

Joint Senate and Assembly Health Committees Testimony  
Improving the Medi-Cal Mental Health Delivery System  
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Written Testimony

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**Executive Summary**

1. California's bifurcated mental health delivery system is overly complicated runs counterintuitive to integration efforts. It is difficult for patients and providers to navigate.
2. Federally qualified health centers (FQHCs) aim to provide comprehensive services under one roof, partly in an effort to simplify the navigation of services so patients can access the care they need when they need. A patient with a mental health need, for example, can enter a health center through the dental department and, via a warm hand off process, navigate that patient to appropriate care. As a result, health centers reach patients who would have otherwise been unreachable.
3. However, FQHCs must overcome systemic challenges to integrate within the complex system. Examples include:
  - a. The state requires a complete separation of costs attributed to each source (i.e. PPS, MHP contracts, DMC-ODS contracts) – including separation of costs for infrastructure, billing, record keeping, and clinical and administrative staffing. The separation results in a complex, inefficient, and ineffective program administration;
  - b. The administrative and documentation burdens that result from clinical care for Specialty Mental Health (SMH) and Drug Medi-Cal (DMC) are onerous and far surpass the documentation standards for mild-moderate mental health reimbursed through Managed Care;
  - c. Contracted SMH and DMC providers are required to undergo a reapplication process every three years that does not lend to a programmatic stability or sustainability.
4. The mental health delivery system pairs the most complicated and most vulnerable patients with the least well-reimbursed services. And we add on additional burdens of paper work and cumbersome operations to clinicians who want to treat patients first. As a result, most FQHCs - who are experts in integrated care and have the most experience and expertise in serving the most disenfranchised and vulnerable community - opt out of providing these services. It's just too much.
5. To improve the mental health system and foster integration, we suggest the state focus efforts to:
  - a. Encourage innovation through county pilots that remove the current county Mental Health Plan and Medi-Cal Managed Care Plan bifurcation into one source of payment for all acuity levels;
  - b. Move toward innovative payment methodologies that would facilitate systemic integration;
  - c. Reduce documentation requirements for SMH billing;

## **Introduction and Background**

My name is Sara Gavin. I am the Chief Behavioral Health Officer at CommuniCare Health Centers, a non-profit FQHC that provides care to 26,000 patients throughout Yolo County. One in every nine residents of Yolo County receive care at some capacity at CommuniCare. Thirty four percent of all visits at CommuniCare are behavioral health or substance use services. We are the primary outpatient drug Medi-Cal provider and one of the primary specialty mental health providers for Youth in Yolo County.

I am also a Licensed Marriage and Family Therapist and a Licensed Professional Clinical Counselor. I have provided direct service in as well administered the provision of substance use and mental health services for over 14 years. Eleven of those years have been within a FQHC.

I am testifying as a representative of California's community health centers, broadly and directly representing the largest FQHC in Yolo County. Today, more than 1,330 community health centers serve the state of California, and provide comprehensive, high quality care to 6.9 million people – or 1 in 6 Californians. Behavioral health has always been a core service in community health centers. As awareness has increased and stigma decreased in the last few years, community health centers have responded by expanding their behavioral health services by 154 percent since 2016.

CommuniCare is a unique FQHC. While most FQHCs primarily provide mild to moderate mental health care integrated within primary care, CommuniCare has provided SMH services (through EPSDT) for decades. We are also a DMC provider and have been providing treatment for substance use disorder since our inception in 1972. We continue to be the largest provider of outpatient substance use and youth specialty mental health in the County, holding multiple contracts to bill DMC and SMH for both children and adults. The majority of our behavioral health services are actually outside of our FQHC/Mild-Moderate services. In our health center alone, within behavioral health, there are over 25 funding streams for behavioral health - each with its own specific set of clinical and administrative requirements.

CommuniCare has been committed to providing integrated mental health services across the spectrum for decades and we continue to see the value for our patients and community. In part, this is because for the moment, we are the primary care continuum in Yolo County. We continue to hope that changes can occur that would support the good work and incentivize more FQHCs to provide these imperative services throughout the state.

