INSTITUTE FOR MEDICAID INNOVATION

Evaluation of the Adoption of A.B. 2193 the California Maternal Mental Health Law Provision

by Medi-Cal Managed Care Health Plans

INSTITUTE FOR MEDICAID INNOVATION

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California Health Care Foundation

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We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

Table of Contents

Acknowledgements

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Executive Summary

In July 2019, California signed one of the most comprehensive maternal mental health bill packages into law. This law, A.B. 2193, required licensed health care practitioners providing prenatal or postpartum care to offer screening to individuals for maternal mental health conditions at least once during pregnancy or the postpartum period. The bill also included the requirement for health care service plans and health insurers to develop maternal mental health programs to support their pregnant and postpartum populations and contracted providers who provide care. The legislation mandated health care service plans develop clinically sound and documented maternal mental health programs to enhance quality at lower costs.

To better understand how this legislation impacted the landscape of maternal mental health care in California, the California Health Care Foundation funded the Institute for Medicaid Innovation (IMI) to conduct interviews with selected representatives from Medi-Cal managed care health plans, commercial health plans, state government officials, advocacy organizations, and professional and clinical associations. Between March and May 2023, the IMI team conducted 19 interviews with a total of 28 representatives from these organizations.

As part of the project's inquiry, we investigated the requirement for health plans to submit reports on the status of their initiatives and coverage. However, due to the cyclical nature and timing of when the reports are due, none had been submitted since the law had been passed.

The five objectives of the evaluation project included the following:

Objective 1:
explore Medi-Cal managed care health plans' knowledge and awareness of A.B. 2193

Objective 2:
understand how A.B. 2193 has moved Medi-Cal managed care health plans toward developing, piloting, and implementing maternal mental health programs (inclusive of program definition, core components, compliance measures, and operationalization)

Objective 3:
compare Medi-Cal managed care health plans' actions to address A.B. 2193 with selected commercial plans

Objective 4:
gain the perspective of state government officials, professional and clinical associations, and advocacy organizations on the intended impact and current implementation of A.B. 2193

Objective 5:
identify the needs and opportunities to support Medi-Cal managed care health plans and contracted providers in full implementation of the law within the context of the broader maternal health policy landscape in California

Overarching Themes

The overarching themes that emerged from these interviews included the following:

- **Workforce shortages, particularly the availability of mental health providers, present significant challenges in individuals being referred to and receiving services.**

  Nearly all the interviewees commented on the dearth of mental health and behavioral health practitioners as a major obstacle to ensuring that individuals receive the services they need. Many noted a resistance to screening individuals in circumstances in which there are no practitioners to provide mental health services.

- **Learning collaboratives were identified as a needed resource and support to ensure optimal impact of maternal mental health initiatives.**

  When asked what resources and supports would be helpful to ensure optimal impact of maternal mental health initiatives, almost all interviewees identified the need for a "learning collaborative." Interviewees emphasized that such collaboratives could be an important vehicle for sharing best practices regarding maternal mental health and coordinating efforts to support individuals needs.

- **The need for providers to receive reimbursement for the additional responsibilities in the legislation. If additional responsibilities are added then additional payment is needed, as well.**

  For example, midwives are required to provide these services, but do not receive additional reimbursement. To incentive providers, payment would motivate.

- **There is still much work to be done about the stigma of mental health.**

  Several interviewees discussed the stigma of mental health as a barrier to pregnant and postpartum individuals seeking and receiving maternal mental health care services.

- **Difficulty capturing data was the challenge most often cited by health plans in the development, pilot, or implementation of maternal mental health programs.**

  Interviewees highlighted the need for accurate data, including contact information for individuals, race and ethnicity data, and proper coding for mental health screening as well as access to depression screening data to identify gaps in services.

- **The legislation provided a solid foundation from which Medi-Cal health plans, advocacy organizations, and professional and clinical associations could continue to build on their existing services**.

  Most interviewees stated that A.B. 2193 supported maternal mental health programs and services that they already had in place.

- **Additional education for providers and the public is crucial to properly identify maternal mental health needs.**

  Many interviewees emphasized the importance of continuing and enhanced education for providers in how to properly screen individuals for maternal mental health needs and for nonclinical providers (e.g., doulas) in recognizing the signs of postpartum depression. Interviewees recommended easily accessible materials (e.g., toolkits) for clinical and nonclinical practitioners and the public. They noted that increased awareness around maternal mental health would have a positive impact on diminishing the stigma of mental health.

- **Medi-Cal health plans are taking an active role in continuing to implement maternal health and maternal mental health initiatives.**

  Most of the health plan interviewees outlined new initiatives, programs, or actions implemented both before and after the 2022 passage of S.B. 1207 in California, which requires that providers providing perinatal care screen for mental health conditions and that screening, diagnosis, and treatment measures are in place. Health Plans are required to develop a mental health program designed to promote quality and cost-effective outcomes. Conversely, when interviewing respondents from advocacy organizations, professional/clinical associations, and state government officials, very few indicated any new maternal mental health initiatives to be implemented.

- **Establishing and maintaining trust is paramount in ensuring that individuals seek and receive services. Many interviewees highlighted the importance of trust between providers and individuals seeking and/or receiving services.**

  They stated that this is particularly poignant within and among certain racial and ethnic groups and emphasized the value of having providers who are part of the community in which they serve. Ensuring culturally and linguistically competent care, including understanding cultural influences on health behaviors (particularly maternal mental health), is crucial to fostering trust, improving patient-provider communication, and ultimately diminishing the stigma of mental health.

This evaluation of A.B. 2193 showed many positive effects of the legislation and identified opportunities to further advance work in maternal mental health. Most interviewees knew about the legislation, which provided a foundation from which health plans, advocacy organizations, and professional and clinical associations could build on their existing work or develop new initiatives.

Opportunities to Advance Maternal Mental Health

Several opportunities to advance maternal mental health in California were identified based on the interview findings. These included strategies to improve access to screening and mental health services, increased education and sharing of information and best practices, enhanced data and measurement, approaches to improve accurate coding and address billing problems, and the development of a concerted focus on health equity.

→ Improve access to screening and mental health services.

- Expand screening efforts by training more professionals and mental health providers.
  - » For instance, training sessions related to screening could be developed and held across health plans and clinical practices.
- Establish procedures in clinical practices to standardize and streamline the screening and referral process.
- Address the provider shortage by convening meetings between health plans, clinical groups, public health practitioners, and legislators to brainstorm innovative approaches and financial resources.

→ Expand education and information sharing.

- Provide education to de-stigmatize mental health.
  - » For example, through social media, the development and distribution of written materials through the health plans or in clinical practices, and conversations between providers and individuals in clinical practices.
- Provide continuing and enhanced education for clinical and non-clinical providers (e.g., doulas and community health workers) about new screening techniques and availability of mental health services and resources.
- Establish a statewide learning collaborative to support cross learning and education, as well as offering a structure for sharing best practices and collaborations.
  - » The ideal learning collaborative would offer opportunities such as obtaining education on evidence-based practices, increasing awareness of quality measures, sharing successes and lessons learned to replicate what works and avoid what does not, offering technical assistance and structure in implementation of initiatives, working through data sharing issues and finding potential solutions, working with multiple stakeholders (e.g., county, state, health plan, community, clinician) to identify challenges/barriers and co-creating solutions, and networking with others charged with leading initiatives on this topic.

→ Enhance data and measurement.

- Expand broader adoption of current measures through awareness campaigns and education.
- Invest in and the development of new mental health measures that are culturally congruent.
- Amplify the potential of data systems to monitor screenings, referrals, and receipt of mental health services by health plans and clinical practices to identify persons who may have "fallen through the cracks" in screening or referrals for follow-up.

