Paying for Integrated Services: FQHC, Medi-Cal and other Funding Strategies

Presented by
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MCPP Healthcare Consulting
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Assumptions about the Attendees

- You are *somewhere in the process* of integrating Primary Care (PC)/Mental Health (MH)/Substance Use (SU) services (planning or doing)
- You want to *get paid* for this work
- You are probably not a *triple expert* in how California financing is designed for FQHCs, Mental Health AND Alcohol & Drug Services
- You may or may not have run into the various *financing barriers*
- You’d like to expand you knowledge in these areas in order to *increase the likelihood of success* for your integration project
Assumptions about the Attendees

- You are working on one or both parts of the **bi-directional model** of Integrated Care; but I'm going to assume both:
- You are attempting to provide Medical Services in MH/SU
- And MH/SU Services in Primary Care
- Using the 4 quadrant integration model and researched-based clinical designs such as the IMPACT model

The 4 Quadrant Clinical Integration Model

**Q I and III: MH/SU services in a Primary Care Clinic**

**Q II and IV: Primary Care services in a MH/SU Clinic**

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### Quadrant II

- MH/SU
- PH

- Outstationed medical nurse/practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP
- MH/SU clinician/case manager w/ responsibility for coordination w/ PCP
- Specialty outpatient MH/SU treatment including medication-assisted therapy
- Residential MH/SU treatment
- Crisis/ED based MH/SU interventions
- Detox/sobering
- Wellness programming
- Other community supports

### Quadrant IV

- MH/SU
- PH

- Outstationed medical nurse/practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP
- Nurse care manager at MH/SU site
- MH/SU clinician/case manager
- External care manager
- Specialty medical/surgical
- Specialty outpatient MH/SU treatment including medication-assisted therapy
- Residential MH/SU treatment
- Crisis/ED based MH/SU interventions
- Detox/sobering
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

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**Physical Health Risk/Complexity**

**MH/SU Risk/Complexity**

<table>
<thead>
<tr>
<th>Physical Health Risk/Complexity</th>
<th>MH/SU Risk/Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Outstationed medical nurse/practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP</td>
</tr>
<tr>
<td>High</td>
<td>Nurse care manager at MH/SU site</td>
</tr>
</tbody>
</table>

**Assumptions about the Attendees**

- Persons with serious MH/SU conditions could be served in all settings. Plan for and deliver services based upon the needs of the individual, personal choice and the specifics of the community and collaboration.
Three Chapters

- Basics of Current California Primary Care, Mental Health and Substance Use Financing
- How can we get Paid Today?
- How are we going to get Paid Tomorrow?
- Q&A
A Tale of 3 Siblings

This session is really a story of 3 “safety net” siblings separated when children - the Health (FQHC), MH and SU (ADP) Systems

Funding Levels for Health, Mental Health and Substance Use

- Health: 88%
- Mental Health: 11%
- Alcohol & Drug: 1%

$41.3 billion for Health
$5.9 billion for MH and SU
90/10% Medi-Cal/Non
61/39% Medi-Cal/Non
Funding Flows for Health, Mental Health and Substance Use

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Priority Populations</th>
<th>Non-Priority Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal Health Services ($40 Billion)</td>
<td>Mostly Managed Care</td>
<td>Mostly FFS</td>
</tr>
<tr>
<td>Medi-Cal Mental Health Services ($2.3 Billion)</td>
<td>Mostly FFS</td>
<td></td>
</tr>
<tr>
<td>Drug Medi-Cal ($204 Million)</td>
<td>Mostly FFS</td>
<td></td>
</tr>
<tr>
<td>Non-Medi-Cal MISP, CMSP Mental Health Services</td>
<td>Mostly FFS</td>
<td></td>
</tr>
<tr>
<td>Non-Medi-Cal Mental Health Services</td>
<td>Mostly FFS</td>
<td></td>
</tr>
<tr>
<td>Non-Medi-Cal ADP Federal, State, Local</td>
<td>Mostly FFS</td>
<td></td>
</tr>
</tbody>
</table>

Cliff Notes: Funding

- California has 57 Medi-Cal Mental Health Plans that operate under contract with the California Department of Mental Health (Sutter-Yuba combined)
- Realignment funded through sales tax and vehicle license fees is combined with Federal Financial Participation (FFP or FMAP) to fund Medi-Cal Mental Health Services
- Realignment is also used, along with Mental Health Services Act (MHSA) monies to fund non-Medi-Cal services and non-Medi-Cal enrollees
Mental Health Cliff Notes: Funding