CommuniCare believes that FQHCs are the perfect venue for hosting substance use and specialty mental health services and we are discouraged that there is not more opportunities for counties to partner with FQHC providers. For context, I should note that a recent survey conducted by the California Primary Care Association, the statewide association representing community clinics and health centers, notes there are approximately 19 health centers concurrently contracted with counties as specialty mental health providers across nine counties in the state. That number could be larger, and thus access to whole person, integrated care could improve, if barriers to providing these services were not so problematic and prolific.

## **What does not work well in the Medi-Cal mental health delivery system?**

1. **The state's trifurcation of mild to moderate, specialty, and drug Medi-Cal reimbursement function in opposition to integration.** For FQHC's the state requires a complete separation of costs

attributed to each funding source – including costs for infrastructure, billing, record keeping, and clinical and administrative staffing. This separation negatively impacts whole-person and integrated care and negatively impacts the motivation of FQHCs to expand and provide these services.

- 2. The administrative and documentation burdens for SMH and DMC are onerous and far surpass the documentation standards for mild-moderate mental health reimbursed through Managed Care.** The average clinician spends 40 percent of their time managing the egregious administrative and documentation standards for County funded Medi-Cal services. It is because of this that we see a reduction in actual services (and, as a result, access) because behavioral health clinicians are managing so many administrative demands. In an environment where mental health providers are in short supply, we cannot afford to waste their talents on paperwork; nor can we afford to burn them out of their professional passions pushing paper all day. Within our health center, “documentation burden” for SMH and DMC is the biggest attribution we hear from mental health providers wanting to transition to a different role or another agency entirely. The public mental health system cannot afford to lose good, competent clinicians serving our most vulnerable population - especially because of paperwork.
- 3. To provide county-funded SMH and DMC services, counties require an organization to reapply every three year through the County RFP process.** The requirement to reapply – as opposed to simply building in accountability measures to contracts – makes it extremely challenging to build and invest in a stable program. And it is another reason FQHC’s, many of whom have held federal contracts for decades, are reluctant to contract. FQHCs are no strangers to audits; we welcome them as vital to ensuring accountability. But, to subject high performing programs to reapplication is counterproductive.

Because of these challenges, most FQHCs - who are experts in integrated care and have the most experience and expertise in serving the most disenfranchised and vulnerable community - opt out of providing these services. It’s just too much.

**What should the state do to improve the mental health plan benefit? What should the state do to better integrate mental health care and physical health care?**

We have several recommendations to improve the mental health plan benefit that we believe will result in better integration across the whole person’s health.

- 1. Encourage innovation through county pilots that remove the current county Mental Health Plan and Medi-Cal Managed Care Plan bifurcation into one source of payment for all acuity levels.** The myriad of payment schemes and documentation requirements from counties and plans for behavioral health services is overly complicated and discourages integration. The ideal system would be integrated in such a manner as to include services under one “roof” with a single unified payer system. It would not have today’s existing service, program and regulatory silos and would support regional flexibility.

Furthermore, while integration between county MHPs and Managed Care is identified as a priority, integration between mental health and substance use is equally important. Those with serious mental illness often have co-occurring SUD and their services are not well coordinated between SMH and DMC and are further siloed. Such integration would include improved data sharing (although acknowledging federal privacy protections), clinical co-location, and coordination, and aligned or coordinated payment.

2. **Move toward innovative payment methodologies that would facilitate systemic integration.** The delivery system, and primarily counties, need the flexibility to develop payment arrangements that move toward national health care reimbursement trends of value-based payment, such as per-member-per-month or case rates. Improving integration through payment reforms and innovation would require the state requesting and CMS approving, simplified Certified Public Expenditure (CPE) protocol requirement or the ability for the state to pilot CPE alternatives. This would allow other entities in addition to, or in lieu of counties, to claim CPEs. Innovation in this sense would facilitate *interested* counties to work with *interested* plans to administer the SMH benefit on their behalf.
3. **Reduce documentation requirements for SMH billing.** Documentation requirements for specialty mental health services are generally seen as laborious and inefficient. For providers considering contracts with county MHPs, including clinics, meeting these requirements can be an impediment to contracting. Furthermore, small counties with limited staffing face significant administrative burdens in complying with these requirements. Documentation should be minimally necessary to ensure clinical quality and programmatic integrity.

Thank you for the opportunity to provide this written testimony. Please do not hesitate to reach out with any questions that result from this information.

Respectfully submitted,

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