

## Integrating Mental Health Services Based on Community-Defined Evidence

**Recommendation:** Medi-Cal managed care plans (MCPs) can advance behavioral health equity by adding mental health services based on community-defined evidence, to the outpatient mental health services available to a plan's beneficiaries. Developed specifically to address the unmet needs and strengths of a cultural group, these services can be an important component of a mental health system that assists diverse communities. These services could be reimbursed by Medi-Cal through a State Plan Amendment as an additional service under the Medi-Cal preventive services benefit.<sup>iii</sup> Alternatively, California could include these services as part of the in-lieu of services (ILOS) that MCPs can offer under the "Medi-Cal Healthier California for All" framework. The Department of Health Care Services is proposing to allow for specific cultural practices for American Indian/Alaska Native communities and reimbursement for the workforce of traditional healers and natural helpers.<sup>iii</sup>

**Background:** Mental health services based on community-defined evidence derive from a community's ideas of illness and healing or positive attributes of cultural or traditional practices. These services originate within the community and the organizations that serve them, and can range from mental health treatments to community outreach to other services and supports.<sup>iv</sup> Examples of these types of practices include traditional healing activities for Native Americans,<sup>v</sup> peer-led community gardens for refugees,<sup>vi</sup> gender-affirming support groups for lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals,<sup>vii</sup> and advocacy training for Latinos and African Americans.<sup>viii</sup>

The term, "community-defined evidence practices" or CDEP describes "a set of practices that communities have used and determined by community consensus

over time and which may or may not have been measured empirically but have reached a level of acceptance by the community."<sup>ix</sup> These practices came about in response to the lack of recognition of mental health services grounded in a community's cultural norms, unique symptoms, and risk and resilience factors. Because most currently reimbursable "evidence-based practices" were primarily tested on White patients there is a growing demand for mental health services based on community-defined evidence. The California Department of Public Health has funded and evaluated CDEP as important interventions for reducing mental health disparities.<sup>x</sup>

Mental health services based on community-defined evidence can be provided by qualified mental health professionals who may not have a medical or social work license. Examples include peer counselors, community health workers, trained facilitators, and traditional healers. These practitioners can help bridge the gap between mental health services and individuals known to face mental health disparities, since they have the ability to connect culturally with local populations, build trusting relationships with individuals and their families, and address their mental health needs effectively.<sup>xi</sup> Such qualified mental health professionals would be able to provide the following services:

1. Initial engagement and mental health screening
2. Linkage to non-specialty and specialty mental health services as needed
3. Psychoeducation
4. Well being workshops and individual support services including but not limited to the following topics:
  - Resiliency development
  - Social and emotional skill development
  - Healthy coping skills
  - Stress reduction

- Mitigating the impacts of trauma
- Prevention skills for depression and anxiety
- Emotional wellbeing for underserved or special populations (individuals with disabilities; LGBTQ communities; caretakers of young children, individuals with disabilities, and older adults)
- Mental health first aid
- Group-based education and skill building

## Problem/Community Evidence:

California’s communities of color need more population-specific services to reduce disparities.<sup>xii, xiii</sup> Asian and Latino Californians are half as likely to initiate and engage in mental health treatment as Whites. Black Californians engage with the specialty mental health system at disproportionate rates, but their outcomes are worse compared to other populations.<sup>xiv</sup> Racial and ethnic disparities also persist in MCPs’ delivery system, with a 2018 report by the Department of Health Care Services showing other racial and ethnic Medi-Cal consumers using mild to moderate mental health visits at half the rate than White Medi-Cal consumers.<sup>xv</sup>

Between 2012 and 2015, CPEHN worked with our partners representing diverse populations across the state to develop population specific knowledge about mental health challenges and a roadmap for reducing mental health disparities.<sup>xvi</sup> Over 7,000 Californians provided input, and the stories told by them shed light on the important role of community-defined mental health services:

*“Learning about our tribal history was one of the most healing things I’ve done; my cultural learning has brought me to a good place.”*

-Native American Community Member

*“Not feeling well physically, I see doctors. Not feeling well mentally, I go to the temple and talk to monks.”*

-API Community Member

*“Our parishioners come to us for help. We have a responsibility to help them. Our biggest need is for community mental health resources to help our people get the right assistance they need.”*

- African American Community Member

*“I didn’t want to be labeled as having a mental health diagnosis when I didn’t feel that I had one.”<sup>xvii</sup>*

- Transgender Advisory Group Member

## Solution/Best Practice:

California could decide to seek federal approval for mental health services based on community-defined evidence through a State Plan Amendment, as an additional service under the Medi-Cal preventive services benefit. The Centers for Medicare & Medicaid Services (CMS) allows providers without medical or social work licenses to provide services under either the preventive services, or “other licensed practitioners” benefits under Social Security Act Section 1905(a) with an approved State Plan Amendment. CMS has used this authority to provide reimbursement of peer support services, provided that the peers are trained and certified and supervised by a competent mental health professional as defined by the state.<sup>xviii</sup> The governor has recognized the important role of qualified mental health professionals who do not have a medical or social work license in meeting the mental health needs of diverse communities in response to efforts to certify peer support specialists.<sup>xix</sup> This is also the same mechanism that California has used to reimburse for the work of community health workers.

