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Financing of Behavioral Health Services within Federally Qualified Health Centers

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1 EXECUTIVE SUMMARY

This report describes the current financing and delivery of behavioral health services at Federally Qualified Health Centers (FQHCs) and the future incentives available under the Patient Protection and Affordable Care Act (ACA) of 2010 for FQHCs and behavioral health providers to join forces to promote improved integration of primary care and behavioral health services. By becoming an FQHC, providers of care can access enhanced funding through Medicare and Medicaid, as well as receive grants from the Health Resources and Services Administration (HRSA) to help offset the cost of covering care for the uninsured. Additionally, this enhanced financing can offer advantages for behavioral health providers to integrate services with FQHCs. However, integration can come in many different forms and present potential difficulties to organizations that are not well informed about FQHC financing mechanisms and their challenges.

FQHCs provide comprehensive primary health care to the uninsured and medically underserved. In 2010, nearly 20 million patients were served at over 1,100 FQHCs operating in over 8,000 sites across the United States (1). It is estimated that FQHCs may serve 40 million patients by 2015 as a result of the passage of the ACA (2). The ACA encourages integration of primary care and behavioral health services. The National Association of Community Health Centers' (NACHC) 2010 Assessment of Behavioral Health Services at FQHCs found over 70% of FQHCs provide mental health services, 55% provide substance abuse services, and 65% provide components of integrated care, such as a shared treatment plan (3).

There are different types of health centers, many of which may be FQHCs, including community, rural, and migrant health centers, and specific health center programs, such as homeless, public housing, and school-based health center programs. Each of these different types of health centers may apply to receive grants under the Health Center Program authorized under section 330 of the U.S. Public Health Service (PHS) Act. Health centers that receive 330 grants are called Health Center Program grantees, or "grantees." If a health center is approved to be reimbursed under Medicare and Medicaid under Titles XVIII and XIX of the Social Security Act, respectively, it is designated an FQHC. FQHC grantees receive grants to cover some of the costs of uncompensated care and enhanced reimbursement from Centers for Medicare and Medicaid Services (CMS) on Medicare and Medicaid claims. Some health centers that do not receive 330 grants may be certified by CMS, based on recommendations provided by the Bureau of Primary Health Care (BPHC) within the Health Resources and Services Administration (HRSA), as meeting all Health Center Program requirements. These health centers are called FQHC Look-Alikes, or "Look-Alikes," and also receive enhanced Medicare and Medicaid reimbursements, although they do not receive 330 grants.

Financing behavioral health services at FQHCs is complex. Payment mechanisms and billable providers vary by payer and state. This report describes the financing of behavioral health services at FQHCs, including payers, payment methods, billable providers, and covered services:

- **Federal 330 Grants:** Grants authorized under Section 330 of the PHS Act cover growth and operating costs and offset some of the cost of uncompensated care and enabling services (e.g. transportation, translation, and education). FQHCs may receive other federal and non-federal grants to cover services and costs as specified in the grants.
- **Insurance:** Insured patients in FQHCs are covered by the following types of insurance:
 - ▶ **Medicaid:** State Medicaid Agencies (SMA) pay FQHCs using a prospective payment system (PPS) or an alternative payment method greater or equal to the PPS rate. Behavioral health services rendered by physicians, physician assistants, licensed clinical psychologists, and licensed clinical social workers practicing within their scope of services are covered. Some states may allow other providers to bill.

- ▶ **Medicaid Managed Care:** Medicaid managed care plans pay FQHCs on either a capitated or fee-for-service basis. Their covered services and billable providers vary by plan. If the rate paid by the managed care company is less than the PPS rate, the SMA pays the FQHC the difference. These supplemental payments are called “wrap-around” payments.
- ▶ **Children’s Health Insurance Plan (CHIP):** CHIP payment policies are similar to Medicaid’s. However, CHIP policies vary depending upon whether the program is a Medicaid expansion, stand-alone or combination program. For services delivered to patients enrolled in managed care plans, FQHCs receive wrap-around payments similar to Medicaid.
- ▶ **Traditional Medicare:** The ACA requires Medicare to implement a PPS similar to Medicaid’s in 2014. Under Traditional Medicare (Part B), FQHCs currently receive an all-inclusive payment for each covered visit, regardless of the specific services provided, that includes a range of primary care services and services accompanying or occurring as a result of primary care services, including clinical psychologist and clinical social worker services.
- ▶ **Medicare Managed Care:** Medicare managed care plans under Medicare Advantage (Part C) pay FQHCs on either a capitated or fee-for-service basis. Their covered services and billable providers vary by plan. They also receive wrap-around payments from traditional Medicare similar to Medicaid and CHIP wrap-around payments.
- ▶ **Private Insurance:** Arrangements vary by private health plan. Many plans contract out behavioral health services to managed behavioral health care organizations (4). FQHCs are not always included in the provider networks established by the carve-out entities; therefore, behavioral health services provided to enrollees may not be reimbursable
- **Patient Self-Payments:** Health centers determine patient charges on the basis of patients’ ability to pay using a sliding-fee scale.

The ACA mandates increased funding for FQHCs. ACA requirements concerning health insurance exchanges, a new Medicare PPS payment, Medicaid expansion, and health homes all offer opportunities for FQHCs to increase Medicare and Medicaid reimbursements and integrate primary care and behavioral health services more fully. FQHCs have a variety of mechanisms through which they can collaborate with behavioral health providers, including community mental health centers (CMHCs), which range from referrals to co-location of services to establishing new FQHC sites with partnering providers.

Given these opportunities, conscious efforts need to be made to expand and integrate behavioral health and primary care services to truly improve access to services and quality and outcomes of care. This report provides important information for mental health and substance abuse providers considering collaborations with FQHCs. Specifically, it discusses the potential financial incentives, as well as the billing challenges, that come with such alliances. The potential benefits for providing quality integrated services, including better outcomes, makes such alliances compelling.

The report also describes the way federal partners, specifically the Substance Abuse and Mental Health Services Administration (SAMHSA), HRSA, and CMS, might promote collaboration and integration between FQHCs and behavioral health providers through training, technical assistance and grant opportunities. Additionally, it highlights that local stakeholders, including FQHCs, CMHCs, SMAs and State Mental Health Authorities (SMHAs), must build partnerships to encourage the best use of financial structures and promote clinical integration. With a better understanding of the complexities of financing substance abuse and mental health services through FQHCs, stakeholders at all levels can play a role in improving integration of primary care and behavioral health services.

2 PURPOSE AND OVERVIEW OF ISSUES

The purpose of this report is to describe the current financing and delivery of behavioral health services at Federally Qualified Health Centers (FQHCs) and the future incentives available under the Patient Protection and Affordable Care Act (ACA) of 2010 for FQHCs and behavioral health providers to collaborate on integrating primary care and behavioral health services. FQHCs, including Health Center Program grantees and FQHC Look-Alikes, are critical health care providers in the health care safety net. They provide comprehensive primary care services and may also provide behavioral health, oral health, pharmacy, and enabling services¹ regardless of their clients' ability to pay. Because they serve medically underserved populations and areas, FQHCs may also be one of only a few available and accessible providers in some geographic areas.

The ACA underscores the importance of FQHCs and behavioral health care services in the health care safety net by providing funding to expand FQHCs, expand the behavioral healthcare workforce, and integrate primary care and behavioral health in medical and health home demonstration projects. These circumstances broaden opportunities for community-based substance abuse and mental health treatment providers to collaborate with FQHCs.

This report addresses the following topics that arise when behavioral health providers and FQHCs consider and build collaborations:

1. The difference between Health Center Program grantees, Look-Alikes, and FQHCs
2. Delivery of primary care and behavioral health services at FQHCs
3. The financial benefits to FQHCs
4. Financing of primary care and behavioral health services at FQHCs
5. The impact of the ACA on the delivery and financing of services at FQHCs
6. Types of integration approaches and a detailed example of collaboration between an FQHC and a behavioral health provider

Understanding the financing and delivery of behavioral health services at FQHCs is an important step towards establishing successful collaborations between public behavioral health settings and FQHCs and improving the health and health care for individuals in the health care safety net. By reviewing published reports and documents, this report provides background information to improve our understanding of the complexities concerning the financing of substance abuse and mental health services within FQHCs and suggests areas where policymakers and providers might focus to further opportunities for integration of behavioral health and primary care services.

The next section of this report, *Background on Federally Qualified Health Centers*, describes what FQHCs are, their role serving the uninsured and medically underserved, and the preventive and behavioral health care services provided within FQHCs. The fourth section, *Financing of Federally Qualified Health Centers*, addresses the financial benefits for FQHCs and provides an overview of FQHC revenue sources. The fifth section, *Public Financing of Federally Qualified Health Centers*, provides detailed financing, billing and provider information on Medicaid, the Children's Health Insurance Program, and Medicare.

¹ Enabling health services are services that enable access to medical services and include case management, transportation, outreach, patient and community education, eligibility assistance, and translation services.

² Note, in this discussion we are referring to situations where the FQHC contracts with a provider for services for

The sixth section, *The Affordable Care Act & FQHCs: Opportunities for Integrating with Behavioral Health Care*, describes the impact of the ACA on FQHCs. This section also describes patient-centered medical homes, models for collaboration and partnerships between FQHCs and public behavioral health providers. The last section concludes with some policy and programmatic opportunities.

In this document, unless otherwise noted, the term “FQHC” is used to refer to both Health Center Program grantees (organizations that receive grants under the Health Center Program as authorized under section 330 of the Public Health Service (PHS) Act) and FQHC Look-Alikes (organizations that meet the definition of “health center” under the Health Center Program but do not receive grant funding). This report does not address health clinics associated with tribal or Urban Indian Health Organizations, which are eligible to apply to the Centers for Medicare and Medicaid Services (CMS) to be designated as FQHCs.

There are three appendices to this report. Appendix A provides information about FQHC cost and utilization data. Appendix B is a map of which states’ Medicaid programs pay for behavioral health visits on the same day as medical visits. Appendix C suggests additional resources and reports on behavioral health services organization and financing at FQHCs.

Health Center Program Terminology (5)

There are different types of health centers—including Community Health Centers, Migrant Health Centers, and school-based health centers—and they may have received the following designations from the Health Resources and Services Administration (HRSA) and the Centers for Medicare and Medicaid Services (CMS):

Health Center Program Grantee

Health Center Program grantees are organizations that receive grants under the Health Center Program authorized under section 330 of the Public Health Service (PHS) Act. The Health Center Program is administered by the Bureau of Primary Health Care (BPHC), within HRSA. Grantees may operate a single site or multiple sites.

Federally Qualified Health Center (FQHC)

FQHCs are organizations approved to be reimbursed under Medicare and Medicaid using specific payment methods to FQHCs. The term FQHC is defined in the Medicare and Medicaid statutes of the Social Security Act. Each individual Grantee or Look-Alike site would be considered an FQHC.

FQHC Look-Alike

FQHC Look-Alikes are health centers that do not receive 330 grants but have been certified by CMS, based on recommendations provided by HRSA/BPHC, as meeting all Health Center Program requirements. Look-Alikes may operate a single site or multiple sites.

3 BACKGROUND ON FEDERALLY QUALIFIED HEALTH CENTERS

3.1 HEALTH CENTER PROGRAM GRANTEES, LOOK-ALIKES AND FQHCs

FQHCs provide comprehensive primary care services and may also provide behavioral health, oral health, pharmacy, and enabling services (e.g., transportation, case management, translation services) regardless of their clients’ ability to pay. Whenever possible, services take into account cultural appropriateness, and CMS and HRSA encourage providers to use health information technology. Health centers have boards of directors requiring over 50% consumer representation. Because they serve medically underserved populations and areas, health centers may also be one of the few available and accessible providers in some geographic areas (6, 7).