- California’s Medi-Cal Mental Health funding is primarily Fee for Service with a Back End Cost Report Settlement Process
- Fees are capped by a Schedule of Maximum Allowable (SMA)
- Plus Funding for Administrative and Quality Assurance Activities
- Realignment and some MHSA serve as the state/local match; if you use them all up, you can’t draw down any more federal Medi-Cal dollars
- The majority of public mental health services in California are provided by County Employees, supplemented by Other Community Providers

Mental Health Cliff Notes: MHSA

- Mental Health Service Act passed in November 2004 via Proposition 63, increasing funding to support county mental health programs
- The MHSA imposes a 1% income tax on personal income in excess of $1 million generating over $1 billion per year
- Targeted Funding to six categories
- Non-Supplantation: “The funding established pursuant to this act shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services.”
- With this funding, California only has roughly half the funding needed to meet demand
<table>
<thead>
<tr>
<th>State</th>
<th>Total State Mental Health Revenue</th>
<th>Target # of Persons to Serve/Year</th>
<th>Revenue per Target Client</th>
<th>Rank</th>
<th>$ Over (Under) Top 10 Average</th>
<th>% Over (Under) Top 10 Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pennsylvania</td>
<td>$3,332,904,698</td>
<td>544,949</td>
<td>$6,116</td>
<td>1</td>
<td>$1,644</td>
<td>37%</td>
</tr>
<tr>
<td>Maine</td>
<td>$464,300,000</td>
<td>76,362</td>
<td>$6,080</td>
<td>2</td>
<td>$1,608</td>
<td>36%</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>$229,400,000</td>
<td>38,093</td>
<td>$6,022</td>
<td>3</td>
<td>$1,550</td>
<td>35%</td>
</tr>
<tr>
<td>Alaska</td>
<td>$183,200,000</td>
<td>33,512</td>
<td>$5,467</td>
<td>4</td>
<td>$995</td>
<td>22%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>$166,100,000</td>
<td>38,394</td>
<td>$4,326</td>
<td>5</td>
<td>-$146</td>
<td>-3%</td>
</tr>
<tr>
<td>Maryland</td>
<td>$810,000,000</td>
<td>233,097</td>
<td>$3,475</td>
<td>6</td>
<td>-$997</td>
<td>-22%</td>
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<tr>
<td>New Jersey</td>
<td>$1,241,600,000</td>
<td>365,082</td>
<td>$3,401</td>
<td>7</td>
<td>-$1,071</td>
<td>-24%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>$721,100,000</td>
<td>213,635</td>
<td>$3,375</td>
<td>8</td>
<td>-$1,096</td>
<td>-25%</td>
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<tr>
<td>Vermont</td>
<td>$122,500,000</td>
<td>36,426</td>
<td>$3,363</td>
<td>9</td>
<td>-$1,109</td>
<td>-25%</td>
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<tr>
<td>New York</td>
<td>$3,982,300,000</td>
<td>1,287,434</td>
<td>$3,093</td>
<td>10</td>
<td>-$1,379</td>
<td>-31%</td>
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<tr>
<td><strong>Top 10 Average</strong></td>
<td><strong>$4,472</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Montana</td>
<td>$137,500,000</td>
<td>51,778</td>
<td>$2,656</td>
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<td>-41%</td>
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<td>Wisconsin</td>
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<td>-$1,870</td>
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<td>Wyoming</td>
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<td>$2,364</td>
<td>13</td>
<td>-$2,108</td>
<td>-47%</td>
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<td>Iowa</td>
<td>$299,300,000</td>
<td>133,468</td>
<td>$2,242</td>
<td>14</td>
<td>-$2,229</td>
<td>-50%</td>
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<td>Arizona</td>
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<td>447,683</td>
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<td>California</td>
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<td>2,474,848</td>
<td>$2,142</td>
<td>16</td>
<td>-$2,330</td>
<td>-52%</td>
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<td>Oregon</td>
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<td>202,819</td>
<td>$2,131</td>
<td>17</td>
<td>-$2,340</td>
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<td>North Carolina</td>
<td>$1,105,400,000</td>
<td>530,609</td>
<td>$2,083</td>
<td>18</td>
<td>-$2,389</td>
<td>-53%</td>
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<td>Michigan</td>
<td>$1,010,000,000</td>
<td>485,839</td>
<td>$2,079</td>
<td>19</td>
<td>-$2,393</td>
<td>-54%</td>
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<td>Washington</td>
<td>$624,500,000</td>
<td>304,553</td>
<td>$2,051</td>
<td>20</td>
<td>-$2,421</td>
<td>-54%</td>
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<td>Missouri</td>
<td>$597,500,000</td>
<td>294,546</td>
<td>$2,029</td>
<td>21</td>
<td>-$2,443</td>
<td>-55%</td>
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**Alcohol & Drug Cliff Notes:**