## Option 1: Submit a State Plan Amendment (SPA)

Under the preventive services benefit, mental health services based on community-defined evidence must be recommended by a physician or other licensed practitioner.

<sup>xx, xxi</sup> In addition, the State Plan Amendment must:

- List the services to be provided to ensure that services meet the definition of preventive services as stated in section 4385 of the State Medicaid Manual (including the requirement for the service to involve direct patient care).
- Identify the type(s) of non-licensed practitioners who may furnish the services.
- Include a summary of the state's provider qualifications that make these practitioners qualified to furnish the services, including any required education, training, experience, credentialing, supervision, oversight and/or registration.

DHCS could convene MCPs, providers, consumers and the Department of Public Health for help in drafting the SPA. Together they could work to develop a plan to reimburse for mental health services based on community-defined evidence as a bridge to the MCPs more traditional clinical practices, as DHCS is proposing to do for cultural practices for AI/AN communities.

*Other State Practices:* Medicaid programs in other states have increased access to the use of mental health services based on community-defined evidence under the preventive services benefit. Arizona has pursued this approach for reimbursement of Tribal Traditional Healing Practices through its Section 1115 waiver.<sup>xxii</sup>

## Option 2: Expand the Category of Reimbursable In-Lieu of Services:

Under the state's Medi-Cal Healthier California for All framework, the state proposes to allow MCPs to be reimbursed for in-lieu of services, which can include supportive housing and other social services that address health-related needs. California could specifically allow Medi-Cal MCPs to use in-lieu-of-services, to address a broader array of issues including access to mental health services based on community-defined evidence. County mental health plans are already encouraged to increase the use of prevention and early intervention programs, including those utilizing mental health services based on community-defined evidence that focus on reducing disparities for unserved, underserved, and inappropriately served racial, ethnic and cultural groups.<sup>xxiii</sup>

*Other State Practices:* Some states invite or encourage MCPs to provide what are known as "value-added" services beyond the standard benefits to adults in order to improve the overall health of plan enrollees. New Mexico has used this value-added approach to pay for traditional healing.<sup>xxiii</sup> Plans each paid \$250 or \$300 per year towards spiritual and traditional healing practices for Native American members. The use of mental health services based on community-defined evidence to engage populations known to face disparities, as well as screen and refer patients to specialty and non-specialty mental health services, would serve as an important value-add to Medi-Cal MCPs.

## Conclusion:

Proposals seeking to improve mental health equity under the Medi-Cal Healthier for All California initiative will have a greater chance of success when they incorporate population-specific mental health approaches that target known drivers of inequity, such as lack of culturally and linguistically appropriate care, provider shortages, and stigma. Adding mental health services based on

community-defined evidence to the suite of outpatient mental health services will help to improve the ability of managed care plans to improve access to mental health care services, target social determinants of health and reduce mental health disparities.

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## Sources:

- i. Senate Bill (SB) X 1-1 (Hernandez, Statutes of 2013) added the following language to the California Welfare & Institutions Code (WIC): WIC §14132.03(a). "The following shall be covered Medi-Cal benefits effective January 1, 2014: (1) Mental health services included in the essential health benefits package adopted by the state(...). To the extent behavioral health treatment services are considered mental health services pursuant to the essential health benefits package, these services shall only be provided to individuals who receive services through federally approved waivers or state plan amendments pursuant to the Lanterman Developmental Disability Services Act(...)." WIC §14189. "Medi-Cal managed care plans shall provide mental health benefits covered in the state plan excluding those benefits provided by county mental health plans under the Specialty Mental Health Services Waiver. The department may require the managed care plans to cover mental health pharmacy benefits to the extent provided in the contracts between the department and the Medi-Cal managed care plans."
- ii. Implementing regulations specified that outpatient mental health services are as follows:
  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
  6. Outpatient laboratory, supplies and supplements; and
  7. SBIRT for alcohol use disorders
- iii. Medi-Cal Healthier California for All Drug Medi-Cal Organized Delivery System Program Renewal and Policy Improvements, Feb. 12, 2020. <https://www.dhcs.ca.gov/services/Documents/DMC-ODS-presentation-BH-SAC.pdf>
- iv. Pacific Southwest Mental Health Technology Transfer Center Network. Resource Compendium: Evaluating Community-Defined Evidence Practices. Retrieved from: <https://mhctnetwork.org/centers/pacific-southwest-mhctc/home>
- v. For a comprehensive list of Native American and Alaskan Native Community-Defined Evidence Practices, See Appendix: Catalogue of Effective Behavioral Health Practices for Native American Communities (pg. 36) in Native Vision: A Focus on Improving Behavioral Health Wellness for California Native Americans. Retrieved from [https://cpehn.org/sites/default/files/native\\_population\\_report.pdf](https://cpehn.org/sites/default/files/native_population_report.pdf)
- vi. For a comprehensive list of Asian Pacific Islander Community-Defined Evidence Practices, See Table 5: Summary of Promising Program and Strategy Submissions