There are different types of health centers, including community health centers, rural health centers, and migrant health centers, and specific health center programs, including homeless, public housing and school-based health center programs. Community Health Centers serve a variety of underserved populations and areas. Migrant Health Centers serve migrant and seasonal agricultural workers. Healthcare for the Homeless Programs reach out to homeless individuals and families and provide primary care and substance abuse services. Public Housing Primary Care Programs serve residents of public housing and are located in or adjacent to the communities they serve (6).

Each of these different types of health centers may apply to receive grants under the Health Center Program authorized under section 330 of the PHS Act. Health centers that receive 330 grants are called Health Center Program grantees, or “grantees.” There were 1,124 grantees in 2010. Health Center Program grantees are supported by the Bureau of Primary Health Care (BPHC) within the Health Resources and Services Administration (HRSA). These health centers are required to be located in or serving a federally designated Medically Underserved Area (MUA) and/or a Medically Underserved Population (MUP), such as migrant and seasonal farm workers, individuals and families experiencing homelessness, and those living in public housing. Grantees may operate a single site or multiple sites within a defined service area (6).

If a health center is approved to be reimbursed under Medicare and Medicaid under Titles XVIII and XIX of the Social Security Act, respectively, it is designated an FQHC. Approval by CMS requires an extensive enrollment process with Medicaid and its state Medicaid agency. FQHCs receive reimbursement from CMS specific to FQHCs. CMS considers each site operated by a health center to be a separate FQHC, meaning a single Health Center Program grantee may consist of multiple FQHCs.

Some health centers that do not receive 330 grants may be certified by CMS, based on recommendations provided by HRSA’s BPHC, as meeting all Health Center Program requirements. These health centers are called FQHC Look-Alikes, or “Look-Alikes.” Look-Alikes may also serve a general underserved population or specifically target migrant and seasonal farm workers, individuals and families experiencing homelessness, and those living in public housing. A Look-Alike may operate a single site or multiple sites within a defined services area. Health centers may become Look-Alikes prior to applying for full grantee status or before they are able to revise their BPHC-approved scope of services to include additional sites. There are approximately 100 Look-Alikes across the United States (8). Look-Alikes are eligible for some Section 330 grants, but if funded would become a grantee rather than a Look-Alike (9).

3.2 SERVICES AND STAFF AT FQHCs

In 2010, 1,124 grantees served 19.5 million patients who were predominately low income (72% of patients were at or below 100% of the Federal Poverty Level (FPL)), uninsured (37%) or on Medicaid (39%), female (59%), and racial or ethnic minorities (62%) (10). These patients were seen during 77 million visits across more than 8,100 service sites (1). In 2010, FQHC grantees employed 131,000 staff, including 9,600 physicians and 6,400 nurse practitioners, physician assistants, and certified nurse midwives (1).

Grantees and Look-Alikes are required to provide primary health services, which consist of health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology; diagnostic laboratory and radiologic services; preventive health services; emergency medical services; and, if appropriate, pharmaceutical services. FQHCs may also provide additional health services—including dental, pharmacy, and behavioral health (mental health and substance abuse) services—as appropriate and necessary. However, health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services. Additional services may be provided either directly (“on-site”) or through established written arrangements and referrals (“off-site”). Grantees have less flexibility than Look-Alikes in the services they provide because grant-funded

FQHCs must have a specific scope of services approved annually. Once approved, FQHCs cannot add or end services or change a site without getting federal approval for a revised scope of services (7, 11).

The rest of this section describes behavioral health services used at Health Center Program grantees only using the latest publicly available data from HRSA's 2010 Uniform Data System (UDS). FQHCs are required to report patient, cost, revenue, utilization, and staffing information to HRSA through UDS. However, there are limitations to the data available. The UDS only recently includes data on Look-Alike FQHCs, so previous years of data under-report actual service provision (12). Further, reimbursement policies and data reporting practices may lead to underreporting of substance abuse services and diagnoses (13, 14). These policies and practices may create challenges to tracking needs, utilization, and costs and implementing co-located and coordinated primary care and behavioral health services.

Appendix A provides more information about FQHC cost and utilization data.

3.2.1 BEHAVIORAL HEALTH SERVICES

In 2010, 951,744 patients used behavioral health services, including mental health and substance abuse services. Of those patients, 852,984 used mental health services and 98,760 used substance abuse services, representing 4% and <1% of all FQHC services used respectively (see figure 1). Concordantly, costs of mental health services represented 5% of all health center costs and costs of substance abuse services represented 1% of all health center costs (see figure 2). (10)

Figure 7
Grant Revenues at FQHCs in 2010

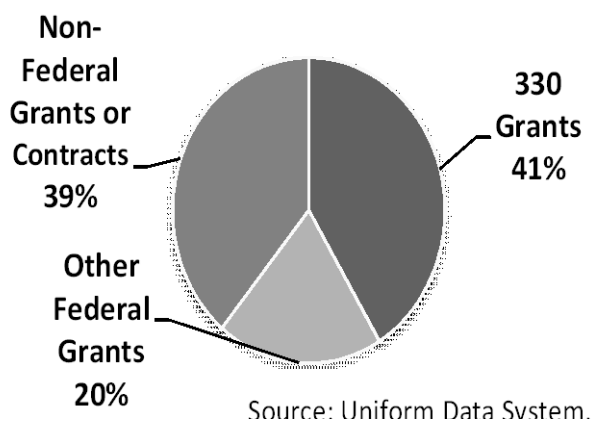


Figure 2
Accrued and Overhead Costs of Services at FQHCs in 2010

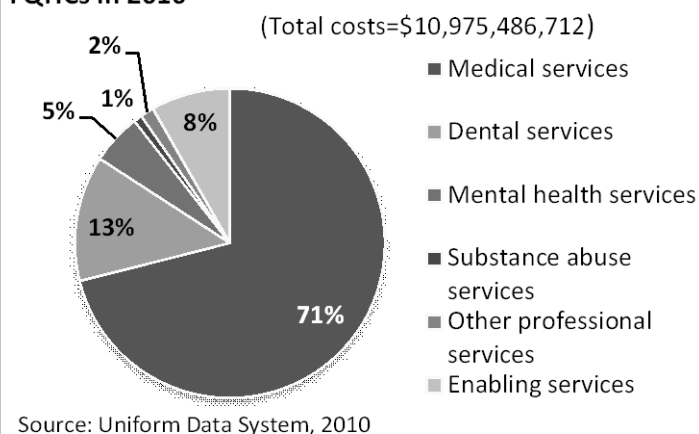
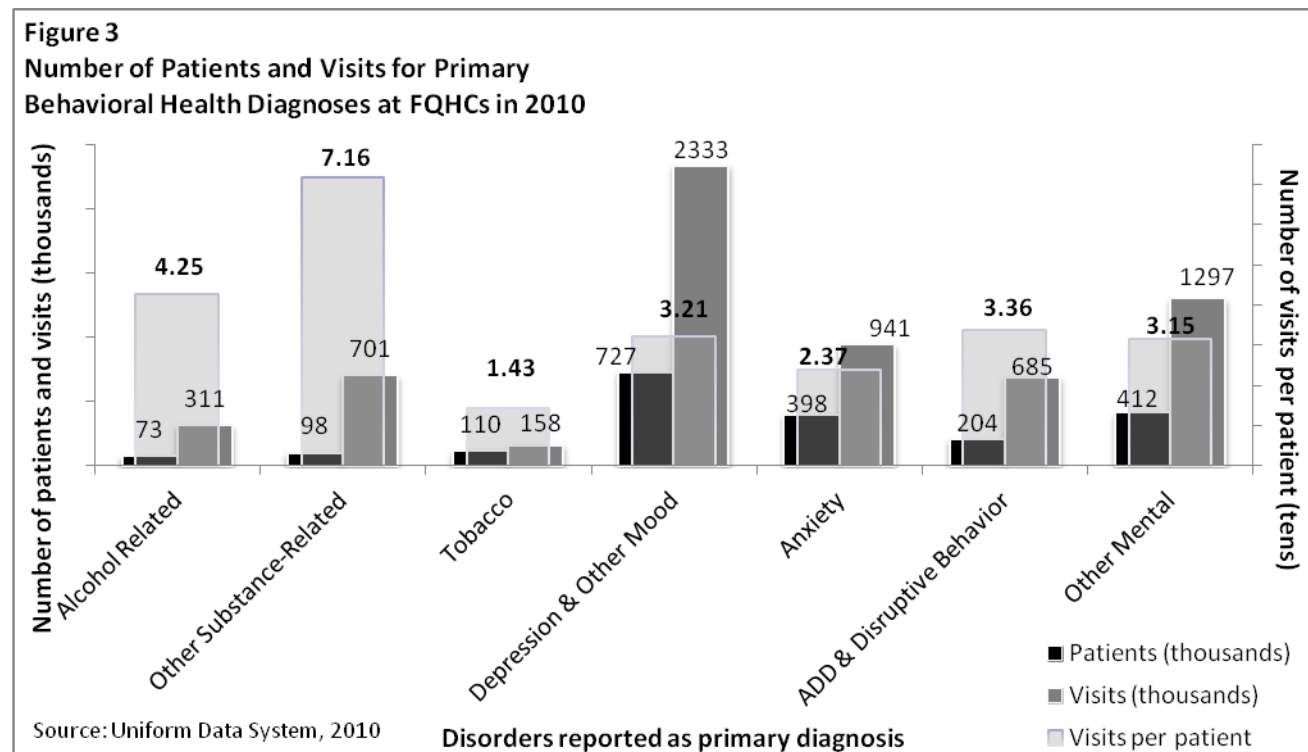


Figure 3 breaks down the patients and utilization into alcohol-related visits, other substance-related visits, tobacco-related visits, depression and other mood disorder visits, anxiety-related visits (which include PTSD), visits for attention deficit disorder and other disruptive behaviors, and any other mental health related visits in 2010. This figure includes patients and services used by patients with a primary behavioral health diagnosis as long as that diagnosis was not given by a case manager. Over 170,000 patients had alcohol and other substance-related disorders as their primary diagnosis. The highest number of patients in the group receiving mental health services had a primary diagnosis of depression

and other mood disorders. The highest number of visits was also for the treatment or prevention of depression and other mood disorders. The lowest number of visits was for the treatment or prevention of tobacco-related disorders. Though predominantly more patients had diagnoses and visits for depression and other mood disorders, there was only an average of 3.21 visits per patient. The highest number of visits per patient was for alcohol-related (4.25) and other substance-related (7.16) disorders. The breakdown of average number of visits per patient by primary behavioral health diagnoses can be seen in figure 3. It is important to note the number of behavioral health visits and patients may be underestimated. Additionally, it is not possible to report on patients with co-occurring mental health and substance use disorders since only primary diagnoses are reported in UDS.



UDS data from 2009 indicates 71% of grantees provided mental health services, while 20% provided substance abuse services, and 20% provided both substance abuse and mental health services. The National Association of Community Health Centers' (NACHC) *2010 Assessment of Behavioral Health Services at FQHCs* found over 70% of grantees provided mental health services, 55% provided substance abuse services, and almost 65% provided all essential components of integrated care. They found that 40% of the grantees offered mental health services at all of their sites, while 32% of grantees offered substance abuse services at all of their sites. Of those providing mental health services, 85.6% reported delivering the services on-site while 14.4% reported using formal contractual arrangements to link patients to services (3).