→ Center equity and justice.

- All individuals should receive appropriate culturally and linguistically congruent care, ideally in their own communities.
  - » For example, designing community-based, innovative models of perinatal care that include mental health.
- Ensure that all new measures developed are validated through the inclusion of all communities in the pilot and testing phases.
- Support the expansion of mental health professionals and clinicians that reflect the diverse communities of California.
- Encourage stratification of data by race, ethnicity, and language (REaL), geographic distribution (i.e., rural, urban), and payer type to identify disparities and inequities.

Introduction

Effective July 1, 2019, California A.B. 2193 required licensed health care practitioners providing prenatal or postpartum care to offer screening to individuals for maternal mental health conditions at least once during pregnancy or the postpartum period. The bill also included the requirement for health care service plans and health insurers to develop maternal mental health programs to support their pregnant and postpartum populations and contracted providers who provide care. The legislation mandated health care service plans develop clinically sound and documented maternal mental health programs to enhance quality at lower costs. A.B. 2193 is one of several legislative acts passed in the last 5 years expressly focused on improving maternal health in the context of increased attention on racial and ethnic disparities in access and outcomes.

The California Health Care Foundation funded the Institute for Medicaid Innovation (IMI) to conduct interviews about the interpretation and implementation of A.B. 2193 by Medi-Cal managed care health plans (MCHPs), corresponding to the goals of the legislation to curtail maternal mental health conditions, improve quality of perinatal care, improve pregnancy outcomes, and support the healthy development of children. The project planned to add a commercial health plan (CHP) component to identify differences with the Medi-Cal managed care health plans in approach or actions. Additionally, interviews with state government officials (SGOs), advocacy organizations (AOs), and professional and clinical associations (PCAs) were added to gain their perspectives on how they were approaching implementation of the new mandate.

The five objectives of the evaluation project included the following:

Objective 1:
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identify the needs and opportunities to support Medi-Cal managed care health plans and contracted providers in full implementation of the law within the context of the broader maternal health policy landscape in California

Methodology

Interview Protocols

To achieve the five objectives, the IMI team developed four interview protocols, one for each of the groups to be recruited, including interview questions for (a) Medi-Cal and commercial health plans, (b) professional/clinical associations, (c) state government officials, and (d) advocacy organizations.

The interview protocols included a set of questions asked across all four interviewee groups as well as questions unique to each group. Interview questions focused on a range of topics, including familiarity with the legislation, the history and passage of the legislation, the maternal mental health initiatives implemented, and opportunities to support maternal mental health efforts.

Recruitment

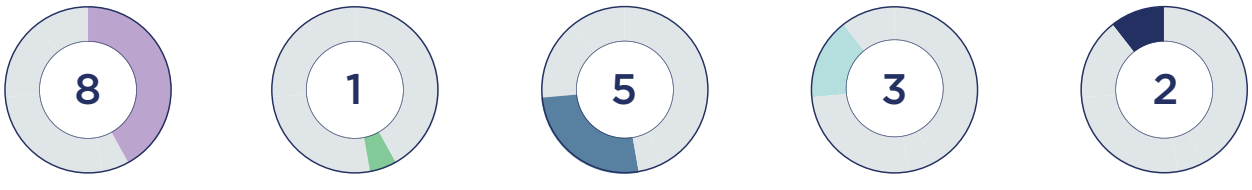
The IMI team employed multiple recruitment techniques to identify and recruit interviewees. For the Medi-Cal managed care health plans, the California Health Care Foundation provided the name of the executive director of the California Health Plan Association (which represents all health plans in California) to aid in identifying the initial list of Medi-Cal managed care health plan interviewees. However, that yielded only one interview. IMI also reached out to its network of Medi-Cal managed care health plans (e.g., through committee and project meetings, individual emails, e-newsletter, and social media) and used snowball sampling to identify health plans outside of its network.

To identify interviewees from the other groups (i.e., state government officials, advocacy organizations, and professional clinical associations), IMI also conducted outreach through its network (e.g., individual emails, e-newsletter, social media, committee meetings) and existing California-based grant-funded projects. Snowball sampling yielded a few additional interviewees.

Recruitment was conducted in February through April 2023.

Interviews

The IMI team conducted interviews between March 20 and May 15, 2023, of 28 persons from 19 organizations.[1] These included the following:



Medi-Cal managed care health plans (including one that also had a commercial line of business)

Commercial Health Plan

Advocacy Organizations

State Government Officials

Professional/ Clinical Associations

The majority of the interviewees held positions of leadership within their organizations, including the following:

- Vice president
- Founder and president
- Deputy director
- Director
- Cofounder and director
- Senior attorney
- Executive director
- Senior program manager
- Chief medical officer

Limitations

This study had two main limitations, including the number of interviewees and the completion of all interview questions.

Number of Interviewees

The goal was to interview up to 24 participants. IMI succeeded in interviewing 28 individuals from 19 different organizations. However, the response rate from health plans (particularly commercial health plans) was lower than anticipated due to competing priorities such as the rollout of the reenactment of the redetermination process as part of the pandemic public health emergency efforts and the California Alliance for Innovation on Maternal Health (CalAIM) initiative.[2]

Completion of Interview Questions

Due to the complex nature of many questions in the interview protocols and the availability of the interviewees (i.e., interviews were limited to 1 hour), the interviewers prioritized certain questions over others to gather as much pertinent information as possible. Additionally, as the interviews progressed and themes were beginning to emerge, the interviewers prioritized certain questions for deeper exploration.

Findings: Overarching Themes

- Learning collaboratives are needed
- Workforce shortages present significant challenges
- Stigma of mental health
- Establishing and maintaining trust is paramount
- Providers need reimbursement for additional responsibilities
- Additional education is crucial
- Medi-Cal health plans are taking an active role
- Difficulty capturing data
- Legislation provides a solid foundation

Learning collaboratives were identified as a needed resource and support to ensure optimal impact of maternal mental health initiatives.

When asked what resources and supports would be helpful to ensure optimal impact of maternal mental health initiatives, almost all interviewees identified the need for a "learning collaborative." Interviewees emphasized that such collaboratives could be an important vehicle for sharing best practices regarding maternal mental health and coordinating efforts to support individuals needs.

Workforce shortages, particularly the availability of mental health providers, present significant challenges in individuals being referred to and receiving services.

Nearly all the interviewees commented on the dearth of mental health and behavioral health practitioners as a major obstacle to ensuring that individuals receive the services they need. Many noted a resistance to screening individuals in circumstances in which there are no practitioners to provide mental health services.

There is still much work to be done about the stigma of mental health.

Several interviewees discussed the stigma of mental health as a barrier to pregnant and postpartum individuals seeking and receiving maternal mental health care services.

Establishing and maintaining trust is paramount in ensuring that individuals seek and receive services. Many interviewees highlighted the importance of trust between providers and individuals seeking and/or receiving services.

They stated that this is particularly poignant within and among certain racial and ethnic groups and emphasized the value of having providers who are part of the community in which they serve. Ensuring culturally and linguistically competent care, including understanding cultural influences on health behaviors (particularly maternal mental health), is crucial to fostering trust, improving patient-provider communication, and ultimately diminishing the stigma of mental health.

The need for providers to receive reimbursement for the additional responsibilities in the legislation. If additional responsibilities are added then additional payment is needed, as well.

For example, midwives are required to provide these services, but do not receive additional reimbursement. To incentive providers, payment would motivate.