- A combination of many funding sources managed at the state or county level
- Each with their own set of restrictions and target populations
- Paid in a variety of ways and also includes a Cost Reporting Settlement Process
- Medi-Cal = 1/3, Federal Grants = 1/2, Other State = 1/6
- Funding levels are even further from approaching need than Mental Health
- And will be found to be significantly out of compliance with the new Parity Law, like many other states
Alcohol & Drug Cliff Notes: Program Budget

California DADP Budget, FY2010-11

<table>
<thead>
<tr>
<th>Description</th>
<th>General Fund</th>
<th>Other State</th>
<th>Federal Grants &amp; Reimbursements</th>
<th>Medi-Cal SGF</th>
<th>Medi-Cal FMAP</th>
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<tr>
<td>Non-DMC Regular Services</td>
<td>$5,189,000</td>
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<td>$5,189,000</td>
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<td>Non-DMC Perinatal Services</td>
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<td>$20,448,000</td>
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<td>Drug Court Partnership</td>
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<td>Comprehensive Drug Court Implementation Act Prgm</td>
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<td>Dependency Drug Court Program</td>
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<td>$4,548,000</td>
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<td>Parolee Services</td>
<td>$33,900,000</td>
<td>$11,184,000</td>
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<td>$45,084,000</td>
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<td>Drug Medi-Cal Regular</td>
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<td>Drug Medi-Cal Perinatal</td>
<td>$87,847,000</td>
<td>$108,106,000</td>
<td>$195,953,000</td>
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<td>HIPAA</td>
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<td>$785,000</td>
<td>$1,570,000</td>
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<td>Residential &amp; OP Program (ROPLF)</td>
<td>$4,479,000</td>
<td>$661,000</td>
<td>$5,140,000</td>
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<td>DUI Program</td>
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<td>Narcotic Tx Program</td>
<td>$1,418,000</td>
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<td>Indian Gaming Special Distribution Fund</td>
<td>$8,484,000</td>
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<td>Audit Repayment Trust Fund</td>
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<td>MHSA Prop 63</td>
<td>$272,000</td>
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<td>Gambling Addiction Program</td>
<td>$166,000</td>
<td>$125,000</td>
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<td>SA Block Grant</td>
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<td>SDPSC Grant</td>
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<td>UDS</td>
<td>$327,000</td>
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<td>Access to Recovery Grant</td>
<td>$4,839,000</td>
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<td>SBIRT Grant</td>
<td>$2,889,000</td>
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<td>SEOW</td>
<td>$157,000</td>
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<tr>
<td>Other</td>
<td>$319,000</td>
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<td></td>
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<tr>
<td>Totals</td>
<td>$87,408,000</td>
<td>$16,577,000</td>
<td>$284,324,000</td>
<td>$91,382,000</td>
<td>$112,713,000</td>
<td>$592,404,000</td>
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Cliff Notes: Drug Medi-Cal Rates, FY2009