3.2.1.1 SUBSTANCE ABUSE SERVICES

In 2009, Gurewich and colleagues surveyed community health centers (CHCs) in California, Texas, and Massachusetts about their substance abuse service provision (N= 132; 85% response rate). Compared to FQHCs nationally, the respondents had slightly larger patient populations, were more urban, and served

more uninsured patients. They found at least 90% of CHCs surveyed provided patients access (on or off site) to screening, diagnostic, counseling and therapy services for both alcohol and other substance-related disorders. Additionally, close to three-quarters of CHCs provided access to intensive outpatient services and outpatient detoxification services. About half of their sample provided all substance abuse diagnostic and treatment services through off-site referrals, while the other half provided at least one service on site. Screening, assessment and counseling services were more commonly provided on site than intensive outpatient and detoxification services (13). Overall, there was a lot of variation in arrangements for service provision.

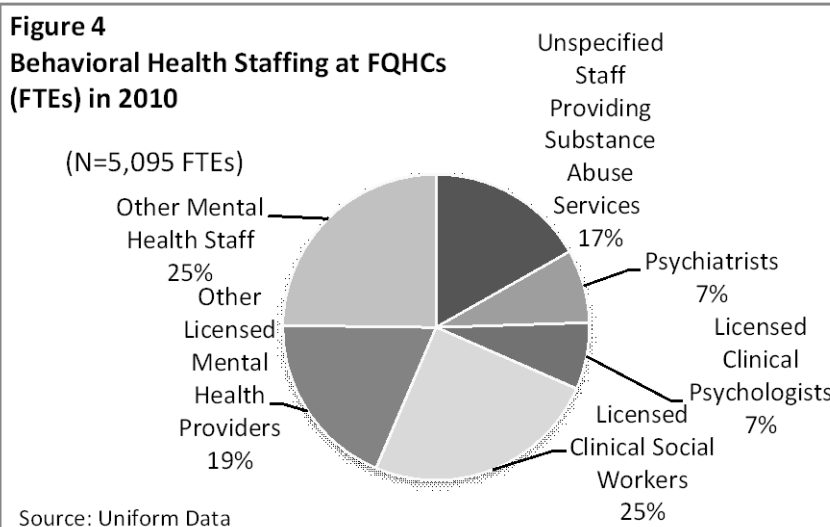
In NACHC's 2010 behavioral health services report, 15% of FQHCs reported offering Buprenorphine treatment. However, 35% of the 348 responding grantees that offer behavioral health services reported that at least one physician at their FQHC would be interested in Buprenorphine training and certification. NACHC concludes this interest indicates that an increasing number of FQHCs are likely to offer medically assisted opiate abuse treatment in the future (3).

SAMHSA has provided much support in this area, with a website focused on the issue, the implementation of a Buprenorphine Physician Clinical Support System (PCSS) (<http://www.pcspb.org>), and provision of training that meets the requirements for certification. Other organizations such as the American Academy of Addiction Psychiatry, American Psychiatric Association and the American Society of Addiction Medicine offer qualifying web-based trainings. FQHCs need to be aware of these training and support opportunities to increase access to buprenorphine treatment through FQHCs. Also, FQHCs should be aware that Buprenorphine must be on their state's Medicaid formulary to allow for reimbursement.

Current data systems may actually under-report the amount of substance abuse services provided by FQHCs. Gurewich and colleagues' recent study of substance abuse treatment services at CHCs found that patients receiving services at sites that provide on-site screening and counseling services were less likely to initiate and engage in treatment compared to patients served at CHCs without on-site screening and counseling (13). They explain this could be occurring because of how counseling services are delivered by community health centers and coded in administrative claims data. Case studies of community health centers indicate some centers code counseling services for patients with less severe substance abuse disorders as a mental health service in their claims data (13, 14). If this occurs frequently, it is possible more patients utilize substance abuse services, but that the treatment is reported as a mental health service.

3.2.2 BEHAVIORAL HEALTH PROVIDERS

In 2012, it was estimated that in a typical primary care practice, behavioral health staff should be available 2-4 hours weekly for every 1,000 primary care patients (15). In 2010, licensed clinical social workers made up the largest proportion of behavioral health staff FTEs at FQHCs (see figure 4). One out of four (25%) of the behavioral health staff FTEs at FQHCs in 2010 were



licensed clinical social workers, while 7% were licensed clinical psychologists, 7% were psychiatrists, 19% were other licensed mental health providers, 25% were other (unlicensed) mental health staff, and 17% were unspecified staff providing substance abuse services.

Behavioral health services may be delivered on site by employed staff or by contracted staff.² Behavioral health services may also be delivered off site by outside staff/programs contracting with the FQHC. Some FQHCs also contract with services sites, which are included in their scope of project, to deliver behavioral health services at a flat rate per session or other similar rate, which is not based on the volume of work performed. There may be some circumstances in which contracted sites may bill third parties for services, which are generally stipulated in the grantees agreement with the contracted site. If a visit at the contracted site is being charged to a third party such as Medicaid, the charges for these services *will not* be reported in UDS table 9D (12).

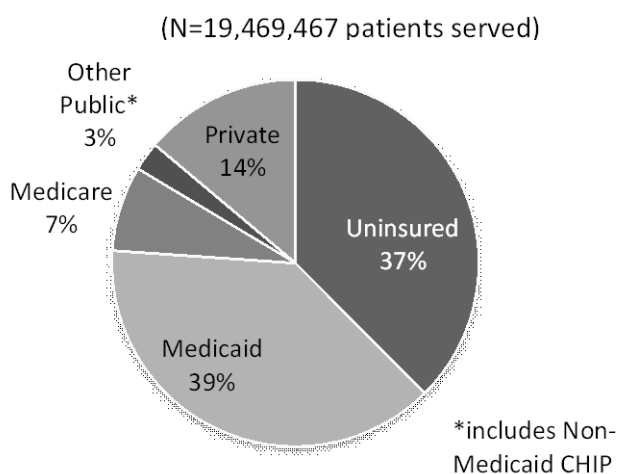
Most of the FQHCs that provided on-site mental health services used staff employed by the FQHC, while some used a combination of staff employed by the FQHC and contracted providers. The 14.4% that reported using contractual arrangements included services provided both on site and off site. Nearly three-quarters of FQHCs that reported providing substance abuse services provided on-site substance abuse services by staff employed by the health center, while 16% used a combination of staff employed by the health center and contracted providers, and about 10% used contracted providers only (3). FTEs reported in the UDS include contracted providers unless the FQHC pays the contractor using a service rate rather than a staff rate (10).

Behavioral health conditions may also be treated by primary care providers (PCPs) in FQHCs (16). Many PCPs at FQHCs are treating depression, anxiety, and attention deficit hyperactivity disorder among other conditions. When a PCP treats a behavioral health condition, the behavioral health condition is often listed as a secondary diagnosis. This may result in an underestimation of costs and utilization of behavioral health services at FQHCs.

4 FINANCING OF FEDERALLY QUALIFIED HEALTH CENTERS

According to HRSA's UDS on all FQHC grantees, in 2010, 37% of grantee patients were uninsured, 39% had Medicaid, 7% had Medicare, 3% had other public insurance coverage (including the Children's Health Insurance Plan [CHIP]), and 14% had private insurance coverage (see figure 5) (10). These figures vary by state, with the greatest variation in the proportion uninsured and the proportion covered by Medicaid, such that states with more

Figure 5
Insurance Source of Patients at FQHCs in 2010



Source: Uniform Data System, 2010

² Note, in this discussion we are referring to situations where the FQHC contracts with a provider for services for the FQHC's patients. In Section 5.1.2 below, we discuss situations where some State Medicaid Agencies carve-out the administration and provision of behavioral health services to other organizations.

Medicaid coverage tend to have proportionally fewer uninsured patients at grantee health centers.

FQHCs are required to provide services to patients regardless of their ability to pay or insurance status. Federal financial policies are designed to enable FQHCs to afford to deliver services to the uninsured and medically underserved without compromising the quality of care. FQHCs receive two forms of revenue: (1) grant money not associated with specific patient services from federal and state governments and non-governmental organizations and (2) payments for patient services from public and private insurers and individual self-payment. This section has two parts: (1) the financial benefits of being an FQHC – distinguishing between grantees and Look-Alikes when appropriate, and (2) an overview of FQHC sources of revenues.

4.1 FINANCIAL AND OTHER BENEFITS OF BEING AN FQHC

Federal and state government financial and administrative policies support FQHCs' mission to deliver health services to the uninsured and medically underserved without compromising quality of care in the following ways (16, 17):

- **330 Grants:** Health Center Program grantees receive federal 330 grants to offset the costs of otherwise uncompensated care and enabling services at sites within the approved scope of services. FQHC Look-Alikes are eligible to apply for new start Section 330 grants to become Health Center Program grantees when funding is available.
- **Capital Improvements:** Grantees are eligible to receive grant support and loan guarantees from HRSA specifically for capital improvements; Look-Alikes are not eligible for these grants.
- **Drug Pricing:** FQHCs have access to favorable drug pricing under Section 340B of the PHS Act. FQHCs that provide, or contract for the provision of, pharmaceuticals are entitled to favorable pricing from the drug manufacturers. The pharmacy discounts are standard nationwide, with a minimum discount of 23.1% for brand name drugs (with some exclusions) and 13% for generic drugs (see more detailed discussion in Section 5.4 below) (17).
- **Support from the BPHC:** BPHC supports performance and operational improvement at FQHCs through BPHC-supported technical assistance that includes programs like disease management learning models. Additionally, BPHC and NACHC provide extensive technical assistance on business operations and have developed detailed financial indicators for FQHCs. Quality improvement at FQHCs is informed by patient and facility-level data submitted by FQHCs to HRSA's UDS (12).
- **Medicaid Reimbursement:** Through the prospective payment system or alternative payment method used by State Medicaid Agencies (SMAs), FQHCs (both grantees and Look-Alikes) receive enhanced Medicaid reimbursements to improve the provision of primary care services in underserved communities, even if the FQHC is a subcontractor to a managed care plan. The method and degree of payment enhancement varies by state. In situations where managed care plans pay below the enhanced rates, FQHCs have access to supplemental funds, called wrap-around payments,³ from the SMA that make up the difference.

³ Wrap-around payments differ from the standard understanding of wrap-around services in behavioral health treatment, which involve services such as employment assistance, housing assistance, and transportation.

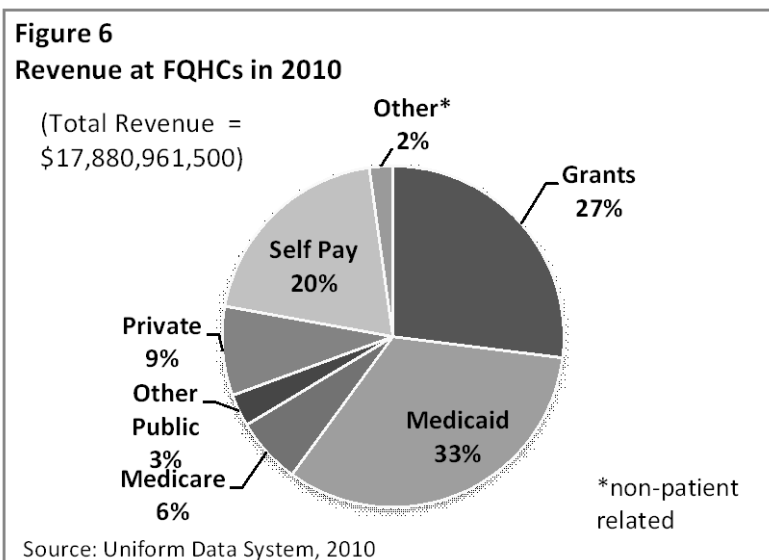
- Medicare Reimbursement:** Reimbursement to FQHCs by Medicare is for the “first dollar” of services rendered to Medicare beneficiaries, which means the deductible is waived and Medicare begins paying its share for an enrollee’s first covered services.