Additional education for providers and the public is crucial to properly identify maternal mental health needs.

Many interviewees emphasized the importance of continuing enhanced education for providers in how to properly screen individuals for maternal mental health needs and for nonclinical providers (e.g., doulas) in recognizing the signs of postpartum depression. Interviewees recommended easily accessible materials (e.g., toolkits) for clinical and nonclinical practitioners and the public. They noted that increased awareness around maternal mental health would have a positive impact on diminishing the stigma of mental health.

Medi-Cal health plans are taking an active role in continuing to implement maternal health and maternal mental health initiatives.

Most of the health plan interviewees outlined new initiatives, programs, or actions implemented both before and after the 2022 passage of S.B. 1207 in California, which requires that providers providing perinatal care screen for mental health conditions and that screening, diagnosis, and treatment measures are in place. Health Plans are required to develop a mental health program designed to promote quality and cost-effective outcomes. Conversely, when interviewing respondents from advocacy organizations, professional/clinical associations, and state government officials, very few indicated any new maternal mental health initiatives to be implemented.

Difficulty capturing data was the challenge most often cited by health plans in the development, pilot, or implementation of maternal mental health programs.

Interviewees highlighted the need for accurate data, including contact information for individuals, race and ethnicity data, and proper coding for mental health screening as well as access to depression screening data to identify gaps in services.

The legislation provided a solid foundation from which Medi-Cal health plans, advocacy organizations, and professional and clinical associations could continue to build on their existing services.

Most interviewees stated that A.B. 2193 supported maternal mental health programs and services that they already had in place.

Objective 1:
Explore Medi-Cal Managed Care Health Plans' Knowledge and Awareness of A.B. 2193

Medi-Cal managed care health plan (MCHP) and commercial health plan (CHP) interviewees (herein also referred to as "health plan" interviewees) were asked questions regarding their knowledge and awareness of A.B. 2193. The majority of interviewees from the health plans indicated they had knowledge and awareness of A.B. 2193.

> *[A.B. 2193] happened to coincide with projects [in our plan] around maternal health and maternal mental health. We were emboldened that the legislature said we were on the right path. We already started some of this work around maternal mental health. (Medi-Cal Managed Care Health Plan)*

> *This has been on the Medi-Cal managed care radar for a few years now. (Medi-Cal Managed Care Health Plan)*

In other interviews (i.e., professional/clinical associations, state government officials, and advocacy organizations), the interviewees were also asked about their knowledge and awareness of A.B. 2193 as well as questions about their involvement in the passage of the legislation and the successes and challenges in getting A.B. 2193 passed.

Familiarity with Legislation

Similar to the health plan interviewees, most interviewees from the other three groups were familiar with A.B. 2193. Interviewees from both professional/clinical associations (PCA), one state government official (SGO), and nearly all advocacy organizations (AO) interviewees indicated familiarity with A.B. 2193. Overall, the advocacy organization interviewees indicated a more in-depth familiarity with the legislation.

> *I heard of it during the planning of [Cal]AIM but was more focused on S.B. 464 at that time. (State Government Official)*

> *We were aware of it pretty immediately. [We] were definitely aware of it and excited about it. (Advocacy Organization)*

Involvement in the Passage of A.B. 2193

Interviewees from the professional/clinical associations and advocacy organizations who indicated they were familiar with the legislation were also asked to what extent they were involved in the passage of A.B. 2193. Of these interviewees, representatives from the two advocacy organizations who indicated a more in-depth familiarity also stated that they were very involved with the passage of A.B. 2193.

Interviewees from another advocacy organizations said they wrote letters of support but were not closely involved with the organization that sponsored the bill. Representatives from the two professional/clinical associations indicated they had limited involvement in the passage of the bill or lobbying efforts (i.e., they were not directly or significantly involved). They further noted that they felt they were often left out of conversations regarding maternal health care in California and had to actively seek out information.

> *[We were] deeply connected to the passage [of the legislation], lots of blood, sweat, and tears, as you can imagine.*
>
> **—Advocacy Organization**

It was on our radar, but we were not super involved. (Advocacy Organization)

I would characterize [us] as being kind of just on the periphery as a supporting organization, for the purposes of making sure the bill got through various committees. But we didn't do more than that. We didn't do any significant lobbying. (Professional/Clinical Association)

The other piece with any legislative update, or anything like that, is that usually midwives are not treated as stakeholders, because we serve such a small but growing population of birthing parents in California. And so, we find that we're not often looped into conversations about maternal health care at all in California; we have to kind of seek them out. (Professional/Clinical Association)

Program Successes and Challenges

Some interviewees from advocacy organizations were asked about their successes in getting A.B. 2193 passed. One advocacy organization stated that having someone with a personal experience of perinatal mood and anxiety disorders give testimony was very effective in getting A.B. 2193 passed. Another advocacy organization stated that A.B. 2193 was an exemplary bill that impacted other state legislative approaches to maternal mental health. Additionally, they noted that the development of and funding for a Healthcare Effectiveness Data and Information Set (HEDIS®)[3] measure came out of the passage of A.B. 2193. A third advocacy organization noted that the bill was a "big win" because it was an example of statewide legislation tied directly to perinatal mental health issues.

Every time we went to provide testimony, we made sure to include a constituent that had a personal experience with perinatal mood and anxiety disorders. And that was very effective. I think we typically had a survivor, for lack of better words, speak about their experience and how the bill would have helped them in their time of need. (Professional/Clinical Association)

We had recommended … that there be a HEDIS® measure that was developed to track how often screening was happening. So they ended up cofunding the development of that HEDIS® measure. (Advocacy Organization)

Just about everyone is screened with this mandate; whoever walks in the door is going to be screened. They're just screening everyone because it's easier. So that was an exciting, unexpected change. (Advocacy Organization)

All the advocacy organization interviewees and one state government official were asked about the challenges in getting A.B. 2193 passed. The most often identified challenge was "workforce shortage," followed by issues with payment and reimbursement. Other challenges identified included timing, competency of maternal mental health screeners and trust in screeners, and oversight.

The screening is great, but you need to actually have the folks available to provide … services. (Advocacy Organization)

California is one of the lowest-paying states when it comes to provider payments. (Advocacy Organization)

Someone may or may not be answering with honesty if they don't trust the provider has their best interests in mind. (Advocacy Organization)

A very large weakness of the bill was the lack of oversight and compliance of it. (Advocacy Organization)

California Association of Health Plans opposed it, and their basis for opposition was cost. (Advocacy Organization)

Wrong time to pass more mandates. (Advocacy Organization)

Objective 2:
Understand How A.B. 2193 Has Moved Medi-Cal Managed Care Health Plans Toward Developing, Piloting, and Implementing Maternal Mental Health Programs (Inclusive of Program Definition, Core Components, Compliance Measures, and Operationalization)

Maternal Mental Health Programs

Representatives from Medi-Cal managed care health plans and commercial health plans were asked about maternal mental health initiatives or programs that their health plans have piloted or implemented. The majority of health plan interviewees mentioned that they were already working on maternal mental health programs before the legislation was passed and that they used A.B. 2193 as leverage to continue or expand their existing programs. For example, one health plan had started its own program in 2018 and then added a nurse who specializes in maternal health after the legislation passed.

> *We've used A.B. 2193 to kind of set the foundation for our program. (Medi-Cal Managed Care Health Plan)*

> *Since A.B. 2193 [our program has] expanded to be more focused and deliberate to address what the required screenings are and what is expected of providers that are treating individuals who are perinatal postpartum, in relation to maternal depression screening. (Medi-Cal Managed Care Health Plan)*

Two health plan respondents, however, were unsure if programs were implemented before the legislation.