<table>
<thead>
<tr>
<th>Program Code: 20 (Alcohol and Drug Services)</th>
<th>Service Function Code</th>
<th>Unit of Service (UOS)</th>
<th>FY 2008-09 UOS Rate</th>
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</thead>
<tbody>
<tr>
<td>Narcotic Treatment Program (NTP) - Methadone</td>
<td>20-21</td>
<td>Daily</td>
<td>$12.44</td>
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<tr>
<td>NTP - Methadone - SACPA Clients</td>
<td>22</td>
<td></td>
<td>1.14 (°)</td>
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<tr>
<td>NTP - Individual Counseling (**)</td>
<td>26</td>
<td>One 10-minute</td>
<td>$15.00</td>
</tr>
<tr>
<td>NTP - Individual Counseling - SACPA Clients (**)</td>
<td>27</td>
<td>Increment</td>
<td>1.37 (°)</td>
</tr>
<tr>
<td>NTP - Group Counseling (**)</td>
<td>28</td>
<td>One 10-minute</td>
<td>$3.49</td>
</tr>
<tr>
<td>NTP - Group Counseling - SACPA Clients (**)</td>
<td>29</td>
<td>Increment</td>
<td>0.32 (°)</td>
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<tr>
<td>Day Care Rehabilitative (DCR)</td>
<td>30-36</td>
<td>Face-to-Face</td>
<td>$67.96</td>
</tr>
<tr>
<td>DCR - SACPA Clients</td>
<td>39</td>
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<td></td>
</tr>
<tr>
<td>Naltrexone (NAL) (**)</td>
<td>50-58</td>
<td>Face-to-Face</td>
<td>$21.19</td>
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<tr>
<td>NAL - SACPA Clients (***)</td>
<td>59</td>
<td>Visit</td>
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<tr>
<td>Outpatient Drug Free (ODF) Individual Counseling</td>
<td>80-83</td>
<td>Face-to-Face Visit (Per Person)</td>
<td>$74.99</td>
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<tr>
<td>ODF Individual Counseling - SACPA Clients</td>
<td>84</td>
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<tr>
<td>ODF Group Counseling</td>
<td>85-88</td>
<td>Face-to-Face Visit (Per Person)</td>
<td>$31.45</td>
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<tr>
<td>ODF Group Counseling - SACPA Clients</td>
<td>89</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Alcohol & Drug Cliff Notes:
National Estimates & Issues

- SU conditions are prevalent in primary care: Tens of millions (McLellan); 21% + (Willenbring)
- SU conditions add to overall healthcare costs, especially for Medicaid
- SU conditions can cause or exacerbate other chronic health conditions
- SU interventions can reduce healthcare utilization and cost

In Treatment ~2.3 million

“Abuse/Dependence” ~23 million

“Unhealthy Use” ?? million

Little/No Substance Use

FQHC Cliff Notes: Federal Program Managed by HRSA

Grants
- Funding Opportunities
- Find Grant Awards
- Be a Grant Reviewer
- State Profiles: Grant Awards

Find Help
- Health Care Regardless of Your Ability to Pay
- Health Professions Scholarships, Loans & Repayment
- Vaccines Injury Compensation
- Countermeasures Injury Compensation
- Heroin Disease Treatment & Research

News

- President Obama Announces Recovery Act Awards to Build, Renovate Community Health Centers in More Than 30 States (12/09/2009)
- President Obama Announces Recovery Act Funding for Community Health Centers (12/09/2009)
- HRSA Congressional Budget Justification and Performance Appendix

HRSA Department of Health and Human Services
Health Resources and Services Administration

HRSA
www.hrsa.gov

Health Centers
Where to go for care you can afford

In Treatment ~2.3 million

“Abuse/Dependence” ~23 million

“Unhealthy Use” ?? million

Little/No Substance Use
FQHC Cliff Notes: Definition of a Federally Qualified Health Center

An FQHC is an entity that receives a grant under Section 330 of the Public Health Service Act

- (1) **In general.** For purposes of this section, the term "health center" means an entity that **serves a population** that is:
  - medically underserved, or
  - a special medically underserved population comprised of:
    - migratory and seasonal agricultural workers,
    - the homeless, and
    - residents of public housing,
- by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements, **required primary health services**
An FQHC is:
An entity that receives a grant under Section 330 of the Public Health Service Act – Health Center Program including:
- Community Health Center Program – Section 330(e) note that school-based health centers must also meet these requirements, per PIN #2001-13
- Migrant Health Center Program – Section 330(g)
- Health Care for the Homeless Program – Section 330(h)
- Public Housing Primary Care Program – Section 330(i)
- An entity that is determined by DHHS to meet requirements to receive funding without actually receiving a grant (i.e., FQHC “Look-Alike”)