These policies are important to the operation and expansion of FQHCs. It is important to note, however, that FQHCs still face challenges collecting payments from public and private insurers and individuals (10, 18). More information about grant revenues is available in section 4.2 and more information about Medicare and Medicaid financing is available in section 4.2 and section 5.

4.2 OVERVIEW OF REVENUE OF FQHCS

Figure 6 shows that in 2010, 33% of FQHC revenues came from Medicaid, 27% from public and private grants, 20% from self-pay, 9% from private insurance, 6% from Medicare, 3% from other public insurance, including non-Medicaid CHIP, and 2% from other sources not related to patient services. 330 grants made up 11% of all FQHC revenue in 2010. These proportions vary across states (10).

The remainder of this section provides an overview of these revenue streams. Because of the complexity of the public financing of FQHCs, more detail on Medicaid, CHIP, and Medicare is provided in section 5.



4.2.1 GRANTS

Grants are an important source of revenue for FQHCs. Grants to FQHCs offset the costs of uncompensated care and enabling services and are used for capital development and improvement to assure that centers can provide high-quality services to vulnerable populations. Figure 7 illustrates the distribution of revenues for the three grant categories to FQHC grantees (does not include Look-Alikes): (1) 330 grants, (2) other federal grants, and (3) non-federal public and private grants and contracts. There are different categories of 330 grants, including capital improvement and development grants and health center cluster grants. Health center cluster grants are awarded to specific types of health centers and programs, including migrant and community health centers and health care for the homeless programs. Four out of five (80%) of the 330 grants are CHC grants (10). Health center

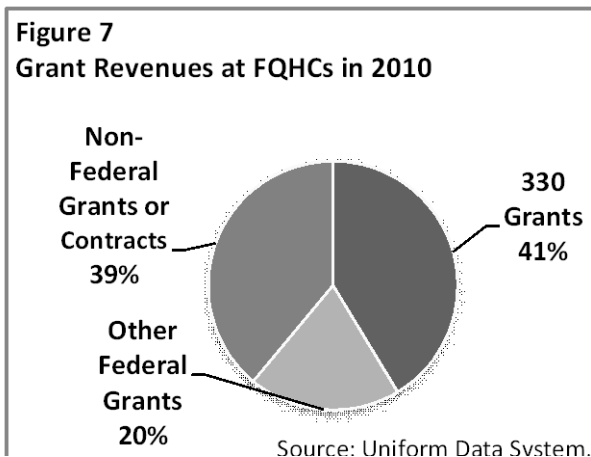


Figure 7 illustrates the distribution of revenues for the three grant categories to FQHC grantees (does not include Look-Alikes): (1) 330 grants, (2) other federal grants, and (3) non-federal public and private grants and contracts. There are different categories of 330 grants, including capital improvement and development grants and health center cluster grants. Health center cluster grants are awarded to specific types of health centers and programs, including migrant and community health centers and health care for the homeless programs. Four out of five (80%) of the 330 grants are CHC grants (10). Health center

cluster grants do not pay for specific patients but cover shortfalls in revenue in delivering care to patients.

FQHCs may receive other federal, state, and non-federal grants and use them to cover services and costs as specified in the grants. Other federal grants include Ryan White Part C HIV Early Intervention funds and American Recovery and Reinvestment Act funds for site improvements and expansions. Non-federal grants or contracts include grants and contracts from state governments (54%), local governments (22%), and foundations/private funders (24%) (10). The amount of grant funding health centers receive is relevant to understanding behavioral health service provision at FQHCs because research has shown that increased federal grant funding increases the probability of FQHCs providing on-site mental health treatment and counseling services, 24-hour crisis intervention services, and substance abuse treatment and counseling services (19).

4.2.2 PUBLIC AND PRIVATE INSURANCE

As noted below in Table 1, insured patients in FQHCs (both grantees and Look-Alikes) are covered by the following payers/plans:

- Traditional Medicaid
- Medicaid Managed Care
- Traditional Medicare (Part B)
- Medicare Managed Care (Medicare Advantage, Part C)
- Other Public, including Non-Medicaid CHIP
- Other Public Managed Care, including Non-Medicaid CHIP
- Private Non-Managed Care
- Private Managed Care

Table 1 details the charges for patient services by public and private insurers and individuals for FQHC grantees as reported to HRSA's UDS.

Payer	Charges	% of Payer	% of All Payers
Medicaid	5,912,248,400	100.0%	46.7%
Non-Managed Care	3,335,369,694	56.4%	26.4%
Managed Care, capitated	1,041,282,619	17.6%	8.2%
Managed Care, fee-for-service	1,535,596,087	26.0%	12.1%
Medicare	1,128,237,597	100.0%	8.9%
Traditional (Part B)	995,049,257	88.2%	7.9%
Managed Care, Capitated	38,164,998	3.4%	0.3%
Managed Care, Fee-for-Service	95,023,342	8.4%	0.8%
Other Public (including Non-Medicaid CHIP)	547,475,196	100.0%	4.3%
Non Managed Care	371,035,505	67.8%	2.9%
Managed Care, Capitated	67,241,273	12.3%	0.5%
Managed Care, Fee-for-Service	109,198,418	19.9%	0.9%
Private	1,512,072,001	100.0%	11.9%
Non-Managed Care	1,282,384,230	84.8%	10.1%
Managed Care (Capitated)	66,616,210	4.4%	0.5%
Managed Care (fee-for-service)	163,071,561	10.8%	1.3%
Self Pay	3,557,780,737	100.0%	28.1%
Total Charges for Patient Services	12,657,813,931		100.0%

Source: Uniform Data System, 2010, adapted from Table 9D. More information on Table 9D can be found in Appendix A.

4.2.3 SELF PAY

Section 330 guidelines—which both grantees and Look-Alikes must meet to retain their federal designation—legally require health centers to serve all patients regardless of their ability to pay and stipulate that the health centers must determine patient discounts on the basis of patients' ability to pay. Patients without insurance coverage and with incomes at or below 100% FPL must be provided full discounts for services and only nominal fees may be charged. Patients without insurance coverage and with incomes between 100% and 200% FPL are charged fees in accordance to a sliding discount policy based on family size and income. Discounts are not provided to patients with insurance coverage or those with incomes over 200% FPL (11). FQHC grantees use the 330 grants to offset some of the cost of uncompensated care. FQHC Look-Alikes, who also fall under the legal obligation to serve all patients regardless of ability to pay, must seek state appropriations, grants or other funding to offset uncompensated care. The charges to uninsured individuals (self pay) can be seen in table 1.

5 PUBLIC FINANCING OF FEDERALLY QUALIFIED HEALTH CENTERS

This section discusses financing issues for FQHCs related specifically to Medicaid, CHIP, and Medicare. Table 2, at the end of this section, summarizes the overall payment methodology, covered services, and billable providers for FQHCs from individuals and public and private insurers.

5.1 MEDICAID

Some SMAs reimburse FQHC grantees and Look-Alikes using a prospective payment system (PPS) reimbursement for services provided to **Medicaid** patients. The PPS payment rate is a per-visit rate. Some states bundle all services into one PPS rate, while other states set different PPS rates for different bundles (e.g., one PPS rate for medical services, another for dental services, and a third for mental health services) (20). When the PPS is used, each service provided under the payment is not specified in claims data. The payment, which is unique to each FQHC, is based on the previous year's cost-per-visit rate and adjusted by the Medicare Economic Index for primary care and any change in the FQHC's scope of services (18). The PPS provides a minimum rate at which FQHCs must be reimbursed. States are not required to reimburse FQHCs using the PPS methodology, but if they use an alternative payment methodology (APM), such as reasonable cost reimbursement, they cannot pay FQHCs less than the PPS rate (18).

MEDICAID REIMBURSEMENT TO FQHCs

- SMA reimburses FQHC using Prospective Payment System (PPS) *OR*
- SMA reimburses FQHC using Alternative Payment Method but Alternative Payment Method must be greater than or equal to PPS *OR*
- Medicaid Managed Care Organization contracts with FQHC as a provider
 - MCO pays FQHC negotiated capitated or fee-for-service payment
 - If MCO payment is less than PPS, SMA pays FQHC balance as wrap-around payment

MEDICAID PROSPECTIVE PAYMENT SYSTEM RATES

- Some states bundle all services into one PPS rate
- Other states set different PPS rates for different bundles (e.g., one PPS rate for medical services, another for dental services, and a third for behavioral health services)

Each year, NACHC surveys state Primary Care Associations regarding PPS implementation and Medicaid policy in their states. In 2011 they found 21 SMAs used PPS rates, 12 used an APM, and 12 used a combination of both (20). Services included in the PPS or APM rates vary by state. Average payment rates by state vary from about \$90 to over \$200 (18). Many states manage utilization by limiting the number of reimbursable visits to one type (e.g., medical, dental, or mental health) per day (discussed in more detail below in section 5.1.5.1) (21).

SMAs are required to contract with FQHCs as providers. Further, if states contract out the administration of Medicaid to managed care organizations (MCOs), SMAs are required to ensure that at least one MCO contracts with an FQHC within the geographical areas covered so patients have access to FQHC services (22). If a **Medicaid Manage Care** plan contracts with an FQHC as a provider, they may have a capitated contract with a Medicaid Managed Care plan that stipulates a specific set of CPT codes for preventative and primary care services that will be covered by the capitated payment regardless of utilization. The contract may also stipulate a set of CPT codes for which the managed care company will pay separately on a fee-for-service basis called “carve out” payments. Carve-out payments for behavioral health services are common (12).

The remainder of this section describes: wrap-around payments, carving out behavioral health services, billable providers, paying behavioral health providers across Medicaid and Medicaid Managed Care, special issues for behavioral health services and integrated primary and behavioral health care in FQHCs, same day billing issues, reimbursement for screening and brief intervention, and payment for group visits, specialty case management and community support services.

5.1.1 WRAP-AROUND PAYMENTS

NACHC found that two-thirds of states reported providing “wrap-around” payments to FQHCs treating Medicaid Managed Care enrollees in 2009. Wrap-around payments are required by CMS through the Medicaid FQHC managed care supplemental provisions. These supplemental payments for all covered services make up the difference between the contracted per claim payments FQHCs receive from managed care companies and the full PPS rate. Although the state essentially subsidizes the payments made to FQHCs, the intent of wrap-around payments is to ensure that FQHCs do not receive a lower payment when it contracts with an MCO than it would if it were contracting directly with the SMA (22). If a Medicaid Managed Care enrollee is seen at an FQHC, the FQHC bills the managed care company the contracted rate and reports the visit to the SMA, which will pay the FQHC a wrap-around payment equal to the difference between the contracted rate and the PPS rate (18).

5.1.2 CARVING OUT BEHAVIORAL HEALTH SERVICES

Some SMAs carve out the administration and provision of behavioral health services to other organizations, including managed behavioral health organizations or state or county behavioral health authorities (23). In 2009, 13 of 39 responding states reported that their SMAs carved out substance abuse services and 23 of 45 responding states reported that their SMAs carved out mental health services to other entities (21). FQHCs are not always included in the provider networks established by the carve-out entities; therefore, behavioral health services provided to Medicaid enrollees may not be reimbursable – they might be covered through the SMA “wrap-around” payment, but over the years some FQHCs have noted anecdotally that when they cannot get into an MBHO network, they find it difficult to receive payment from the SMA as they claim that the state covers the service through the MBHO.

