AAA9A05B4/files/a95d3923830d484db68654aad1674084.pdf.

Regular (fee-for-service) Medi-Cal beneficiaries: The CPSP protocols and model CPSP assessment forms also apply in fee-for-service Medi-Cal. Not all fee-for-service Medi-Cal maternity providers, however, opt to become certified for CPSP. A provider who is not certified misses out on the bonus payments available for rendering all of the enhanced CPSP services a woman needs[14]; more importantly, women go without SDOH interventions.

Referral and treatment for mental health issues during pregnancy/postpartum

Under the CPSP benefit, pregnant/postpartum women in Medi-Cal are to receive an Individualized Care Plan (ICP) to address any mental health or other psychosocial issues identified during the CPSP assessments (in addition to nutrition and health education issues).[15] The ICP is to be updated as necessary, but at least each trimester. The woman is also to receive follow up services, with documentation in her medical chart, for any identified risks.[16]

As with the assessments, an essential focus of the referral and related follow up services under CPSP are SDOH, such as social isolation, anxiety, stress, and lack of emotional support; food or housing insecurity; domestic violence; immigration issues; and other social factors that can have a profound impact on outcomes.

Under the CPSP benefit, **pregnant/postpartum women in Medi-Cal are to receive an Individualized Care Plan (ICP) to address any mental health or other psychosocial issues** identified during the CPSP assessments

Plan members with mild to moderate mental health care needs: A Medi-Cal plan member's primary care provider (PCP) is responsible for conducting the initial mental health screening. If the PCP's evaluation indicates that the patient needs treatment for a mild to moderate mental health issue, then the PCP is to provide the treatment if doing so is within his or her scope of practice.[17] A PCP's scope of practice usually includes brief counseling and prescribing anti-depressants or other medications for treating the symptoms of mild to moderate mental health conditions. But if the treatment the patient needs for a mild to moderate mental health condition is beyond the PCP's scope of practice, then the PCP must refer the patient to the appropriate mental health practitioner within the plan's network. Capitation rates—that is, the

[14] See Figure 1, CPSP Enhanced Treatment.

[15] The ICP form is included with the initial, trimester, and postpartum assessment forms.

[16] Welfare and Institutions Code § 14134.5(d); *CPSP Provider Handbook,* p. 2-21.

[17] All Plan Letter No. 17-018, pp. 1, 6-8.

monthly payments the state pays the Medi-Cal plans to provide care to each of their members—were raised in 2014 to cover the cost of expanding outpatient mental health services.[18]

Instructions to the plans now specifically require that the following be provided by the plan to treat members' mild to moderate mental health needs:

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 [with some exclusions]; and
5. Psychiatric consultation.[19]

Note that for adult Medi-Cal plan members generally, mental health conditions that do not rise to the level of a DSM diagnosis are excluded from coverage.[20] But for pregnant and postpartum women, Medi-Cal's CPSP psychosocial benefit steps in to provide coverage even without a DSM diagnosis. So, for example, while stress, tension, anxiety, relationship issues, and mild

...**stress, tension, anxiety, relationship issues, and mild depression are covered for pregnant and postpartum women under CPSP**.

depression are generally not covered by Medi-Cal for adults absent a DSM diagnosis, such conditions are covered for pregnant and postpartum women under CPSP. MCH Access is interested in hearing from consumers and providers whether requiring a DSM diagnosis is a barrier to services for mild to moderate mental health conditions for pregnant/postpartum plan members.

At the other end of the spectrum, if a plan member with a DSM diagnosis is not eligible for the county's specialty mental health plan (see below) because her diagnosis does not meet the high bar of severity for that level of care, her Medi-Cal plan is required to provide her with outpatient mental health services.[21]

[18] All Plan Letter No. 17-018, p. 3.
[19] All Plan Letter No. 17-018, p. 6 and Column 1 at pp. 9-10.
[20] All Plan Letter No. 17-018, p. 3 and p. 9.
[21] All Plan Letter No. 17-018, p. 7.

Plan members with specialty mental health needs: For more serious mental health conditions, plan providers are to refer the woman to, as well as coordinate her care with, the county's Medi-Cal Behavioral Health Services Specialty Mental Health plan.[22]
This also means that the responsibility for case managing the individual's medical and mental health services remains with the woman's Medi-Cal physical health plan.[23] But coordinating and case managing care between the woman's health plan provider(s) and her separate county specialty mental health plan provider(s) can be challenging, even more so when the woman's Medi-Cal is with a private plan, like Kaiser or Blue Cross, but she is being seen by the county system for her specialty mental health treatment.

Fee-for-Service: As noted above, based on the initial, interim, and postpartum CPSP assessments, providers must prepare individualized care plans for the woman's identified needs, update the ICP as necessary, and document what follow up services are provided.