Program Stages

As most health plans had programs in place before the legislation, many indicated these programs are still in the implementation and performance monitoring stages. Two health plan respondents said they have programs in the development stage. One of those health plans initiated a program in 2013 but updated the programming in 2019

> *We contracted with a behavioral health group that provided the services and over the course of 2019/2020; [at that time] we were delving into all things maternal care.*
>
> **—Medi-Cal Managed Care Health Plan**

after the legislation was passed. The other health plan had one program in place before the legislation but has another program scheduled for implementation in 2023.

Primary Populations

The primary populations of these programs are pregnant and postpartum persons, but some programs also serve persons in the preconception and interconception periods. Two respondents noted that they also have programs that specifically focus on high-risk populations such as racial and ethnic (e.g., African American, Native American) populations and those with high-risk medical conditions affecting their pregnancies.

Program Objectives and Components

Responses about the objectives of the programs varied but generally centered around supporting prenatal and postpartum persons through depression screening, education (e.g., when to see a provider, signs and symptoms that should be reported to their providers), and accessing postpartum care. Interviewees from the health plans also identified the provision of resources for providers and community resources (e.g., via family support centers) for individuals and addressing health inequity and equity as program objectives. Four interviewees also noted that their programs conduct outreach and provide case management.

Measuring Success

When health plan interviewees were asked how they measure the success of their program(s), most said that they have multiple measures of success. Three respondents cited HEDIS® measures specifically. One health plan interviewee said they received feedback from their network that there were some challenges in accessing maternal mental health services, so they made a concerted effort to work more closely with that plan and track numbers of referrals, volume, etc.

Only one respondent said that their health plan was still developing quality and cost-effective measures specific to their initiative (such measures are anticipated by the end of 2023, as of the time of the interview).

Examples of other measures of success identified by respondents included the following:

- National Committee for Quality Assurance measures
- number of postpartum depression screenings per quarter
- number of behavioral health follow-ups that happen after screenings for those who test positive for depression
- distribution of physician incentives for doing depression screening
- of the plan members who had positive screenings, number of members who received follow-up care
- number of mental health referrals made

> *We are in the works of trying to get at least the PHQ-9[5] embedded in our medical record system so that we can administer it to our members.*
>
> **—Medi-Cal Managed Care Health Plan**

Respondents were also asked specifically in what way, if any, they are using HEDIS® measures (i.e., prenatal depression screening, the follow-up measure, and the postpartum depression screening and follow-up measure). Of those that responded to the question, all but one health plan respondent stated that they do not use the HEDIS® measures. The health plan representative that said "no" stated that the program measures success through a general health assessment developed by the plan.

Program Successes

Health plan representatives were asked to identify successes that they have achieved so far in the development, pilot, or implementation phases of their maternal mental health programs. Collaboration was noted by two health plan interviewees. One interviewee provided a recent success story about providers working together to support a pregnant mom in need of care. Another respondent talked about not working in linear pathways, stating that their program team makes sure to collaborate with their network and their members with a focus on diversity. This interviewee also stated that they work to identify gaps in access to care by race, ethnicity, and region and tailor the interventions based on racial and ethnic group data.

I think I can confidently say we're at a good place, and I feel like the health plan has a really good sense of what we do, as do our providers and our [obstetricians and gynecologists]. There's more awareness of what the health plan has and how to work collaboratively with our program. (Medi-Cal Managed Care Health Plan)

We have been able to stand up and engage our provider network in a more meaningful way in the last year than we ever have in the prior few years before that. (Medi-Cal Managed Care Health Plan)

A third interviewee identified screenings and referral pathways for maternal members as a success of the program. The respondent also highlighted their new provider orientation trainings, which include the maternal mental health program. All providers are trained on the program.

Finally, a fourth health plan interviewee detailed their plan's program successes as identifying staff passionate about behavioral health and having strong relationships with community-based organizations that serve the plan's primary population, improved HEDIS® prenatal and postpartum measures, and improved participation on a community advisory committee.

Program Challenges

Regarding challenges encountered so far during the development, pilot, or implementation phases of their programs, health plan respondents most commonly identified difficulty capturing data, particularly accurate data, as a challenge.

Making sure provider and provider offices know that they have to code for [mental health] assessments and how to do that are our biggest challenge right now. (Medi-Cal Managed Care Health Plan)

[We have] a low rate of depression screening data. (Medi-Cal Managed Care Health Plan)

One of the biggest challenges we've always had is correct contact information, especially for our Medi-Cal population. (Medi-Cal Managed Care Health Plan)

The next most commonly reported challenge was workforce shortages.[4] For example, one interviewee stated that the capacity of mental health providers is only half of what is needed.

What we hear again and again is 'we don't want to screen if we don't have a good intervention' to offer. (Medi-Cal Managed Care Health Plan)

Provider capacity is always a challenge. In California, probably also nationwide, we are seeing an increasing workforce challenge really permeating through the entire health care landscape. Turnover rate is pretty high. … It has been quite challenging to recruit adequately. (Commercial Health Plan)

Respondents from two health plans cited cultural and linguistic competency and cultural reception of mental health services as barriers, particularly when combined with the workforce shortages.

Other challenges identified included competing time priorities for provider engagement in information sharing and members' buy-in and trust.

Maternal Mental Health Priorities

Health plan interviewees were asked how maternal mental health would rate as a priority in their plans (on a scale from 0 to 10, with 0 being the lowest priority and 10 being the highest priority). Responses from the five health plans ranged from 6 to 9, with an average score of 8 across all respondents.

Health plan respondents were also asked about how clinical program priorities are determined in their plans. Respondents identified two main determinants of clinical program priorities—state legislative, regulatory, compliance, and/or accreditation structures and staff; and population needs assessments and/or community needs assessments. Beyond legislative and

> *There's an acceptance among some groups that there's a mild to moderate issue but not in others. It's important that the workforce reflect the diverse population that we serve.*
>
> **—Medi-Cal Managed Care Health Plan**

regulatory structures, priorities are determined by leadership (e.g., clinical leadership, chief medical officers, vice presidents, and presidents).

> *Highest priority are things that come in from the state legislation. (Medi-Cal Managed Care Health Plan)*

> *We are most beholden to contract requirements. … But when it comes to prioritizing everything and trying to get to everything, I would say that's a constant cycle and it depends on the day. And it depends on which audit we are going through. And it depends on the audit findings. And it depends on which teams have … staffing to get it done. (Medi-Cal Managed Care Health Plan)*

> *[Clinical program priorities] are determined through a collective process that looks at community needs based on community health assessments, [such as] strategic planning within counties for their health care assessments to identify gaps and/or big needs … measuring how we are performing against HEDIS® measures … [and] focusing on areas where there is high need and high impact. (Medi-Cal Managed Care Health Plan)*

As far as who is responsible for developing and implementing initiatives prioritized in their organizations or mandated by Medi-Cal managed care health plans, respondents noted that it depends on the programming and mandate and/or whether it is a collaborative or multidisciplinary process.