5.1.3 BILLABLE PROVIDERS

State and federal policies impact which type of FQHC staff may be reimbursed for delivering behavioral health services. SMAs are required to reimburse FQHCs for behavioral health services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, and clinical social workers working within their scope of practice, whether or not the services provided are included in the State Medicaid plan. SMAs are also required to reimburse FQHCs for services provided by these providers whether or not they are provided to Medicaid beneficiaries under a PPS rate or alternative payment method (e.g., fee-for-service). This requirement applies to services rendered to categorically eligible Medicaid beneficiaries.⁴ Additionally, if the SMA has elected to provide FQHC services to its medically needy population (not categorically eligible), this requirement also applies to services rendered to this population (24).

5.1.4 PAYING BEHAVIORAL HEALTH PROVIDERS ACROSS MEDICAID AND MEDICAID MANAGED CARE

Medicaid payment for behavioral health services at FQHCs varies by state. In 2009, 29 of 40 responding states reported paying FQHCs for substance abuse services under fee-for-service (FFS) Medicaid rather than through an MCO, while 39 of 48 responding states reported paying health centers for mental health services under FFS Medicaid. Half of the responding states (19 of 35) paid a PPS rate for substance abuse services and nearly two-thirds of responding states (30 of 47) reported paying PPS rates for mental health services. States paying for behavioral health services at a non-PPS rate varied in the APM used and how the payment rate was determined. Two states reported covering substance abuse services through grants (21).

5.1.5 SPECIAL ISSUES FOR INTEGRATED PRIMARY AND BEHAVIORAL HEALTH CARE IN FQHCs

There are several other special issues with Medicaid reimbursement for behavioral health services and integrated primary and behavioral health care in FQHCs, including: (1) same day billing for behavioral health and medical visits; (2) reimbursement for alcohol screening and brief intervention; and (3) payment for group visits, specialty case management and community support services.

5.1.5.1 SAME DAY BILLING

Many states manage utilization by limiting the number of reimbursable visits to one type (e.g., medical, dental, or mental health) per day; this is an issue for all Medicaid providers in general, and FQHCs specifically (21, 25). This limitation may include billing for medical, dental, behavioral health, and even enabling services (e.g., transportation, translation, education, and case management), which creates a barrier to providing these services in an integrated, timely, and possibly clinically appropriate manner. NACHC and SAMHSA combined data to specifically assess state Medicaid policies for paying for behavioral health visits on the same day as medical visits (26). As of 2010, 30 states allowed for same day billing, while 14 states specifically did not allow behavioral health and medical visits on the same day. Same day billing policies were not determined for three states (CO, NM, and WI). Additionally,

⁴ Federal Medicaid rules limit eligibility to individuals who fall into specified categories. Overall, there are more than 25 different eligibility categories, but they can be classified into the following five groups: children, pregnant women, adults in families with dependent children, individuals with disabilities, and the elderly.

three states allowed for same day billing in Medicaid FFS but not Medicaid payments to FQHCs (see Appendix B).

In an effort to prevent improper payment of Medicare procedures that should not be submitted together, CMS initiated the National Correct Coding Initiative (NCCI). Under NCCI, CMS limits same-day billing for certain paired codes of services and practitioner types (27). NCCI restrictions prevent joint billings for component and comprehensive services, billings for mutually exclusive services, and numerous dual code billing errors (28). Although developed for Medicare, states have adopted NCCI-like measures in their Medicaid programs, attempting to mimic Medicare's cost savings as well as the program's efforts to reduce fraud, waste, and abuse.

For behavioral health,⁵ NCCI restrictions prevent:

- Same day billing by behavioral health practitioners for psychiatric codes (CPT 90801-90899) and Health Behavior Assessment and Intervention (HBAI) codes (CPT 96150-96155) – services that identify behavioral health components of physical health problems.
- Billing for family and individual psychotherapy on the same day and prohibits practitioners from billing for evaluation and management (E/M) services separately from psychiatric diagnostics evaluations (28-30).⁶
- Billing for certain psychiatric codes that include drug management⁷ with Pharmacological Management Services codes (30).

These billing restrictions are designed to reduce the risk of inappropriate billing but appear to have the unintended consequence of limiting behavioral health providers' ability to bill the full range of provided services (27).

5.1.5.2 REIMBURSEMENT FOR SCREENING AND BRIEF INTERVENTION

Reimbursement for alcohol screening and brief intervention (SBI) faces additional challenges. Reimbursement is available through commercial insurance CPT codes, Medicare G codes, and Medicaid HCPCS codes for those with a substance abuse diagnosis, but states must opt to turn on these codes for Medicaid reimbursement (21, 31). Under the codes, providers eligible to bill Medicaid for SBI may be different than providers eligible to bill for other substance abuse services delivered at FQHCs. Ten of 36 responding states reported having approved SBI codes for use in 2009 (21). Eight of the ten states (IN, MI, NC, OK, OR, TN, VA, and WI) reported having activated the codes in their Medicaid system so that FQHCs were actually able to bill for and receive payment (21). According to SAMHSA, 11 of 50 states paid for screening and brief intervention in 2010 (26). However, one state (IA) only pays for screening and brief intervention in hospitals (26). The same day billing issue discussed above may be inhibiting the use of SBI billing codes in affected states.

⁵ CMS publishes a comprehensive list of disallowed NCCI code pairs; however, the list does not include code descriptions and is not current as of 2010. The NCCI Policy Manual for Medicare Services provides guidelines for disallowed NCCI codes effective October 1, 2009 (v15.3). The National Technical Information Service (NTIS) sells updated comprehensive code sequences (v.16.3). CMS allows free access to the disallowed code pairs as of v15.3; however, they are presented as raw codes without descriptions and therefore not conducive to listing within this document. <http://www.ntis.gov/products/cci.aspx>

⁶ Unlike individual practitioners, facilities may bill E/M codes separately from individual psychotherapy codes if the services are performed at separate patient encounters on the same day.

⁷ E.g. CPT 90801-90829, 90845, 90847-90853, 90865-90880, CPT 90862.

There are also opportunities for expanding SBI at FQHCs under the ACA, which will require that all employer and Medicare plans cover—without cost sharing—prevention services deemed effective by the US Preventive Services Task Force (USPSTF). The USPSTF has deemed that depression screening and alcohol screening and brief intervention are effective clinical prevention treatments. In the fall of 2011, CMS made a National Coverage Determination that alcohol SBI for risky drinking in primary care should be covered under Medicare. CMS will now work with the AMA to develop a reimbursement code and rate to enable implementation of alcohol SBI with no co-pays under all Medicare plans. As Medicare often sets the standard for state Medicaid and commercial plans, this is expected to also speed recognition and reimbursement of alcohol SBI under Medicaid and employer plans.

5.1.5.3 PAYMENT FOR GROUP VISITS, SPECIALTY CASE MANAGEMENT AND COMMUNITY SUPPORT SERVICES

About half of responding states indicated that their SMAs paid for substance abuse group therapy visits (20 of 38) and mental health group therapy visits (23 of 45) in 2009 (21). When a behavioral health provider renders services to several patients at the same time, in group substance abuse counseling or family therapy sessions for example, the provider can be credited with a visit for each person if the provision of service is noted in each patient's health record. Only behavioral health providers may provide group visits (12). Medicare does not pay for group therapy visits of any type, which was cited as a reason one state was phasing out Medicaid payment for group visits in 2009 (21).

The PPS and APM rates paid by Medicaid cover behavioral health assessments, prescribing, therapy by physicians, and counseling with Licensed Clinical Social Workers (LCSWs) and PhD Psychologists. Generally, however, FQHCs cannot bill Medicaid for specialty case management and community support services for either general or behavioral health. Funding for these services often comes from other grants (27).

5.2 CHILDREN'S HEALTH INSURANCE PLAN (CHIP)

A system similar to Medicaid's PPS was implemented by CHIP in response to the CHIP Reauthorization Act (CHIPRA) of 2009. CHIPRA legislation applies only to stand-alone CHIP programs, not Medicaid-expansion CHIP programs,⁸ and only applies to payment rates for FQHCs. Additionally, wrap-around payment provisions apply to PPS payments in stand-alone CHIP programs. There are two key differences between FQHC payment provisions in Medicaid and CHIP. First, Medicaid requires that its insured population has access to FQHC services, whereas CHIP does not. This means CHIP programs, unlike Medicaid programs, are not required to contract with FQHCs as long as there are other providers to deliver CHIP services to recipients. Second, in the CHIP statute, FQHC services are not defined or even listed as a service; in contrast, Medicaid statute defines FQHC services as including all rural health clinic services as well as any other ambulatory services. Thus, the CHIP statute provides less guidance and leaves more to the discretion of the state CHIP agencies (22).

⁸ States can design their CHIP programs in one of three ways: (1) use CHIP funds to expand their Medicaid program ("Medicaid expansion CHIP program"), (2) separate CHIP from Medicaid ("stand-alone program"), or (3) a combination of these approaches.

5.3 MEDICARE

5.3.1 TRADITIONAL MEDICARE

To be reimbursed by traditional Medicare (i.e., Part B), FQHC grantees and Look-Alikes are required to enroll in Medicare as an FQHC; FQHCs can begin billing on the effective date of approval. Each service site operated by an FQHC grantee must be individually enrolled as an FQHC in Medicare. If an FQHC is not yet an approved Medicare provider, the Health Center's providers that are individually enrolled in Medicare may bill Medicare Part B directly, and assign payment to the health center, for services that they provide on behalf of the health center prior to an FQHC's effective date (32).

A system similar to Medicaid's PPS will be implemented by Medicare in 2014 to be in compliance with the ACA. Medicare currently reimburses FQHCs under a payment methodology referred to as the Medicare FQHC benefit. These reimbursement rates are usually higher than other Part B reimbursement rates and are intended to reflect the broad range of services and complexity of care that FQHCs provide (32).

Under Medicare Part B, FQHCs currently receive an all-inclusive payment for any covered visit, regardless of the specific services provided. The all-inclusive visit rate includes a range of primary care services and services accompanying or occurring as a result of primary care services, including behavioral health services from clinical psychologists and clinical social workers. Beneficiaries pay no Part B deductible for FQHC services. Billable providers include physicians, physician assistant, nurse practitioners, and certain other non-physician practitioners, including masters' level clinical social workers and PhD clinical psychologists. The capitated payment amount is calculated as either the FQHC's reasonable costs, determined through Medicare cost reports, or an upper payment limit (UPL), whichever is lower. Medicare sets separate UPLs for urban and rural areas (32, 33).

The co-insurance Medicare beneficiaries are expected to pay for FQHC services is Medicare's typical 20% of the FQHCs reasonable and customary billed charges, except for mental health services, which are subject to Medicare's higher outpatient mental health treatment co-insurance. This mental health treatment co-insurance requires beneficiaries to pay a 50% co-insurance on all outpatient mental health services, calculated on the FQHC's reasonable and customary billed charges. This increased co-payment does not, however, apply to diagnostic services. The higher co-insurance was changed in the Medicare Improvements for Patients and Providers Act of 2008, so that beginning in 2010, the amount of the co-insurance gradually falls to the typical Medicare 20% co-payment by 2014; this is also consistent with the requirements of the Wellstone and Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (33).

5.3.2 MEDICARE MANAGED CARE (MEDICARE ADVANTAGE)

The Medicare FQHC benefit is structured differently for beneficiaries enrolled in the managed care model of Medicare Advantage instead of traditional FFS Medicare. Medicare Part C is administered by managed care organizations (32). Under Medicare Advantage (Part C), FQHCs may receive either fee-for-service or capitated payments, depending upon the plan's covered providers and services. FQHCs may receive wrap-around payments from Medicare as under Medicaid and CHIP. These wrap-around payments equal the difference between what the Medicare Advantage plan pays the FQHC and the capitated amount the FQHC would receive under Medicare FFS (32).