If the woman's mental health needs are assessed as being mild to moderate, then the ICP should explain whether the fee-for-service maternity care provider will counsel, prescribe medication, etc., or instead refer the woman elsewhere for the appropriate level of mental health care. As with plan members, women in fee-for-service with severe mental health issues are to be referred to the county's Medi-Cal Specialty Mental Health plan.

In fee-for-service, coordination between the pregnancy care and mental health providers, when they are separate providers, is also challenging. But it is important to note that CPSP does compensate for some case coordination by fee-for-service providers without prior approval.[24] MCH Access is very interested in hearing from both pregnancy-care as well as mental health providers whether this benefit is sufficient to cover case coordination in fee-for-service.

Disconnect between policy and implementation

There are many reasons why pregnant women are not getting the mental health services and SDOH interventions they need through Medi-Cal and the CPSP benefit. We summarize some of the key ones in the last section of this document, *Improving Mental Health and Other Psychosocial Services Under Medi-Cal for Pregnant and Postpartum Women.*

[22]All Plan Letter No. 17-018, p. 7.
[23]All Plan Letter No. 17-018, p. 8.
[24] See Figure 1, CPSP Enhanced Treatment.

Spotlight on "social determinants of health" (SDOH)

As we note below, one of the main challenges involves communication and coordination between pregnancy care providers and entities that can assist with peer support groups and/or other "wraparound" services in the community to help address fear, confusion, stress, anxiety, or loneliness, food or housing insecurity, domestic violence, immigration problems, transportation (using Medi-Cal's new transportation benefit), and similar SDOH. Many pregnancy providers are not aware of the critical importance of SDOH on birth outcomes; others may struggle with gaps in resources for referral and coordination.

On the positive side, however, with CPSP:

- The time that a medical provider's staff spends arranging for and case managing SDOH interventions in the community for the woman's comprehensive care is reimbursable.
- In addition, as discussed below, proposals are under consideration to include "promotoras" or other trained peer advocates among the health educators or other members of the pregnancy care team whose services can be reimbursed as CPSP practitioners.

Who to contact for help getting access to Medi-Cal mental health or SDOH services

- **HCA: The Health Consumer Alliance (HCA)** is a network of Legal Services organizations throughout the state. Call 1-888-804-3536, give your zip code, and you will be connected to the nearest office.
- **DRC: Disability Rights California (DRC)** helps people with mental health or other disabilities with Medi-Cal issues, among other things. Call DRC at 1-800-776-5746 or fill out this Short Term Assistance Request Form.
- State hearings, plan grievances, and DMHC complaints: Here are some other things women can do, with or without help from the groups above.

Anyone can ask for a state fair hearing: Whether the woman's Medi-Cal is with a plan or not, she can ask for a state fair hearing if she is having trouble getting needed mental health or other medical care. Pregnant/ postpartum women can also ask for a hearing on SDOH interventions under Medi-Cal's CPSP benefit. At the hearing, women should explain what they did to try to get their doctor or clinic to help with a medical, mental health, or SDOH issue and what happened after that.

- Note: If the woman has Medi-Cal in fee-for-service and what she needs are CPSP's SDOH interventions but her fee-for-service provider is not certified for CPSP, contact LucyQmas@gmail.com for more information.

Pregnant women (and others) who need services right away should ask for an "expedited" (speeded up) hearing and explain the details about why they need services right away.

To ask for a state hearing, use one of the following:

- Call telephone # 1-800-952-5253;
- Make the request on-line: https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx#a-main-form;
- Fax the request to the State Hearings Division at fax # 1-916-651-5210 or 1-916-651-2789; OR
- Mail the request to:
  California Department of Social Services, State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, California 94244-2430.

If faxing or mailing, to get an idea of the information to include for the request, see or print out the on-line hearing request form at the link above.
Plan members only:

- **Plan Grievance:** Medi-Cal plan members can also file a grievance with the health plan. Contact plan Member Services to find out how. It is not necessary to go through the plan grievance process first to get a state fair hearing (see above). It's OK to file a grievance with the plan and ask for a Medi-Cal hearing at the same time; however, the hearing may be delayed until the plan makes a decision on the grievance.

- **DMHC Complaint:** Plan members can also file a complaint with the Department of Managed Health Care (DMHC). But DMHC will hear complaints only if the person goes through the plan grievance process first and loses there unless the medical care needed is urgent and the plan hasn't responded. The phone number to call for DMHC complaints is 1-888-466-2219. For the complaint forms and more info, go here: https://www.dmhc.ca.gov/FileaComplaint/SubmitanIndependentMedicalReviewComplaintForm.aspx

Improving mental health and other psychosocial services under Medi-Cal for pregnant and postpartum women

The following discussion is by no means exhaustive. Maternal and Child Health Access (MCHA) looks forward to working with all stakeholders to move solutions forward.