(pg. 67) in Asian Pacific Islander (API) Population Report: In Our Words. Retrieved from: [https://cpehn.org/sites/default/files/api\\_population\\_report.pdf](https://cpehn.org/sites/default/files/api_population_report.pdf)

vii. For a comprehensive list of LGBTQ Community-Defined Practices, see "Community Defined & Promising Practices" (pg. 181) in First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual Transgender, Queer and Questioning Populations in California. Retrieved from: [https://cpehn.org/sites/default/files/lgbtq\\_population\\_report.pdf](https://cpehn.org/sites/default/files/lgbtq_population_report.pdf)

viii. For a comprehensive list of Latino Community-Defined Evidence Practices, see "Latino SPW Matrix of Organizations with Community-Defined Evidence Programs" in Community-Defined Solutions for Latino Mental Health Care Disparities. Retrieved from: [https://cpehn.org/sites/default/files/latino\\_population\\_report.pdf](https://cpehn.org/sites/default/files/latino_population_report.pdf)

ix. For a comprehensive list of "D4. Models: Community-Defined PEI Practices for Blacks" (pg. 188) in We Ain't Crazy! Just Coping with a Crazy System: Pathways into the Black Population for Eliminating Mental Health Disparities. Retrieved from: [https://cpehn.org/sites/default/files/african\\_american\\_population\\_report.pdf](https://cpehn.org/sites/default/files/african_american_population_report.pdf)

x. The California Reducing Disparities Project (CRDP) is focused on funding and evaluation promising practices. There are currently 35 community-defined evidence practices funded by the CRDP. Evaluation results are available upon request and approval.

xi. Incorporate citation

xii. It should be noted that California law already specifies standards for county mental health plans and Medi-Cal Managed Care Plans to coordinate mental health referrals. § 1810.370. MOUs with Medi-Cal Managed Care Plans.

xiii. DHCS APL 13-018

xiv. Existing Disparities in California's Specialty Mental Health System. The California Pan-Ethnic Health Network. Retrieved from: <https://cpehn.org/blog/201905/existing-disparities-california%E2%80%99s-system-specialty-mental-health-care>

xv. The Department of Healthcare Services Medi-Cal Managed Care Performance Dashboard

<https://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx>

xvi. The California Reducing Disparities Project: Strategic Plan to Reduce Mental Health Disparities. Developed by the California Pan-Ethnic Health Network in Partnership with the California Reducing Disparities Project Partners. Retrieved from: [https://cpehn.org/sites/default/files/crdp\\_strategic\\_plan.pdf](https://cpehn.org/sites/default/files/crdp_strategic_plan.pdf)

xvii. First, Do Not Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California. The California LGBTQ Reducing Mental Health Disparities Population Report. Retrieved from: [https://cpehn.org/sites/default/files/lgbtq\\_population\\_report.pdf](https://cpehn.org/sites/default/files/lgbtq_population_report.pdf)

xviii. (See this 2007 CMS letter to Medicaid Directors.)

xix. SB 10 Veto Message. Office of the Governor. Retrieved from <https://www.gov.ca.gov/wp-content/uploads/2019/10/SB-10-Veto-Message.pdf>

xx. (42 CFR 440.130(c)),

xxi. described in Families USA's brief.

xxii. Proposed AZ 1115 Waiver Language: AHCCCS Reimbursement for Traditional Healing Services. However, a facility governing body may serve as the Qualifying Entity or designate another Qualifying Entity from the Tribe(s) served to endorse qualified Traditional Healing Providers.

xxii. Welfare and Institutions Code 5840.5.

xxiii. as explained here.