5.3.3 DUAL ELIGIBLES

Dual eligibles are persons who are entitled to Medicare and eligible for some form of Medicaid benefit. Although there are complexities involved in dual eligibility, generally Medicaid covers the Medicare premium, deductible, co-insurance, and copayment amounts so that dually eligible patients incur no financial costs for treatment. In all cases of dual eligibility, Medicare is responsible for reimbursing FQHCs and other service providers for the costs of Medicare covered services. For services that Medicare does not cover, Medicaid pays for covered Medicaid services from recognized providers, like FQHCs. For services where Medicare reimburses at a lower rate than Medicaid, Medicaid pays the FQHC the standard Medicaid rate (PPS or APM) less the amount paid by Medicare. FQHCs and other providers cannot "balance bill" or charge the dually enrolled to make up the difference between the amount FQHCs charge and the amount Medicaid reimburses; if they do, they are subject to sanctions. They can only use the dual program to receive Medicaid payments in cases where Medicare payments fall below the Medicaid rate (34).

5.4 HRSA'S OFFICE OF PHARMACY AFFAIRS 340B DRUG PRICING PROGRAM

The 340B Drug Pricing Program is a federal program that requires drug manufacturers to provide outpatient drugs, including those for substance use and mental health disorders, to eligible health care centers, clinics, and hospitals (termed "covered entities") at a reduced price to provide financial relief to those facilities that provide care to the medically underserved, including FQHCs. The 340B Drug Pricing Program is administered by HRSA's Office of Pharmacy Affairs (OPA). In all of its activities, OPA emphasizes the importance of comprehensive pharmacy services being an integral part of primary health care. The 340B Program is a way in which eligible safety-net organizations can ensure access to medications, a key component of clinical pharmacy services and the continuum of care. Comprehensive pharmacy services include patient access to affordable pharmaceuticals, application of "best practices" and efficient pharmacy management and the application of systems that improve patient outcomes through safe and effective medication use. Covered entities purchase from wholesalers and, once established as eligible for the program, receive a minimum discount of 23.1% for brand name drugs (with some exceptions) and 13% for generic drugs. All patients of the covered entity, including non-Medicaid patients, may receive discounted drugs from a participating provider under Section 340B (35).

Table 2. FQHC Payment, Services and Billable Behavioral Health Providers by Payer			
PAYER	PAYMENT METHODOLOGY	COVERED SERVICES	BILLABLE PROVIDERS
Medicaid			
State Medicaid Agencies (SMA) (21)	PPS (or APM greater or equal to PPS rate)	Services rendered by billable providers so long as those providers are practicing within their scope of services	Physicians, physician assistants, licensed clinical psychologists, ⁹ licensed clinical social workers ⁹ ; some states allow other types of providers to bill Medicaid for behavioral health services rendered at FQHCs, such as licensed professional counselors, licensed mental health counselors, licensed marriage and family therapists, and licensed clinical additions specialists
Medicaid Managed Care	Fee-for-Service and capitated; Wrap-around payments from SMA make up difference between negotiated rate MCO pays per service and PPS rate	At least one managed care organization in each service area must contract with an FQHC so patients have access to FQHC services	Varies by state and managed care organization; MCOs may allow out-of-network providers to bill in addition to Medicaid Billable providers (21)
Children's Health Insurance Plan (CHIP) (22) – State Option to Provide Under or Outside of Medicaid Program			
CHIP as a Medicaid Expansion	PPS	Same as Medicaid above	Same as Medicaid above
Separate (Non-Medicaid) CHIP Program	PPS	Varies by state, but often similar to Medicaid	Varies by state, but often similar to Medicaid
CHIP Managed Care	Varies by MCO; wrap-around payment applies	Varies by MCO/state, but often similar to Medicaid	Varies by MCO/state, but often similar to Medicaid
Medicare (32)			
Traditional Medicare (Part B)	All-inclusive per-visit rate (regardless of service provided); a new Medicare PPS system will be implemented in 2012 as mandated by the Affordable Care Act	Range of primary care services and related services as a result of primary care services, including clinical psychologist and clinical social worker services; Mental health services have a higher co-insurance rate than medical care	Physicians, physician assistant, nurse practitioners, and certain other non-physician practitioners including clinical social workers and clinical psychologists
Medicare Managed Care (Medicare Advantage, Part C) (36)	Fee-for-service or capitated; Wrap-around payments from Medicare make up the difference between FFS all-inclusive per-visit rate and managed care payment	Must include original Medicare covered services, can also add supplemental benefits, which vary by insurance company's offerings	Similar to traditional Medicare providers; providers must be approved by Medicare except those providing supplemental benefits, which varies by insurance company's offerings
Other Public Insurance	Varies	Varies	Varies
Private Insurance	Varies	Varies	Varies
Self pay (11)	Cost, based on sliding scale (Nominal fee ≤100% FPL; Sliding scale 100%-200% FPL; No discount >200% FPL)	Services provided by FQHC; services provided off-site are subject to the off-site agency's fees and may not meet sliding scale guidelines	Employed or contracted behavioral health providers

⁹ State practice laws for social work vary in defining what services professionals can provide, thus services for social workers vary by state.

6 THE AFFORDABLE CARE ACT AND FEDERALLY QUALIFIED HEALTH CENTERS: OPPORTUNITIES FOR INTEGRATING BEHAVIORAL HEALTH CARE

The ACA impacts health center revenue and operations in a number of ways. This section is divided into two parts. The first part describes several specific impacts of the ACA on FQHCs (3, 37-39), emphasizing primary care, prevention and the integration of primary care and behavioral health services. The second part of this section discusses opportunities, challenges, and models for integrating behavioral health at FQHCs.

6.1 IMPACT OF THE ACA ON FQHCs

6.1.1 SECTION 330 GRANTS AND PROGRAMS

The ACA primarily impacts 330 grant revenue, not reimbursement mechanisms. The law established a minimum level and maximum level of federal grant funding. To meet the minimum level of funding, \$11 billion in new federal grants will be awarded to FQHCs between 2011 and 2015. This money is intended to increase the number of health center grantees in high need areas in order to expand services to an estimated 40 million patients. HRSA identified behavioral health, as well as dental, pharmacy and vision, as targets of service expansion (39). The ACA also permanently authorized the Community Health Centers Program, which is one type of health center supported by the BPHC that can qualify as an FQHC.

While the ACA mandates increased funds for FQHCs to expand and serve new patients, these funds are tied to federal budgets through the annual Congressional budget allocations. With a current focus on deficit reduction, reduced funding to FQHCs would require HRSA to use funds allocated for expansion of services to maintain current services (40). At this point, however, federal deficit reduction proposals have not proposed cutting FQHC funding (41). The 2012 Omnibus Appropriations Act proposes to fund FQHCs at the total programmatic level of \$2.78 billion, enabling FQHCs to maintain existing operations and expand services (42).

On May 1, 2012, the Department of Health and Human Services announced that it will award more than \$728 million to support building, expansion, and improvement of health centers. The awards are part of a series of capital investments made available to health centers under the ACA (43).

6.1.2 HEALTH INSURANCE EXCHANGES

The ACA requires that insurance plans operating under health insurance exchanges contract with essential community providers, including community health centers. It also requires that plans operating under health insurance exchanges pay FQHCs and Look-Alikes the same amount that would be paid under Medicaid PPS. This would eliminate the need for wrap-around payments for the qualified health plans within health insurance exchanges.

6.1.3 MEDICARE

The ACA requires Medicare to develop and implement its own PPS to FQHCs that takes into account the type, duration and intensity of services provided. While similar to state Medicaid PPS, this will be a nationwide payment system for all Medicare beneficiaries receiving services at FQHCs. Medicare is

currently collecting and analyzing data to develop the new payment system. Medicare is mandated to pay FQHCs using its PPS in January 2014.

6.1.4 MEDICAID EXPANSION

The expansion of Medicaid stipulated in the ACA will result in some currently uninsured FQHC patients gaining Medicaid coverage, decreasing the number of uninsured patients served. This will reduce the amount of uncompensated care delivered at FQHCs. Because FQHCs will be able to bill Medicaid for services delivered to new Medicaid enrollees, FQHCs will increase their patient-related revenue (39).

6.1.5 HEALTH HOMES

The ACA emphasizes the importance of prevention and primary care services seen as pivotal to improve health outcomes and to reduce health care spending through a variety of initiatives. One of these changes is Medicaid's new health home option, which became available on January 1, 2011. Section 2703 of the ACA defines the services that must be offered in a Medicaid health home: comprehensive care management, care coordination, health promotion, transitional care from hospital to the community, individual and family supports, referral to community services and use of health information technology to promote integrated care. To be eligible for health home services, Medicaid beneficiaries must have at least two chronic conditions, including asthma, diabetes, heart disease, obesity, mental health condition, and substance abuse disorder; one chronic condition and be at risk for another; or one serious and persistent mental health condition. Other aspects of health homes, such as conditions included and provider requirements, are determined by the state through a state plan amendment. Health home programs receive a 90% federal match for the first two years. All states are required to consult with SAMHSA about the prevention and treatment of mental health and substance abuse services prior to preparing their state plan amendment for establishing health homes (44-46).

6.1.6 OTHER INNOVATIONS

Other initiatives in the ACA that impact FQHCs include a demonstration program, the Advanced Primary Care Practice Demonstration, to test the patient-centered medical homes in FQHCs¹⁰ and a bundled payment initiative, Bundled Payments for Care Improvement, which pairs hospitals with community providers, some of which have considered FQHCs as possible partners.¹¹

6.2 BEHAVIORAL HEALTH INTEGRATION INITIATIVES AT FQHCs

Almost 65% of FQHCs that responded to NACHCs 2010 Behavioral Health Assessment survey exhibited all of the following components of integrated care:

- Services are co-located on site
- Good communication and coordination among behavioral health and primary care providers
- Shared behavioral health treatment plans
- Shared problem lists
- Shared medication and lab results
- Joint decisions on patient treatment (3)

¹⁰ <http://www.fqhcmehicalhome.com/>

¹¹ <http://www.innovations.cms.gov/initiatives/Bundled-Payments/application.html>

The successful implementation of patient-centered medical homes and other primary care and behavioral health integration initiatives requires coordination, collaboration, and communication between FQHCs and behavioral health providers, including community mental health centers (CMHCs). FQHCs are required to make an effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center (11). Katz argues that safety-net providers are incentivized to collaborate because the low-reimbursement rates paid to safety-net providers forces providers to be more efficient (46).

6.2.1 FQHC COLLABORATIONS

FQHCs may collaborate with other organizations in the delivery of behavioral health or other services. While FQHC collaborations are varied, there are several common types (47):

- **Referrals:** The FQHC and partnering agency routinely refer to and provide services for each other's patients.
- **Co-location:** One of the two partnering agencies provides services at the other partner's location with each partner maintaining its own practice and control. SAMHSA promotes bi-directional integration with behavioral health services made available at primary care sites as well as primary care services made available at substance abuse/mental health treatment facilities.
- **Nonexclusive contract:** The FQHC and its partner(s) establish a joint contract to purchase and provide services or capacity and operate these services on behalf of each other. Each partner may have a number of nonexclusive contracts with other partners.
- **Umbrella affiliation agreement:** The FQHC and its partner agree to collaborate on multiple initiatives and work toward common goals. They plan and operate together under a broad, binding affiliation agreement yet they maintain their own practice and control.
- **Corporate integration strategies:** The FQHC and its partner establish a legal agreement where they are each formally involved with the other agency's corporate governance but do not have formal control over the other agency. This allows the two partners to align their activities and goals while remaining independent.
- **New health center sites:** In this arrangement a non-health center provider, that is, a provider that practices outside of a health center, becomes a health center service site of a partnering FQHC. The new health center service site must meet all federal health center requirements and falls under the governance and operations of the existing FQHC.
- **Creating new non-health center entities:** FQHCs and non-health center providers may create a new care center that is separate from the FQHC but is governed jointly by the FQHC and partner(s).