- **Quality assurance for Medi-Cal mental health care and related supportive services:** One of the main reasons women with Medi-Cal do not receive needed mental health care with wraparound social supports is that, for years, there has been inadequate monitoring of whether the plans and fee-for-service providers render covered services, and, if not, why not and what needs to be done to drive better care. MCHA's 2018 recommendations for improving oversight and monitoring are here: Closing the Gaps: Psychosocial Services to Improve Maternal and Child Health.[25] Advocacy is ongoing to ensure that pregnant/ postpartum women enrolled in Medi-Cal or MCAP receive CPSP's initial, interim and postpartum assessments, an Individual Care Plan for identified psychosocial needs, and documented follow-up services for addressing social determinants of health (SDOH).

- **Maternal Mental Health Safety Bundle:** Widespread implementation by providers of the ACOG-approved Maternal Mental Health Safety Bundle, which includes SDOH interventions, is essential.[26] Medi-Cal mental health and CPSP benefits can cover the safety bundle's screening, coordination, and education components, which means a payment source is already in place.

- **Coordination with community support services:** For women with mild to moderate mental health issues who could be appropriately referred to peer or support groups offered by community organizations or Family Resource Centers, the time and effort required for communication between medical providers and referral entities often impedes women's access to psychosocial supports. One response here is to make better use of the CPSP case management benefit. Another is to create a statewide peer support specialist certification program and cover peer specialist services under Medi-Cal, as proposed in SB 906 (Beall).

- **Peer advocates and other community supporters:** Federal approval to implement SB 147 (Hernandez), a bill passed in 2015, would allow clinics to be reimbursed by Medi-Cal for services provided by community health workers (also known as "*promotoras*" and by other titles), who would help patients navigate services, including services to address SDOH.

[25] http://www.mchaccess.org/pdfs/alerts/CPSP%20Closing%20the%20Gaps%20Spring,%202018.pdf
[26] https://safehealthcareforeverywoman.org/patient-safety-bundles/maternal-mental-health-depression-and-anxiety/

- **Same-day mental health services at clinics:** For women who are patients at a federally qualified health center (FQHC) or rural health clinic (RHC), billing for a mental health visit on the same day as another clinic visit is generally not allowed, creating a serious barrier to access. SB 1125 (Atkins) would remove it.

- **Group prenatal care with supportive services:** Group prenatal care is a model for delivering pregnancy care that involves groups of women going through clinic and other visits together, providing emotional and psychological support to each other, reducing stress, and helping in other ways to prevent or address mental health (and other) conditions. The approach can be covered by CPSP when certain criteria are met. MCHA and others are pursuing options for making it easier for FQHCs and RHCs to use the benefit "outside the four walls" of the clinic site. (This is not a concern for non-FQHC/RHC providers.)

- **Education and training:** Many emphasize that pregnancy-care providers need education about the prevalence and seriousness of perinatal mental health issues and training on their role. A critical aspect of training for providers, as well as for child protective services and ths police, is avoiding the unnecessary removal of children or other sanctions against mothers who need mental health care.

- **Insufficient number and distribution of mental health providers:** There are not yet enough mental health providers to serve Medi-Cal patients. As a result, a woman may go from crisis-to-crisis, with no preventive or other treatment services to help stop the next emergency from happening. In some parts of the state, crisis emergency mental health services are also lacking. Health plans need to do more to improve their mental health network adequacy for mild to moderate conditions, as do the county Behavioral Health Services plans for specialty mental health. There is also a need for more fee-for-service providers for Medi-Cal mental health. Workforce, pipeline, and reimbursement rates all need to be addressed.

  In the meantime, the following two laws passed in 2016 and 2017, respectively, could help improve access for clinic patients when fully implemented. AB 1863 (Wood) allows FQHCs and RHCs to be reimbursed for services provided by Marriage and Family Therapists on par with other behavioral health providers, such as Psychologists and Licensed Clinical Social Workers. SB 323 (Mitchell) allows clinics direct payment for their Specialty Mental Health services.

- **Midwifery:** Research shows the high quality and safety of maternity care provided to low-risk women by certified nurse midwives. But access to nurse-midwives is limited: according to the Certified Nurse Midwives Association, CA is one of only five states that still require these practitioners to be supervised by a physician—even though nine CA counties have no practicing obstetrician at all, and 19 counties have five or fewer. AB 2682 (Burke) would

have expanded access to nurse-midwifery services; while the bill recently failed in committee, a similar measure may be presented next year. Access for low-risk women could also be expanded by lifting administrative barriers to Medi-Cal services from licensed midwives.

- **Other measures:** Several other measures also relate to maternal mental health, with www.2020Moms.org and www.maternalmentalhealth.now leading the charge. For example, AB 1893 (Mainschein; signed July 20, 2018) may provide more funding; AB 2193 (Mainschein) would require private as well as public plans and health insurers to develop maternal mental health case management programs and offer women screening. AB 3032 (Frazier) would require hospitals that have a perinatal unit to educate providers and patients about maternal mental health conditions and inform patients about post-hospital treatment options and community resources.