> *All teams work collaboratively—all this work falls under medical management. Leadership of different initiatives is based on the type of programming. (Medi-Cal Managed Care Health Plan)*

> *Depends on the mandate. Many are implemented through the social service department, but other mandates are the responsibility of case management teams (goes from the president or [chief executive officer] and trickles down). (Medi-Cal Managed Care Health Plan)*

> *The person/team responsible for leading an initiative is based on the type of initiative and target audience. (Medi-Cal Managed Care Health Plan)*

Urgency Created by New Legislation

Interviewees from health plans were asked in what ways the new S.B. 1207 legislation passed in California, which expanded coverage of maternal and pandemic-related mental health conditions, created any urgency or help with prioritization of maternal mental health plan initiatives within their health plans. Most interviewees outlined various actions taken in response to the new legislation. Two Medi-Cal managed care health plan interviewees stated that they started a doula benefit and service program to comply with S.B. 1207. Another managed care health plan interviewee said that they created a report to review their maternal mental health program and determine how to make it more robust. The commercial health plan interviewee stated that S.B. 1207 helped prioritize and elevate maternal mental health programs and identified new HEDIS® measures and the state's Comprehensive Quality Strategy policy guide (which lays out the 2025 state goals) as positive outcomes of the legislation. Only one Medi-Cal managed care health plan interviewee said that the legislation did not change much because they felt they were already meeting the requirements set forth.

[Our] doula benefit went live this year. Doulas are a great way to track any level of care for this population. (Medi-Cal Managed Care Health Plan)

[S.B. 1207] helps prioritize and elevate maternal mental health programs and dovetails nicely with the newer HEDIS® measures that all health plans in CA will be held accountable for starting in 2024 (two specific perinatal and postpartum depression screening and follow-up). (Commercial Health Plan)

[We are] looking a little bit more at [positive screening] data in our population than we have before. I think that's an opportunity that we've been kind of digging in since that Senate bill passed. (Medi-Cal Managed Care Health Plan)

Objective 3:
Compare Medi-Cal Managed Care Health Plans' Actions to Address A.B. 2193 with Selected Commercial Plans

Per the limitations outlined in the Methodology section above, the following section is limited to an overview of the interview with the commercial health plan representative in comparison to the interviews with the Medi-Cal managed care health plans. It is important to note that information provided in this section has been incorporated into the other objectives, as appropriate.

Familiarity with Legislation; Maternal Mental Health Programs

Like the managed care health plan respondents, the interviewee from the commercial health plan stated familiarity with A.B. 2193. However, unlike the other health plan interviewees, the commercial health plan respondent was unsure if their plan had implemented any maternal mental health programs before the legislation or whether their current programs were the result of A.B. 2193. The commercial health plan interviewee said that two CalAIM initiatives—the enhanced care management and community support programs—were launched in January 2022. They also noted they partner with a vendor to support a third nonspecialty mental health program that focuses on individuals with mild to moderate anxiety and depression. As with the majority of the managed care health plan programs, these programs are also in their implementation stage. The interviewee said that the objectives of the programs are to reduce health disparities and improve health equity.

> *Because of the new requirement for maternal mental health programs … we've been working really hard with [our mental health vendor] to establish that pathway.*
>
> **—Commercial Health Plan**

Measuring Success

Consistent with the other health plans, the commercial health plan interviewee said that they track multiple measures of success for both the enhanced care management and nonspecialty mental health programs; they noted that metrics for the community support program are harder to track, and they were unsure how that program is currently being tracked. For enhanced care management, they track enrollment rates, opt-in rates, wait times, outreach, success rates, and average time of engagement. For the nonspecialty mental health program, they are required to track the number of outcomes and report those metrics to the state on a regular basis. Furthermore, as with the other health plans, the commercial health plan respondent was familiar with HEDIS® and indicated that the programs are using HEDIS® measures.

Program Successes and Challenges

When discussing program successes and challenges, the commercial plan respondent noted improved communication ("Now all entities are talking to one another") and an alignment of priorities as program successes. Consistent with other interviewees, including the Medi-Cal managed care health plan interviewees, the commercial health plan respondent identified workforce shortages, member engagement, and Health Insurance Portability and Accountability Act regulations (specifically member privacy, regulation, and data security) as program challenges.

> *In California, probably also nationwide, we are seeing an increasing workforce challenge really permeating through the entire health care landscape.*
>
> **—Commercial Health Plan**

Urgency Created by New Legislation

Regarding the impact of S.B. 1207 on creating urgency or helping to prioritize maternal mental health plan initiatives within their health plan, the commercial health plan interviewee said that the new legislation helped prioritize and elevate mental health programs and noted new HEDIS® measures that all health plans in California will be held accountable for starting in 2024, including two specific perinatal and postpartum depression screening and follow-up measures.

Supports or Resources

Finally, when asked what additional support(s) or resource(s) would amplify the actions their plan is already taking to address birth equity and maternal mental health in the Medi-Cal population, the commercial health plan interviewee was consistent with that of the other health plans in identifying a learning collaborative, technical assistance, increased mental health provider capacity and need for more mental health professionals—particularly funding mental health professionals serving marginalized populations (to provide linguistically culturally competent care)—and a strong community partnership with community-based organizations.

Historically, marginalized members typically do not have a lot of trust outside of their primary care doctor's office. … We really have to inject more resources to providers that primarily serve marginalized or disenfranchised populations. (Commercial Health Plan)

Objective 4:
Gain the Perspective of State Government Officials, Professional/Clinical Associations, and Advocacy Organizations on the Intended Impact & Current Implementation of A.B. 2193

Implementation

Interviewees from advocacy organizations were asked about how they envisioned Medi-Cal managed care health plans implementing A.B. 2193 and how the bill has been implemented since its passage. One interviewee stated that they envisioned a mandate that requires screening but allows for the freedom and flexibility for providers to choose what works for them and their workflows. When asked about how the bill has been implemented since it was passed, they indicated that most of what they do is training, capacity building, and providing technical assistance to providers. They reported being able to measure the effectiveness of trainings on the individual health care providers by measuring changes in knowledge, comfort, and preparedness to screen or respond to perinatal mental health conditions.

We use the legislation in training to make the case to the audience and why they should be doing the screening. We are trying to expand people's definition of what perinatal depression treatment looks like and to think outside the box and highlight and lift up different organizations and initiatives and resources at the community level that providers can refer their patients. (Advocacy Organization)

What we do less well, but have made some strides towards addressing, is measuring the impact of our training and technical assistance and capacity building on institutions. (Advocacy Organization)

Another advocacy organization respondent envisioned that mental health programs would be implemented by providers, that the sponsoring organizations would review mental health programs for the health plans, and that there would be efforts to expand community-based organizations' mental health programs across health plans. However, they are unsure how much the bill has contributed to an increase in the capacity of mental health services.

> *A state website has some statistics about pregnant people and mental health but not much about how to get a provider.*
>
> **—Advocacy Organization**

A third interviewee who provided insight on how the bill has been implemented noted that they have heard from obstetricians and gynecologists that they would prefer to do their own screening to ensure it is being done correctly.

One respondent from a **professional/clinical association** noted that the bill was already the standard of care for maternal mental health screening and widely embraced by clinicians, but there is still work to be done to ensure the availability of effective, impactful maternal mental health care.

> *I am not sure how much the bill itself really impacted that change in practice, because in my opinion, that practice was already happening. (Professional/Clinical Association)*

> *The bill was a good start. But it didn't mandate or include everything that needs to be done to create actual effective, impactful programming for maternal mental health in California. Health insurers have to take up more responsibility around case management and how to assist the patient in navigating once we've identified they have an issue, what's the follow-up going to look like, and really putting some more responsibility on them, instead of always solely on the clinician or on the patient. (Professional/Clinical Association)*

This respondent also stated that the bill initially included more language about the programs the insurers would be mandated to create, including more direct support for treatment and case management (e.g., a more collaborative, wraparound care model). However, in the process of negotiating language for the final approved bill, that language was removed.