6.2.1.1 A MODEL OF INTEGRATING PRIMARY AND BEHAVIORAL HEALTH SERVICES AT AN FQHC: CHEROKEE HEALTH SYSTEMS

Cherokee Health Systems in Knoxville, Tennessee is an example of an FQHC that was initially created to integrate primary and behavioral health services. From its creation, it has expanded and now includes external collaborations for contracted off-site services. The following description of Cherokee's model is excerpted from Rosenbaum and colleagues' report "Assessing and Addressing Legal Barriers to the Clinical Integration of Community Health Centers and Other Community Providers" (47):

Cherokee Health Systems, Knoxville, Tennessee

Type of integration. Cherokee integrates a full spectrum of primary care and behavioral health services in a single, seamless system, and externally collaborates with other local providers to offer specialty services that complement Cherokee's services. These external collaborations provide electronic access to health information for shared patients.

Background. Cherokee is a large FQHC with 20 sites in 14 counties. Originally established as a mental health center in the 1960s, Cherokee expanded its scope of practice to primary care in 1984 and was an early pioneer in creating a holistic, integrated model of care for the dual provision of primary care and behavioral health care services. This approach closely resembles a patient-centered medical home model wherein primary care and behavioral health clinicians function in teams to seamlessly manage patient care. Primary care patients are automatically screened for behavioral health issues and vice versa, and treatment for both is often provided to patients in the same visit.

Integration details. To implement its internal integration efforts, Cherokee has developed numerous evidence-based intervention and treatment protocols over the years. Primary care and behavioral health clinicians undergo extensive and ongoing training to appropriately manage patient care in accordance with this integrated model. To support and further its commitment and belief in an integrated care model, and to utilize its extensive experience in establishing such a model, Cherokee has created an integrative care training academy that educates providers from across the country on establishing this model of care.

Cherokee's integrative approach has been expanded to external collaborations with local specialists interested in adopting Cherokee's integrated approach to care delivery, including a local sleep center. The sleep center works with Cherokee's behavioral health providers to develop evidence-based intervention protocols for Cherokee's patients with sleep disorders. Similar collaborations have been established with other community providers, resulting in intervention protocols used to assess patient care needs quickly and effectively in Cherokee's clinics. In addition, Cherokee has developed technological capabilities with a local hospital to allow electronic access to patient information for shared patients.

Plans for additional integration. Cherokee continues to identify ways in which it can externally collaborate with local providers to offer patients a full continuum of services, including specialty care.

Perceived legal barriers to integration. Given that Cherokee's initial integration efforts were largely confined to a single entity, the health center perceives few legal barriers to integration. Instead, the primary initial barrier was bridging the cultural divide between mental health and primary care providers. However, Cherokee indicated that legal barriers do exist, most notably those related to payment as an FQHC and reimbursement for behavioral health services, more generally. Further, barriers involving state-based licensure and corporate practice of medicine laws also have arisen.

Cherokee has noted that the FQHC PPS system may limit more global integration of behavioral health care because the PPS payment methodology covers only a portion of the range of services that patients receive. As a result, in the case of its privately insured patients, Cherokee has sought to test other payment models that allow it to receive a more fully global payment covering all phases of health care, with incentive structures that are tied to patient outcomes.

Results of integration. Cherokee reports that its emphasis on integrating primary care and behavioral health and its collaborations to enhance the coordination of care among local providers has had a substantial, positive impact in improving patient care and outcomes. In addition, the close interaction between providers has had a major impact in enhancing provider cultural competency with Cherokee's multiethnic patient population, as well as informal peer review among providers that has increased the qualitative level of provider services and the general standard of documenting patient information and treatment.

6.2.1.2 THINGS TO CONSIDER WHEN EXPLORING AND DEVELOPING COLLABORATIONS

When exploring and developing collaborations with FQHCs, there are a number of issues for public behavioral health providers to consider, including:

- What is the percentage of Medicaid clients and percentage of uninsured clients you serve? This is important in determining the fiscal viability and stability of the partnership.
- Can your consumers access more affordable medication through the 340B prescription drug discounts? How does the 340B drug pricing compare to other prescription discount programs your consumers may have access to?
- What are your state's same-day billing policies? How might they impact the structure of collaboration with an FQHC?
- What types of cross training are important for integrated staff? Which staff can most efficiently provide behavioral health screenings and assessments? Which can most efficiently provide general medical screenings and assessments? What are the potential roles for peer navigators? Determining these training and practice guidelines is important so both organizations may make best use of their workforce.
- Where should patients obtain services? It is important to consider the optimal location for different types of patients to obtain care in a collaborative model. If a patient has more serious chronic medical conditions, he/she should obtain care primarily in primary care settings. However, if a patient has more serious behavioral health conditions, he/she may be better served in specialty behavioral health settings (48).
- How will you share information about consumers? Can your electronic health records interface between departments and with other organizations? When you share information, are you in compliance with federal and state privacy regulations? Do you need to establish Qualified Service Organization agreements?

These are some issues to consider. Collaborations will take effort and present challenges, but integrating behavioral health and primary care through partnerships with FQHCs, community mental health, and substance use treatment service providers is a promising and exciting initiative to improve health and health care in the safety net.

7 CONCLUSIONS

Despite recent developments in policies concerning the provision of substance abuse and mental health services, such as the MHPAEA and ACA, concerted efforts need to be made to expand and integrate behavioral health and primary care services to truly improve access to services and, subsequently, outcomes (49). Financial and administrative policies governing FQHCs impact the integration of behavioral health services. Despite the challenges, models such as the Cherokee Health Systems in Knoxville, Tennessee, demonstrate that FQHCs can successfully integrate behavioral health services into their Centers. SAMHSA, HRSA and CMS have opportunities to educate, train and support FQHCs and behavioral health providers to promote the development of coordinated and integrated services that lead to better, yet less costly, care.

There are a variety of different models of collaboration that FQHCs may adopt to integrate behavioral health and primary care services. The development and implementation of these models may be supported by federal policy makers in a number of ways. The following policy and programmatic changes could result in significant increases in collaborations and integration:

- Building on best practices across the country, federal partners can support training on integrative care for FQHCs and behavioral health providers.
- HRSA can provide technical assistance to help FQHCs figure out the complicated interactions between 330 grant funding, the cost-based reimbursement methods under Medicaid/Medicare and other funding that could be used for behavioral health services at FQHCs. If FQHCs can build a viable business/fiscal model that includes behavioral health services, they might be more likely to include these services in their scope of services.
- HRSA has encouraged expansion of behavioral health services and integration at FQHCs by offering 330 grants to support hiring behavioral health providers and delivering services at new or existing sites.
- States and appropriate federal agencies can specifically fund the provision of behavioral health services at FQHCs through grants. Some states already provide this funding (21).
- CMHCs and other behavioral health providers can collaborate with FQHCs to encourage their Medicaid patients to enroll at the FQHC for general primary care. This would allow access to the less costly 340B pharmacy pricing for these patients' medications. SMAs would benefit from this arrangement for those enrolled in Medicaid.
- Local stakeholders, including FQHCs, CMHCs, SMAs, State Mental Health Authorities (SMHAs), and behavioral health providers, must build partnerships to encourage the best use of financial structures and promote clinical integration.
- Federal partners can provide technical assistance for CMHCs and FQHCs seeking to merge.
- SAMHSA and HRSA might develop a jointly-funded grant opportunity that is only available to behavioral health provider/FQHC pairs seeking to partner.
- HRSA might encourage CMHCs and other behavioral health providers to expand their services to include primary care, either independently or through collaboration, and apply for new FQHC and FQHC Look-Alike designation. HRSA can encourage this by giving some additional proposal scoring points for being a behavioral health provider.
- Federal partners could advocate for changes in federal policies that limit same day billing by FQHCs to allow for multiple visits across service and provider types (e.g., primary care, oral health, behavioral health).

Through a better understanding of the complexities concerning the financing of substance abuse and mental health services within FQHCs, stakeholders at all levels, including federal and state policymakers, health plans, administrators, providers and consumers, can all play a role in improving integration of primary care and behavioral health services.

8 APPENDICES

8.1 APPENDIX A – FQHC COST AND UTILIZATION DATA

Cost and Utilization Policies and Data Reporting at FQHCs

SMAAs and providers may want to understand existing services and plan for future services in their own areas. Access to FQHC cost and utilization data can facilitate this effort. Cost and utilization data for behavioral health services provided at FQHCs exists in Medicaid Analytic eXtract files, the Uniform Data System, and possibly state-level data files from state Primary Care Associations and/or State Medicaid Agencies. Because services provided to Medicare enrollees at FQHCs are currently paid for in an all-inclusive visit rate, there is limited data on services provided at each visit available in Medicare's Standard Analytic Files (50). However, services subject to the Medicare outpatient mental health treatment limitation are billed under a separate revenue code. Medicare FQHC cost report data may be available from state Medicare fiscal intermediaries¹² responsible for collecting FQHC cost reports from most states (52).

Medicaid Analytic eXtract (MAX) files, maintained by CMS, contain some FQHC cost and utilization data. MAX is a person-level data file on Medicaid eligibility, service utilization, and payments. MAX data are derived from the Medicaid Statistical Information System. MAX data includes unique Medicaid provider numbers for FQHCs. MAX data have been used to study substance use service utilization at FQHCs (13). MAX data are available for approved research activities only through a Data Use Agreement with CMS and there is usually a lag time between collection and availability. Complete 2008 data and beta versions of some 2009 and 2010 files are currently available (53).

FQHC grantee cost and utilization data are collected annually by HRSA in the Uniform Data System (UDS) (12). Grantees are required to report data on patients, services, staffing, and financing. These data are collected at different levels (patients, patient sub-samples, or aggregated) depending on the information being reported. UDS data are maintained by the BPHC's Office of Data, Evaluation, Analysis and Research and can be obtained from this office or from NACHC. The aggregated state and national data are publicly available; however, some health center-level staffing and financial data are only available to NACHC and George Washington University.

Before 2012, data from Look-Alikes was collected on paper forms and not reported with grantee data in the UDS. Because UDS data do not account for Look-Alikes, it is likely that UDS data underreport the cost and utilization of care delivery by health centers (8). However, beginning in January 2012, Look-Alikes are required to submit UDS data to HRSA electronically using the same tables described below except table 6A.

¹² Fiscal Intermediaries handle the adjudication of all institutional claims processed. CMS is in the process of replacing the FIs with Medicare Administrative Contractors (MACs) 51. Research Data Assistance Center. Medicare Frequently Asked Questions. 2012 [5/14/12]; Available from: <http://www.resdac.org/medicare/medicarefaq.asp>.

Uniform Data System Tables

FQHCs must report data for the following 11 tables each calendar year. Data collected and policies concerning behavioral health services are discussed for each table.

- **Patient Origin Form: Patients Served by ZIP Code**

Data reported to UDS can only count patients once regardless of the number of different types of services they receive.

- **Table 3A: Patients by Age and Gender**

- **Table 3B: Patients by Race, Ethnicity, and Language**

- **Table 4: Patients by Income (percent of poverty level) and Third Party Medical Insurance Source**

- **Table 5: Full-Time Equivalent Staff by Position, and Visits and Patients by Provider Type and Service Type** Centers using the designation “behavioral health” staff and services are required to divide their staff between the specified mental health and substance abuse services or choose to identify all services as “Mental Health Services.” This table includes:

- ▶ visits and patients for substance abuse services and for mental health services;
- ▶ visits and patients by mental health provider type (psychiatrists, licensed clinical psychologists, licensed clinical social workers, other licensed mental health providers, other mental health staff, and substance abuse services);
- ▶ FTEs for substance abuse services (this includes substance abuse workers, psychiatric nurses, psychiatric social workers, mental health nurses, clinical psychologists, clinical social workers, and family therapists and other individuals providing counseling and/or treatment services related to substance abuse); and
- ▶ FTEs for mental health service providers (psychiatrists, licensed clinical psychologists, licensed clinical social workers, other licensed mental health providers, other mental health staff).