FQHC Cliff Notes – Five Decades of Unfolding

<table>
<thead>
<tr>
<th>Decade</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960s</td>
<td>Migrant Health Act of 1962 for farm workers/families&lt;br&gt;Economic Opportunity Act of 1964 funds CHCs</td>
</tr>
<tr>
<td>1970s</td>
<td>Section 330 of the Public Health Services Act&lt;br&gt;- Community Health Center Program – Section 330(e)&lt;br&gt;- Migrant Health Center Program – Section 330(g)&lt;br&gt;National Health Service Corps begins</td>
</tr>
<tr>
<td>1980s</td>
<td>Health Care for the Homeless Program – Section 330(h)&lt;br&gt;The 3 Types of CHCs become known as FQHCs&lt;br&gt;FQHC Cost-Based Payments for Medicare &amp; Medicaid</td>
</tr>
<tr>
<td>1990s</td>
<td>Free Federal Tort Protection (Malpractice Insurance)&lt;br&gt;Public Housing Primary Care Program – Section 330(i)</td>
</tr>
<tr>
<td>2000s</td>
<td>Prospective Payment System&lt;br&gt;States Required to Cover Difference between Rates &amp; PPS&lt;br&gt;Expansion of Funding and Capacity, adding BH Services</td>
</tr>
</tbody>
</table>
FQHC Cliff Notes: California

- California Primary Care Association is designated by the Federal Bureau of Primary Health Care as the state primary care association and receives federal program support to develop and enhance services for 800+ member clinics; not all are FQHCs and County FQHCs are not members
- California Department of Public Health, Center for Health Care Quality licenses FQHCs
- California Department of Health Care Services (DHCS) interprets federal policy regarding FQHCs, with the bulk of the rule setting being done by Federal BPHC through PINs (Policy Information Notices) and PALs (Program Assistance Letters)

FQHC Cliff Notes: Payments

- FQHC Medi-Cal Reimbursement: All Inclusive Rate Per Visit
- Visit = Face to Face Encounter with an approved provider, providing an approved service, at an approved site
- FQHC Per Visit Payment = a Prospective Payment (PPS) that is adjusted annually based on Federal law
- California has a wraparound process for the PPS system—this is a reconciliation process for backfilling the difference between the PPS rate and what ended up being paid during the year through Managed Care, the Child Health and Disability Prevention program, and Medi-Medi Crossover visits
- Unlike some other states, California does not require the submission of annual Cost Reports
| 1. Operating Grants | Federal Grants to support the costs of uncompensated primary health care and enabling services delivered to uninsured and underinsured populations at sites within the approved scope of project |
| 2. Medicaid Reimbursement | Enhanced reimbursement under Prospective Payment System (PPS) or other state-approved alternative payment methodology; every service provided is a mandatory Medicaid service (i.e. can’t get cut) |
| 3. Medicaid Enrollment Workers | The right to have Medicaid eligibility workers on site, or receive reimbursement for outstationed intake and enrollment conducted by Center personnel |
| 4. Medicare Reimbursement | PPS-type reimbursement by Medicare for the “first dollar” of services rendered to Medicare beneficiaries (deductible is waived) |
| 5. Capital Improvements | Access to Federal loan guarantees for developing and operating managed care and practice management networks or plans and capital improvements (including IT) |
| 6. Drug Pricing | Access to favorable drug pricing under Section 340B of the PHS Act; centers that provide, or contract for the provision of, pharmaceuticals are entitled to favorable pricing from the drug manufacturers |
| 7. Safe Harbor | Safe harbor under the Federal anti-kickback statute for waiver of co-payments patients below 200% FPL; certain arrangements with other providers or suppliers of goods, services, donations, loans, etc. |
| 8. FTCA Coverage | Access to Federal Tort Claims Act (FTCA) coverage for the Center and its health care professionals, including certain contracted professionals in lieu of purchasing malpractice insurance |
| 9. Recruitment | Access to providers through the National Health Service Corps if the Center’s service area is designated as a health professional shortage area |
| 10. Quality Improvement | The opportunity to participate in BPHC disease management learning models and the Health Disparities Collaboratives |
### FQHC Cliff Notes: Requirements

**1. Eligible Entities**
- Private, charitable, tax-exempt nonprofit organization or public entity; Note: FQBHC could add: plus Licensed or certified by the State in which it is located as a CMHC or SU Provider

**2. Service Area**
- In order for a primary care clinic to qualify for FQHC status, it must be located in a high need designated area (designated as a Medically Underserved Areas or Medically Underserved Population)

**3. Target Population**
- Each FQHC must identify the medically underserved population to be served; Note: FQBHCs will focus on residents with MH/SU disorders

**4. Clinical Operations**
- Must employ a core staff of clinical staff that is multidisciplinary, and culturally and linguistically competent; must provide an agreed-upon set of clinical services directly or through contract

**5. Service Providers**
- Providers are individual healthcare professionals who exercise independent judgment and document services in the patient’s record; Note: FQBHC add language - peers and non-licensed providers to work under the oversight of a licensed provider