Finally, the state government official who was asked how A.B. 2193 intended to achieve equity in health outcomes for the maternal health communities of California stated that, while at baseline, all managed care health plans were already required to cover the United States Preventive Services Task Force recommendations for screening, the commercial health plans had "a little bit more of a need to implement it, or just start a little bit more of an implementation phase to align it across the board." As such, A.B. 2193 potentially created a balance between Medicaid and the commercial health plans.

> *The very first time it was introduced, the bill had more specific things like the health plan shall create a program of case management, that the health plan shall provide a program of direct support for patients who are diagnosed with a mental health condition. And so it was, while even that might be vague sounding, it was definitely much more specific in both intent and actual language than what ended up being in the bill.*
>
> **—Professional/Clinical Association**

Tracking

One state government official was asked how they are tracking implementation

efforts since A.B. 2193 was passed, specifically within the context of CalAIM. The interviewee stated that they are tracking through compliance monitoring, to make sure all plans are meeting the requirements in the contract; state facility site review, including blind random chart reviews; and auditing managed care health plans. They also noted that if a plan is not meeting the requirements of the contract, then penalties can be applied and escalated, as necessary.

Guidelines for Follow-Up

When asked about guidelines for follow-up with individuals who screen positive for mental health conditions, one state government official stated that once members are screened, it is about making sure appropriate services are provided.

Maternal Mental Health Initiatives, Programs, or Legislation

When asked about any maternal mental health initiatives, programs, or legislation supported or led by their organizations between 2019 and 2023, four advocacy organization respondents detailed their efforts. Examples included cosponsoring new legislation, working in partnership with the Department of Public Health, and collaborating with other entities such as the Alliance of Community Health Plans on its Raising the Bar program.[6] Only one advocacy organization interviewee said they did not support or lead efforts specific to maternal mental health.

> *CalAIM is helping to bridge [the] delivery system and connect everyone together.*
>
> **—State Government Official**

One professional/clinical association representative stated that their organization is concentrating almost exclusively on two related initiatives (though not specifically focused on maternal mental health)—the formation of a licensed midwife board and a quality improvement program that is aimed at improving the safety of licensed midwife care. Otherwise, their organization's capacity for legislation and legislative advocacy is limited.

> *Preserving mental health is embedded in our model of care. … We do not have a specific maternal mental health initiative because it is woven into everything that we do. (Professional/Clinical Association)*

The three **state government officials** identified initiatives they have supported since 2019, including a peer support group for Black pregnant and parenting women, a group prenatal program, a comprehensive perinatal support program, and home visitation programs that perform maternal mental health screenings. The primary populations for these initiatives are pregnant and postpartum people. However, one program defines postpartum as having a child within the last 5 years, and one program also includes intrapartum women.

Regarding initiatives scheduled to launch in the future, one respondent from an **advocacy organization** said that they launched a peer support program and are planning to launch a perinatal peer support program (Perinatal Women's Health 101). The primary population of the peer support program is birthing people in Los Angeles County, and the program's key objectives are to provide an empathetic ear, social support and connections, and local resources to Los Angeles County's birthing population affected by perinatal mood and

anxiety conditions. The primary population of Perinatal Women's Health 101 is providers who work with pregnant or postpartum persons. The key objective of this program is capacity building (i.e., providers working with providers).

One **state government official** said they are working on a contract with the Southern California Counseling Center to provide individual counseling sessions and possibly group counseling sessions as an affordable option for maternal clients.

Other interviewees from the **professional/clinical associations** and **advocacy organizations** indicated that they do not have any initiatives scheduled to launch in the future.

Measurement of Success and HEDIS® Metrics

When asked about how the success of programs is measured, one **state government official** responded that programs have their own measures of success. For example, the department uses results-based accountability as its metrics of measurement as well as client satisfaction surveys. Specifically for mental health screenings, the completion of screenings is the measured outcome.

Interviewees from both **professional/clinical associations** were asked about their familiarity with HEDIS® measures and whether they use them and/or any other tools to screen for maternal mental health conditions in their practices. Interviewees stated they are familiar with and use HEDIS® measures.

Program Challenges

One state government official described a cumbersome reimbursement process as a challenge or barrier that programs face.

Organizational Interest

Representatives from **advocacy organizations** were asked to describe their organizations' interest in prioritizing mental health. Interviewees from only one advocacy organization identified maternal mental health as a high priority for their organization. Respondents from another advocacy organization clarified that the organization is like a public interest law firm that does policy and advocacy work related to maternal health, mental health, and behavioral health (e.g., trying to expand access to doula care and postpartum coverage). A third advocacy organization respondent stated that the organization primarily takes a systems change approach, with the largest program area being training, followed by policy and advocacy.

> *I know that in my practice, we submit for HEDIS® for billing. Many licensed midwives are not contracted with health plans and never encounter HEDIS® in their practice at all. I know that many licensed midwives utilize a more holistic model of screening where it is interview based motivational interviewing or history taking or communicating with the support people in a family.*
>
> **—Professional/Clinical Association**

Maternal mental health has always been a high priority for us. Our programmatic approach has always prioritized mental health and screening for families. (Advocacy Organization)

I wouldn't say that maternal mental health specifically is a big priority for us. Like, not just that area in particular. (Advocacy Organization)

Urgency Created by New Legislation

Some **advocacy organization** interviewees were asked in what way S.B. 1207 created any urgency or help with prioritization of maternal mental health initiatives. Of the interviewees who were aware of the newer legislation, one respondent said that although S.B. 1207 does not explicitly state that it is connected to A.B. 2193, it extends the deadline by which health plans are required to create maternal mental health programs. Another respondent noted that the new bill includes requirements related to quality management and monitoring.

I think it's a much better version of A.B. 2193 requirements for insurers to do something around maternal mental health. (Advocacy Organization)

The **professional/clinical association** interviewee who was asked about the influence of S.B. 1207 on the prioritization of maternal mental health stated that because midwives were already screening for maternal mental health, it did not influence prioritization or create any urgency.

I don't think it's changed much in terms of our understanding or planning, again, because of on the clinician end, we've already been doing what it's been mandated. (Professional/Clinical Association)

Future Impact

Finally, interviewees from all **three groups** (i.e., professional/clinical association, state government officials, and advocacy organizations) were asked about the future impact of maternal mental health initiatives focused on the Medi-Cal populations. Responses across the interviewees varied, but many cited an increase in appropriate maternal mental health screening, improved and more timely access to well-trained providers, and more providers working across the perinatal community to support clients (e.g., more community engagement, addressing the whole person, wraparound care). However, an interviewee from a professional/clinical association seemed more wary about the impact of such initiatives.

I feel that implementing standardized screening tools is one very small piece of a very disturbed mental health system. One of the first things that we've learned is that if you are screening for something, you should have a plan if you have a positive screen. And there is just simply not enough maternal mental health infrastructure in the Medicaid system. It is very segmented, it is very challenging. … I don't see the maternal mental health system getting a whole lot better, with more requirements for providers if we don't have an underlying infrastructure for it. (Professional/Clinical Association)

Individuals will have multiple touch points monitored by multiple providers with 2– to 7–day turnaround with a warm handoff and appointment with a provider that can support needs. (State Government Official)

Other examples of anticipated future impacts of these initiatives identified by respondents included the following:

- reductions in maternal and infant mortality
- improved quality of prenatal care and the inclusion of respectful care
- reduced trauma
- increased collaborations between providers and those working in communities to support pregnancies (e.g., doulas)
- greater adoption of HEDIS® measures related to maternal mental health in other states
- additional efforts to diminish the stigma of mental health
- more postpartum support

Objective 5:
Identify the Needs and Opportunities to Support Medi-Cal Managed Care Health Plans and Contracted Providers in Full Implementation of the Law within the Context of the Broader Maternal Health Policy Landscape in California

Medi-Cal Managed Care Health Plans and Commercial Health Plans

Health plan interviewees were asked what additional support(s) or resource(s) would amplify the actions their plans are already taking to address birth equity and maternal mental health in the Medi-Cal population. The most common response was a learning collaborative, followed by technical assistance. Other additional supports and resources identified by health plan respondents included increased mental health provider capacity, more linguistically and culturally competent care, a more integrated health care approach to maternal mental health, enhanced communication with plan members to make sure they are aware of maternal mental health services, improved communication between health plan staff and community-based organizations, support to providers to achieve more accurate coding of mental health assessments, and convening stakeholders and workgroups.