If an FQHC contracts with and pays a provider to provide additional services, including specialty medical and behavioral health services, the providers are counted as staff in this table if the contract is for a portion of an FTE but are not counted if the contract is for a service. Visits to contracted providers are always counted, regardless of method of provider payment or if the service is provided on-site or off-site in the contract provider’s office.

- **Table 6A: Primary Diagnoses for Medical and Mental Health Visits and Selected Medical and Dental Services Provided**

Diagnoses reported on this table are primary diagnoses made by a medical, dental, mental health, or substance abuse provider only, not a case manager. This table reports the number of visits by primary diagnosis, number of patients with primary diagnosis, and visits per patient for the following selected mental health and substance abuse conditions:

Diagnostic Category	Applicable ICD-9-CM Codes
Alcohol Related Disorders	291.xx, 303.xx, 305.0x; 357.5x
Other Substance Related Disorders (Excluding Tobacco Use Disorders)	292.1x - 292.8x, 304.xx; 305.2x - 305.9x, 357.6x; 648.3x
Tobacco Use Disorders	305.1
Depression and Other Mood Disorders	296.xx; 300.4, 301.13; 311.xx
Anxiety Disorders Including PTSD	300.0x; 300.2x, 300.3; 308.3; 309.81
Attention Deficit and Disruptive Behavior Disorders	312.8x; 312.9x; 313.81, 314.xx
Other Mental Disorders, Excluding Drug or Alcohol Dependence (includes mental retardation)	290.xx; 293.xx - 302.xx (Excluding 296.xx; 300.0x, 300.2x; 300.3; 300.4; 301.13), 306.xx - 319.xx (Excluding 308.3; 309.81; 311.xx; 312.8x, 312.9x; 313.81; 314.xx)

Diagnosis and services provided by contracted providers are counted in this table.

- **Table 6B: Quality of Care Indicators**

This table includes a Tobacco Cessation Intervention performance measure. The performance measure is defined as the percentage of patients aged 18 and over who were identified as users of any and all forms of tobacco during the program year or the prior year (i.e., during 2010 or 2011) who received a tobacco use intervention (cessation counseling and/or pharmacological intervention).

- **Table 7: Health Outcomes and Health Disparities**

- **Table 8: Financial Costs**

This table includes FQHCs' direct and indirect expenses, including mental health and substance abuse services expenses. If a "behavioral health" program provides both mental health and substance abuse services, the cost should be allocated between the two programs. Allocations may be based on staffing or visits (from Table 5) or any other appropriate methodology.

- **Table 9D: Patient Related Revenue**

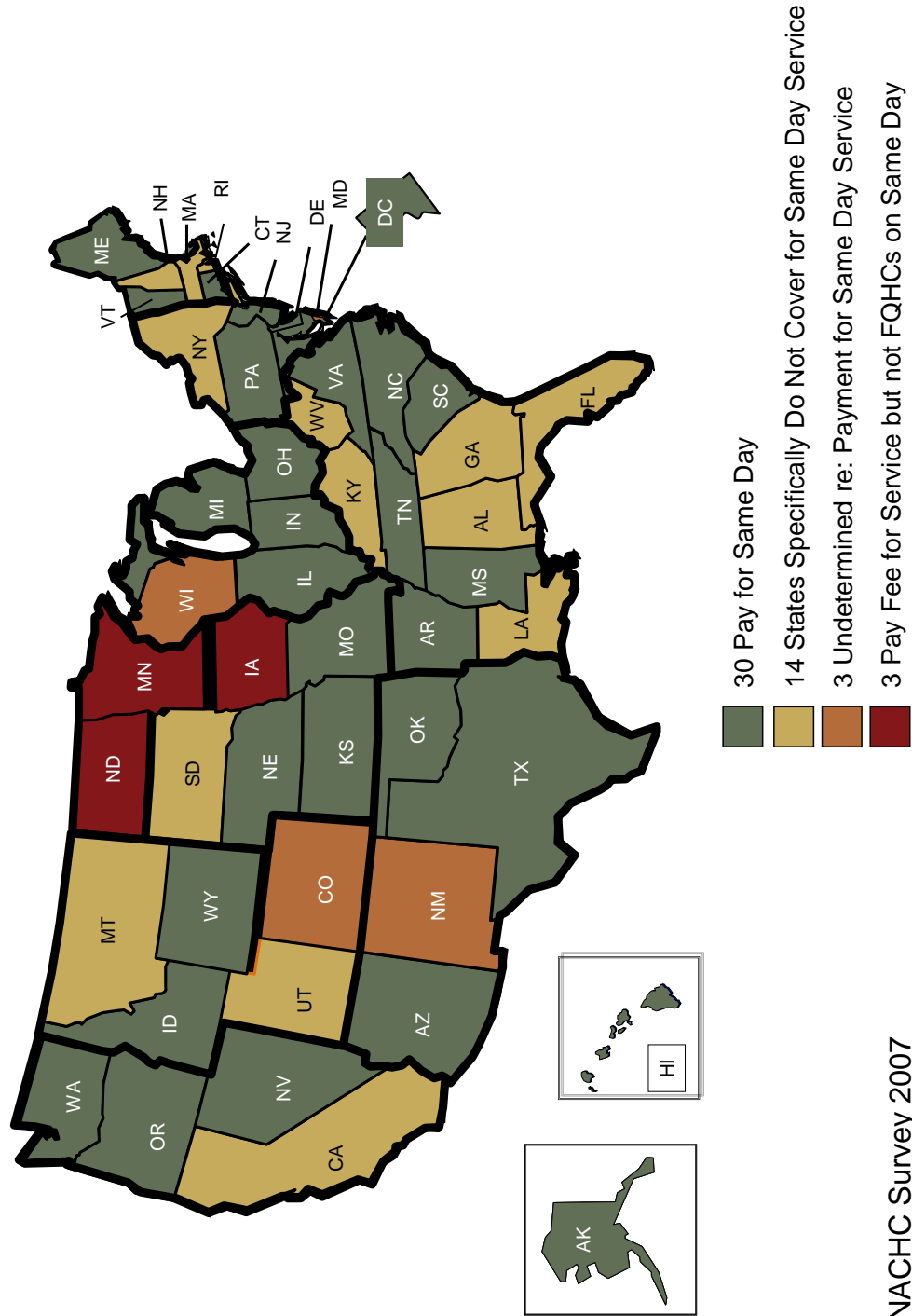
This table includes full charges, collections, and allowances by payer type as well as sliding discounts and patient bad debt. If specialty behavioral health care is provided by a contracted provider on site, the charge for the service is the grantee's usual and customary rate. However, if the care is provided by contracted provider off site, the charge for the service is the contractor's usual and customary rate.

- **Table 9E: Other Revenue**

This table collects information on income received from Section 330 and other grants. The amount of grant funding health centers receive is relevant to understanding behavioral health service provision at FQHCs because research has shown increased federal grant funding increases the probability of FQHCs providing on-site mental health treatment and counseling services, 24-hour crisis intervention services, and substance abuse treatment and counseling services (19).

8.2 APPENDIX B—STATES PAYING FOR BEHAVIORAL HEALTH VISITS ON SAME DAY AS MEDICAL VISIT (26)

States Paying for Behavioral Health Visits On Same Day as Medical Visit*



*NACHC Survey 2007

8.3 APPENDIX C – ADDITIONAL RESOURCES

Health Resources and Services Administration (HRSA)

www.hrsa.gov

Websites

Bureau of Primary Health Care Home
bphc.hrsa.gov/index.html

About Health Centers
bphc.hrsa.gov/about/index.html
 Includes program requirements and benefits

Operating a Health Center
bphc.hrsa.gov/policiesregulations/index.html
 Includes information on policies, legislation, and regulations

Health Center Data
bphc.hrsa.gov/healthcenterdatastatistics/index.html

Technical Assistance
bphc.hrsa.gov/technicalassistance/index.html

Primary Care Associations:
bphc.hrsa.gov/technicalassistance/partnerlinks/associations.html

Relevant Policy Information Notices (PINs)/Program Assistance Letters (PALs)

PIN 2009-06: Federally Qualified Health Center Look-Alike Guidelines and Application FAQs
bphc.hrsa.gov/policiesregulations/policies/pdfs/pin200906faqs.pdf

PIN 2005-05: Medicaid Reimbursement for Behavioral Health Services
bphc.hrsa.gov/policiesregulations/policies/pdfs/pin200405.pdf

National Association of Community Health Centers (NACHC)

www.nachc.com

Websites

Health Center Information
www.nachc.com/health-center-info.cfm

Research & Data
www.nachc.com/research-data.cfm
 Includes data and maps, tools for research, reports, fact sheets, and research snapshots.

Publications & Resources
www.nachc.com/publications.cfm

Relevant Reports and Resources

An Assessment of Behavioral Health Services in FQHCs, January 2010
http://www.nachc.com/client/NACHC%202010%20Assessment%20of%20Behavioral%20Health%20Services%20in%20FQHCs_1_14_11_FINAL.pdf

Health Centers' Role in Addressing the Behavioral Health Needs of the Medically Underserved, September 2004
www.nachc.com/client/documents/publications-resources/ib_8_04.pdf

Billing 101 Webinar Series
www.nachc.com/Billing101WebinarSeries.cfm

Update on the Status of the FQHC Medicaid Prospective Payment System in the States, November 2011
www.nachc.com/client//2011%20PPS%20Report%20SPR%2040.pdf

Health Center Reimbursement for Behavioral Health Services in Medicaid, November 2010
www.nachc.com/client/Reimbursement%20for%20Behavioral%20Health%20Services_MentalHealthSA_PPSReport-%20Final%20Nov%202010.pdf

Centers for Medicare & Medicaid Services

Federally Qualified Health Centers (FQHC) Center
www.cms.gov/center/fqhc.asp

Substance Abuse and Mental Health Services Administration

www.samhsa.gov

Coding for SBIRT Reimbursement
www.samhsa.gov/prevention/SBIRT/coding.aspx

Reimbursement for Mental Health Services in Primary Care
www.integration.samhsa.gov/financing/SMA08-4324.pdf

SAMHSA-HRSA Center for Integrated Health Solutions

www.integration.samhsa.gov

Strategies and Opportunities
www.thenationalcouncil.org/cs/strategies_opportunities

Integrated Care Models
www.integration.samhsa.gov/integrated-care-models

Paying for Primary Care and Behavioral Health Services Provided in Integrated Care Settings
www.integration.samhsa.gov/financing/billing-tools
 Interim state-based billing and financial worksheets, includes FQHC services, diagnostic codes, and providers billable to Medicare and Medicaid.

The National Council for Community Behavioral Health

www.thenationalcouncil.org

Increasing Access to Behavioral Healthcare: Managed Care Options and Requirements, July 2011
www.thenationalcouncil.org/galleries/business-practice%20files/Increasing%20Access%20to%20Managed%20Care%20Report.pdf

Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home, 2009
www.thenationalcouncil.org/galleries/resources-services%20files/Integration%20and%20Healthcare%20Home.pdf

Behavioral Health/Primary Care Integration: Finance, Policy and Integration of Services, 2006
www.thenationalcouncil.org/galleries/business-practice%20files/Finance-Policy-Integration.pdf

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