**6. IT System**
- Must have an IT system that is able to collect, organize and analyze data for reporting and to support management decision-making and submit the Uniform Data System (UDS)

**7. Quality Improvement Activities**
- FQHCs must participate in Health Disparities Collaboratives and other structured quality improvement activities

**8. Productivity Expectations**
- Physicians are expected to provide 4,200 encounters and midlevel clinicians 2,100 encounters per FTE per year
Where FQHC Funding is Headed

- Healthcare Reform Law – March 2010
  - FQHCs are acknowledged as a critical component of healthcare reform
  - Grant Funding will nearly triple over five years

<table>
<thead>
<tr>
<th>Year</th>
<th>Grant Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2010</td>
<td>$2.98B</td>
</tr>
<tr>
<td>FY2011</td>
<td>$3.86B</td>
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<tr>
<td>FY2012</td>
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<td>FY2013</td>
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<td>FY2014</td>
<td>$7.33B</td>
</tr>
<tr>
<td>FY2015</td>
<td>$8.33B</td>
</tr>
</tbody>
</table>

On the Horizon? FQBHCs

- Language from the PPACA that didn’t make it into the final bill but will likely resurface
- Possibly in the SAMHSA reauthorization process

“(c) CRITERIA FOR FEDERALLY QUALIFIED BEHAVIORAL HEALTH CENTERS.—

“(1) IN GENERAL.—The Administrator shall certify, and recertify at least every 5 years, federally qualified behavioral health centers as meeting the criteria specified in this subsection.

“(2) REGULATIONS.—Not later than 18 months after the date of the enactment of the Affordable Health Care for America Act, the Administrator shall issue final regulations for certifying centers under paragraph (1).
How can we get Paid Today?

6-Step Integration Game Plan

The emerging Best Practice involves developing a workgroup of local PC/MH/SU integration partners to:

1. Design the **Clinical Model** you will implement (what works best for the patient/consumer)
2. Identify and address the **Funding Barriers**
   - Draw on the Integration Policy Initiative Report (see next slide) and **local resources** to address barriers within your expertise
   - Get **additional help** to address the barriers you think may be solvable but can’t figure out on your own
3. Craft an **Integration Budget** based on this work, sorting what will be funded by PC/MH/SU
4. Revise your **Business Processes** and **Obtain Necessary Approvals** to support the Clinical Design and achieve financial stability
5. Design your **Implementation Plan** that covers all the necessary tasks
6. Go for it, **monitoring and adjusting** your plan as you move forward

Note: the IBHP toolkit has more details ([www.ibhp.org](http://www.ibhp.org))
California is Leading the Way with Numerous Integration Projects

New Patient’s first Visit to PCP includes behavioral health screening
Possible BH Issues?
Behavioral Health Assessment by BH Professional, working in primary care
Need BH Services?
Clients with Low to Moderate BH need enrolled in Level 1; to be case managed and served in primary care by PCP and BH Care Coordinator with support from Consulting Psychiatrist and other clinic-based Mental Health Providers
Clients with High to Moderate BH need referred to Level 2 specialty care; PCP continues to provide medical services and BH Care Coordinator maintains linkage; this is a time-limited referral with expectation that care will be stepped back to primary care

Referrals to other needed services and supports (e.g. CSO, Vocational Rehabilitation)

Person Centered Healthcare Home Clinical Design based on IMPACT Model
- Systematic outcomes tracking (e.g., PHQ-9 for depression, GAD-7 for anxiety)
- Treatment adjustment as needed including stepped care (e.g. up to specialty BH) (based on clinical outcomes, evidence-based algorithm; in consultation with team psychiatrist)
- Relapse prevention
Identify & Address Funding Barriers

- Because *All Healthcare is Local*, a Primary Care, Mental Health, Substance Use Ecosystem has evolved in each community in California that has assembled the PC/MH/SU pieces differently, working within the state and federal funding frameworks
- Six sets of issues were identified by the Integration Policy Initiative, (Volume II) as a result of studying these “ecosystems”
- Some things currently can’t be funded by PC, some can’t be funded by MH, some can’t be funded by SU

Caveat about Addressing Barriers

- Many of the financing barriers that have been identified are the result of federal or state law/regulation that would need to be changed before they stop being a barrier
- This creates a “Serenity Prayer” moment: grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference
- And pushes a number of issues over into the “how do I get paid tomorrow” category
- **Service Codes/Allowable Costs**

  - **FQHC Billing:** The Feds have very clear rules governing this issue. Generally, an FQHC can modify its “Scope of Project” to expand the Services, Sites, and/or Providers covered by the FQHC. Look to PIN 2008-01 and PIN 2009-02 for guidance, making sure to obtain Prior Approval from the BPHC.