The table below highlights some of the identified support and resources and relevant quotes from health plan interviewees.

Health Plan Identified Support and Resources and Relevant Quotes

Learning collaborative	*Particularly as there is a shortage of certain types of providers, it's really great when we can share the information that eases access for services to the whole population. (Medi-Cal Managed Care Health Plan)*
Technical assistance	*The technical assistance really needs to get as close to the practice level as you can get. (Medi-Cal Managed Care Health Plan)*
Proper coding and accurate data	*Providers just want to take care of patients; they don't always want to be worried about billing codes. (Medi-Cal Managed Care Health Plan)*
Improved communication between stakeholders	*[Health] plan folks speak a different language than some of the community-based organizations. So, everybody has to learn each other's language … [so] that expectations can be received and understood by everybody. (Medi-Cal Managed Care Health Plan)*
Integrated health care	*Sometimes it feels that health plans aren't integrated enough with providers. (Medi-Cal Managed Care Health Plan)*
Linguistically culturally competent care	*Historically, marginalized members typically do not have a lot of trust outside of their primary care doctor's office. … We really have to inject more resources to providers that primarily serve marginalized or disenfranchised populations. (Commercial Health Plan)*

Source: Institute for Medicaid Innovation. (2023). Evaluation of the Adoption of A.B. 2193 the California Maternal Mental Health Law Provision by Medi-Cal Managed Care Health Plans.

Regarding specific topics that could be used to support the resources identified above, health plan respondents mentioned information sharing across and learning from other health plans (e.g., best practices, program development) to ultimately improve programming. Examples of other responses included training for community-based organizations, engaging providers and members, improving provider support, and improving how to get data and contact information.

When asked about ideal outcomes from access and use of these resources or their participation in a learning collaborative, health plan interviewees identified several strategies to address the mental health screening and outcomes. These included streamlining referral processes for providers, equipping providers with knowledge about programs (e.g., point of contact), providing 100 percent prenatal and postpartum visit rates, providing 100 percent maternal mental health screening or marked improvement, closing the health inequity gaps across different racial and ethnic groups, and developing a survey to learn more about discrimination experiences among marginalized groups.

Other Interviewee Groups

Interviewees from professional/clinical associations, state government officials, and advocacy organizations were also asked about what additional support or resources would amplify the actions they are taking to address maternal mental health and equity in the Medi-Cal population (state government officials) or would be helpful to ensure optimal impact of maternal mental health initiatives focused on those who are covered by Medi-Cal managed care health plans (advocacy organizations and professional/clinical associations). The most common responses across all three groups were learning collaboratives and training for medical providers and birth workers (e.g., best-practice mental health interventions that could be used by people with different experience levels, including those who are not licensed clinicians). Other supports and/or resources identified by interviewees included convening stakeholders, integrated mental health care and incentivizing integrated mental health care technical assistance, data sharing, provider availability, capacity, and adequacy to provide mental health services—particularly in underserved areas (e.g., rural areas), creating easier access to mental health resources and improved navigation to help individuals access mental health services.

Similar to the table above, the table below highlights some of the identified support and resources and relevant quotes from interviewees from the professional/clinical associations, state government officials, and advocacy organizations.

> *How do we make sure the members receive the services they need, at the appropriate level of provider giving those resources, so we can free up physicians for things that really a physician can only do.*
>
> **—Medi-Cal Managed Care Health Plan**

Identified Support and Resources and Relevant Quotes from Professional/Clinical Associations, State Government Officials, and Advocacy Organizations

Learning collaborative	*The learning collaborative actually being a space where there is training on navigating billing and reimbursement or providing a training on PHQ-2 and [PHQ]-9 that is free and open for both providers and birth workers and community members. (State Government Official)*
Learning collaborative	*If there is a space to share ideas and strategies, to have mutual kind of influence on the work together, and how to build a system cohesively … a space like that would be really critical and helpful, both at the state level and locally. (Advocacy Organization)*
Training	*I think that producing a ready-made toolkit for providers that they can easily reference—an app or something—here is how you screen. Here is exactly where you can send this person based upon their health plan and zip code. (Professional/Clinical Association)*
Convene stakeholders	*Convene Medicaid enrollees to find out what some of the challenges are to trying to access maternal mental health services. (Advocacy Organization)*
Integrated mental health care	*When referring to a program that places mental health providers in the clinician's office, it is "a warm handoff between clinicians and mental health providers." (Professional/Clinical Association)*
Integrated mental health care	*I also think about how to intervene with payers to incentivize truly integrated mental health care, because I think one of the big obstacles that is actually getting worse is how often … mental health is a different corporation from prenatal care or health care. At best, they will refer to one another, but they're not operating as an integrated whole. Figuring out ways that payers can incentivize fully integrated, dedicated mental health clinicians for prenatal and postpartum programs would be super helpful. (State Government Official)*

Source: Institute for Medicaid Innovation. (2023). Evaluation of the Adoption of A.B. 2193 the California Maternal Mental Health Law Provision by Medi-Cal Managed Care Health Plans.

When asked what they hoped to get out of the supports and/or resources identified above, interviewees responded that they hoped to build a nationwide bridge to work through obstacles together; develop a learning collaborative to be a space where there is training on navigating billing and reimbursement or trainings that are free and open for providers, birth workers, and community members; get reimbursement for services rendered; and advocate with the legislature and others to address, monitor, and fix maternal mental health services.

Even though this is a required component in California for licensed midwives … we can't bill Medi-Cal. Medi-Cal won't let us bill for it. So it is another unpaid service that we render. We are not getting reimbursed. Some sort of strategy for reimbursement is realistically going to motivate providers more than giving them more to do and no reimbursement. (Professional/Clinical Association)

Interviewees across all three groups identified specific topics for which they could use support, including cultural humility and competency, intensive training around trauma-informed practices for medical providers and community workers serving birthing individuals, trainings on PHQ screening tools, and technical assistance in mitigating barriers to reimbursement and billing.

Finally, interviewees from advocacy organizations and professional/clinical associations were probed about the ideal outcomes from access and use of these resources and/or their participating in group activities. Interviewees identified building relationships between providers and individuals to nurture trust, connection and relationship building between providers to be able to ask questions or seek support and treatment for individuals in need, and legislative hearings.

> *If I knew someone I could call up and be like, 'Hey, I'm curious about this data set,' and they could find that information, that would be amazing.*
>
> **—Advocacy Organization**

Key Takeaways from Interviews

As the wrap-up to the end of the interviews, all interviewees were asked to identify the three most important points or key takeaways from their interviews.

Takeaways from Medi-Cal Managed Care Health Plans and Commercial Health Plans

Limited provider capacity directly impacts individuals being able to get the services they need.