  - **Same Day Billing Restriction:** NOT a Federal issue. In California, AB 1445 was introduced in 2009 to allow Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) to bill up to two visits per day and receive federal matching funds in order to address this problem. This would require a Medicaid State Plan Amendment by the State and necessitate a Change in Scope by the FQHC/RHC in order to obtain an adjustment in the per visit rate. This bill, which has not yet been passed into law, should be supported in order to address the identified barrier.
Site of Service

- **Psychiatric Consultation to PCP or Care Mgr:** This is an example of where we need to say the Serenity Prayer and acknowledge that the Feds won’t pay for a consultation where the person has not been directly seen by the Psychiatrist. This is an issue that needs to be address through Healthcare Payment Reform through the adoption of new payment models that cover the costs of evidence-based care and care management.

- **Email, Telephone, Telemedicine:** As above, not billable. As above, another example of Federal regulation not catching up with current practice.

- **Site Certification Processes:** Yes, we have to say the Serenity Prayer again. This time, California needs to address these barriers. **Important:** California will have to “radically alter” its Drug Medi-Cal benefit because it is vastly out of compliance with the Parity and Health Reform Laws; this will be an opportunity to address numerous, outdated regulations and practices.

Who Can Provide/Bill

- **No MFT/LPC in FQHCs:** The Healthcare Reform Law has new definitions for Mental Health Service Professionals that includes: “an individual with a graduate or post-graduate degree.. in.. substance use disorder prevention and treatment, marriage and family counseling, school counseling, or professional counseling.” I’m assuming that the FQHC regulations will need to be updates accordingly. Clarification needs to be pursued.

- **No Recognition of Team-Based Care:** Another issue that needs to be address through Healthcare Payment Reform through the adoption of new payment models that cover the costs of evidence-based care and care management.
Service Limits

- There are a number of service limits that are imposed through California regulations.
- This includes the California Code of Regulations that make it difficult to provide mental health services to persons with mild/moderate need in mental health (1830.205).
- And lists as “excluded services” for County Mental Health Programs, specialty mental health services provided by FQHC, IHCs and RHCs.
- Changes to support integrated care should be addressed when the 1915(b) Medicaid mental health waiver is renewed.

Target Populations and Consumer Coverage

- When an FQHC expands its Scope of Practice to add MH/SU Services, Sites, and/or Providers, the FQHC has to make those services available to all patients; i.e. they cannot say, “Oh, we’re just adding MH/SU for Medi-Cal enrollees because we’d go broke if we also provided these services to the uninsured.
- The California 1115 Waiver Renewal with expansion of the Coverage Initiatives and Medicaid Expansion will radically alter this equation.
Identify & Address Funding Barriers

- There is a great deal of local expertise that have figured out what can and can't be done in this environment
- Study Volume III of the IPI Report ([www.ibhp.org](http://www.ibhp.org))
- CIMH is attempting to obtain funding to develop a *Toolkit of Promising Practices for Financing Integrated Care in the California Safety Net*, which could be available by Fall 2010
- Examples Include:
  - San Mateo County Behavioral Health Services hired and placed clinicians, all supervised and with one exception paid for by them, in each of six primary clinic sites. The clinicians provide treatment and arrange access to more intensive mental health services should clients need it.
  - Stanislaus County Behavioral Health outstationed four LCSW's at four County-run primary care clinics funded with MHSA PEI funds.
  - A nurse practitioner from Tom Waddell Health Center in San Francisco comes to South of Market County Mental Health Services twice a week to conduct assessments, triage, preliminary treatment and referrals.