Providers are stretched and especially in areas like our counties where the number of providers available for the number of people that live here, those ratios are really small. And therefore, we need to make sure that the providers get all the support that they need. (Medi-Cal Managed Care Health Plan)

Maternal mental health management will improve when there are enough providers to do the screening and do the follow-up for members who need care and be able to provide the care that's needed. (Medi-Cal Managed Care Health Plan)

To properly address maternal mental health, a collaborative approach is necessary (e.g., population health management perspective).

I think that the role of the health plan in working with both the provider network itself and then directly with members can really bolster the success in addressing a problem like maternal mental health. (Medi-Cal Managed Care Health Plan)

Training, education, and access to information are important.

We've always thought how important it was to make sure our pediatricians are aware of the signs and symptoms of postpartum anxiety, depression. (Medi-Cal Managed Care Health Plan)

Health equity and providing culturally and linguistically competent care is paramount.

A growing edge is figuring out how to do all this with [a] health equity lens. I would say internally, we have dashboards built to look at our health outcomes for maternal morbidity, but we don't have a health equity view right now for maternal mental health or maternal depression and anxiety. (Medi-Cal Managed Care Health Plan)

In terms of Medi-Cal Managed Care, the idea is to be preventive, to be proactive in assessing the member where they're at in a culturally and linguistically appropriate way that will inform their care, the identification of any screening that's needed, treatment that's needed, based on the diagnosis that's been made, but also to ensure that the referrals to any other services, whether it's mental health, behavioral health, or another type of specialist, that those are made in a timely way. (Medi-Cal Managed Care Health Plan)

Clinicians' quality of care benefits from incentive programs.

I think clinicians' quality [of] care does benefit from incentive programs that are targeted to the outcomes that we're looking for because it provides financial support to put in systems to make care regular for everyone. (Medi-Cal Managed Care Health Plan)

Proper coding for mental health assessments ensures proper treatment for individuals.

Reiterating this whole issue with coding, because…the biggest heartbreaker is when you see a positive screen in medical records and nothing was done about it. (Medi-Cal Managed Care Health Plan)

Takeaways from Professional/Clinical Associations, State Government Officials, and Advocacy Organizations

Training and access to information are important.

Consistently providing access to training and information … like what resources are in a given area and how to access them is going to be really important. (State Government Official)

Evaluation monitoring and data collection are crucial.

Collecting the data is critical from the counties that collect it, particularly for the screenings and implementation … (Advocacy Organization)

There is a disconnect between insurance companies and the needs of people.

Insurance companies are driven by the bottom line. As a result, care for people is suffering. People are not getting the services that they need in a timely manner. (Advocacy Organization)

There are gaps in communication between health plans and providers regarding billing codes.

Plans aren't communicating to providers what the billing codes are, so they don't even know that they can get reimbursed for screening. The billing piece is huge, and plans can influence that. They can share the codes that are set up to allow for billing outside of the global cap payment for screening and treatment of maternal mental health disorders. (Advocacy Organization)

There is a resource disparity between providers and health plans.

All stakeholders in maternal mental health are strapped for cash and are strapped for resources, except the health plans, who are not strapped for cash or resources. Therefore, the onus is on them to make these big changes, and they don't. They don't seem to be responding to any regulatory pressure. (Professional/Clinical Association)

Collaborative, comprehensive, and holistic service provision (e.g., looking at individuals through a holistic lens, including their social determinants of health, providing continuity of care) is critical.

This work [maternal mental health screenings and connecting people to mental health services] is already happening in many communities, usually in a silo separate from the health system. How do you support and enable making those connections, that sharing of data, so that we really create more of a cohesive system that leverages what is already occurring in communities? (Advocacy Organization)

Piecemeal solutions are not going to improve outcomes or help anyone. (Professional/Clinical Association)

It is important to support individuals through navigating the health care system.

So often, with many of these things, it lands on the patient to navigate a really complicated system. And if you're having a mental health challenge, it's already so hard to navigate these systems. And it's impossible especially if you're postpartum, taking care of an infant, and having depression or anxiety, your ability to navigate a complex system that's not really set up to work well or easily—it's just impossible. (Professional/Clinical Association)

Addressing maternal mental health should be done through paid family leave, doulas, and community support.

I think if we are thinking about a really ideal scenario for addressing maternal mental health, it really does include like paid family leave, it includes doula support, and it includes community support. (Professional/Clinical Association)

Conclusions and Opportunities

This evaluation of A.B. 2193 showed many positive effects of the legislation and identified opportunities to further advance work in maternal mental health. Most interviewees knew about the legislation, which provided a foundation from which health plans, advocacy organizations, and professional/clinical associations could build on their existing work or develop new initiatives.

Several opportunities to advance maternal mental health in California were identified based on the interview findings. These included strategies to improve access to screening and mental health services, increased education and sharing of information and best practices, enhanced data and measurement, approaches to improve accurate coding and address billing problems, and the development of a concerted focus on health equity.

Improved access to screening and mental health services are needed. Opportunities to improve access may include expanding screening efforts by training more professionals and mental health providers (e.g., training sessions related to screening could be developed and held across health plans and clinical practices). Establishing procedures in clinical practices to standardize and streamline the screening referral process can also be implemented. An approach to address the provider shortage could be to convene meetings between health plans, clinical groups, public health practitioners and legislators to brainstorm innovative approaches and identify financial resources.

Through this evaluation, many opportunities to expand education and information sharing across different topics were identified. Education focused on de-stigmatizing mental health should be provided regularly and routinely. This could potentially be done through social media, the development and distribution of written materials through the plans or in the practices, and through conversations between providers and individuals in clinical practices. Continuing and enhanced education for clinical and non-clinical providers (e.g., doulas and community health workers) about screening techniques and the availability of mental health services and resources should be readily available. Learning collaboratives also were identified as an important venue through which education on maternal mental health, as well as the sharing of best practices and collaborations, can be provided.

Maternal mental health measures and data systems are two other areas that provide opportunities to better address maternal mental health. Broader adoption of current measures through awareness campaigns and education could be expanded. Investing in, and the development of, new health measures that are culturally congruent would also help plans and providers identify and understand the number of these conditions among their individuals. Amplifying the potential of data systems to monitor screenings, referrals, and receipt of mental health services by health plans clinical practices can help to identify persons who may have “fallen through the cracks” in screening or referrals for follow-up.

Finally, although addressing maternal mental health through the opportunities outlined above can help address inequities among the maternal health populations, initiatives to specifically address disparities and health equity are critical. At a minimum, all individuals should receive appropriate culturally and linguistically competent care, ideally in their own communities. Designing a community-based model of perinatal care that includes mental health is important to improving the outcomes of some of the most vulnerable populations in the US. To do so, the state should support the expansion of mental health professionals and clinicians that reflect the diverse communities of California. Additionally, to ensure that they are centered in equity, any newly developed health measures should be validated through the inclusion of all communities in the pilot and testing phases. It should be encouraged to stratify data by race, ethnicity, and language (REaL), geographic distribution (i.e., rural, urban), and payer type to identify disparities and inequities.

End Notes

1 Note: Seven interviews were conducted with two interviewees; one interview included three interviewees.

2 CalAIM is a multiyear California Department of Health Care Services initiative to improve quality of life and health outcomes by implementing broad delivery system, program, and payment reform across the Medi-Cal program.

3 HEDIS® is one of health care's most widely used performance improvement tools.

4 Note, beyond just this question, workforce shortage was a consistent theme throughout the interviews. Although the legislation put requirements in place for screening, the difficulty was having providers to refer individuals.

5 Patient health questionnaire (PHQ)-9 is a depression screening tool.

6 The Raising the Bar program sought to convene key stakeholders to identify how health care organizations can approach their goal to increase equity.