Budget Who will Fund What

- Budget the clinical design, identifying the Clinician, Service, Site and Funding Sources
- Remember to take into account the possibility of higher no show rates for consumers with serious MH/SU disorders

<table>
<thead>
<tr>
<th>Clinician</th>
<th>Service</th>
<th>Site</th>
<th>Funding Source</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IMPACT Model Team</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>Prescriber</td>
<td>FQHC</td>
<td>FQHC PPS</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Professional</td>
<td>Care Coor, Tx</td>
<td>FQHC</td>
<td>Short Doyle Medi-Cal, Realignment</td>
<td>For Medi-Cal, Non-Medi-Cal</td>
</tr>
<tr>
<td>Consulting Psychiatrist</td>
<td>Consultation</td>
<td>FQHC</td>
<td>MHSA PEI</td>
<td></td>
</tr>
<tr>
<td><strong>Primary Care Team in MH Center</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>Primary Care</td>
<td>MH Center</td>
<td>FQHC PPS</td>
<td>Expand Scope of Practice</td>
</tr>
<tr>
<td>Primary Care Supervising MD</td>
<td>Supervision</td>
<td>MH Center</td>
<td>FQHC PPS</td>
<td></td>
</tr>
</tbody>
</table>
Revise Business Processes & Obtain Approvals

- There are numerous details that may tease out additional startup and ongoing expenditures that will need to be wrapped back into the budget
  - Does the FQHC need a change in Scope of Project?
  - Who will own Charts and how will documentation be shared?
  - Will a shared Patient Registry be implemented?
  - What Outcome Tools and Measures be used?
  - Will existing Productivity Standards work in the new model?

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Note: the IBHP toolkit has more details (www.ibhp.org)
How are we going to get Paid Tomorrow?

Healthcare Reform

- Three components
  - Universal coverage (with parity)
  - Delivery system design (medical homes and accountable care organizations)
  - Payment reform (case rates, global payments)
- Integrating MH/SU services with healthcare more important than ever before—can’t achieve quality and cost reduction goals without it
  - Especially in systems that historically have served the safety-net population
The “Big Fix”

- Need to invert the Resource Allocation Triangle
- Prevention Activities must be funded and widely deployed
- Primary Care must become a desirable occupation and
- Decrease Demand in the Specialty and Acute Care Systems
- These are dramatic shifts that will not *magically* take place

Coverage Expansion

- Medicaid non-elderly enrollment will be 46% higher in 2019 than it would have been without the new law (this will vary by state)
- Large reduction in uninsured; it is likely that most uninsured with moderate to high MH/SU disorders will obtain coverage in Medicaid expansion (up to 133% of FPL), some will be in subsidized plans through the state Health Insurance Exchange (up to 400% of poverty)
Future Funding Environments

- New funding mechanisms will be utilized to fund services that manage total healthcare expenditures
- Medical Homes likely funded with a 3-layer model

### Potential Avoidable Complications (PACs)

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Rate</td>
<td>Prevention, Early Intervention, Care Management for Chronic Medical Conditions</td>
</tr>
<tr>
<td>Fee for Service/PPS</td>
<td>Per Service Payment, Prospective Payment System (PPS) Settlement (FQHC model) to cover shortfalls</td>
</tr>
<tr>
<td>Bonus</td>
<td>Share in Savings from Reduced Total Healthcare Expenditures (bending the curve)</td>
</tr>
</tbody>
</table>

- Payment for inpatient care will bundle hospital and physician services that only pay for part of Potentially Avoidable Complications (PACs)
- Bundled payments may include all costs in the 30 days post an inpatient stay, including any return to the hospital
- Accountable Care Organizations organize to handle new payment models

Accountable Care Organizations (ACOs)

- ACOs dual purpose:
  - Organization structure for managing bundled payments for inpatient care
  - Vehicle for small to mid-sized primary care practices that want to become Person-Centered Medical Homes

Harold Miller, How to Create an Accountable Care Organization, [www.chqpr.org](http://www.chqpr.org), page 4
Accountable Care Organizations (ACOs)

- Accountable Care Organization (ACO) Model

Medical Homes

Hospitals

Medical Homes

Food Mart

Specialty Clinics

Food Mart

Specialty Clinics

Medical Homes

Clinic

Clinic

Accountable Care Organization

Health Plan (Maybe)

Summarizing what the Future Holds

Current Healthcare Environment: Cost and Quality Problems

Coverage Expansion: Medicaid

Coverage Expansion: Exchanges

Aged, Blind, Disabled shift from FFS to Managed Care

Accountable Care Organizations

Integrated Delivery Systems

Health Plans at Risk for Managing Care and Costs
California’s Puzzle

There are eight existing “raw ingredients” that are coming into play as stakeholders in California redesign current waivers and other structures to align with healthcare reform.

Major Initiatives Coming Soon

- 1115 Waiver initiatives, including Health Care Coverage Initiative expansion to get ready for 2014 Medicaid Expansion
  - Local Dollars converted to Medi-Cal
- Expand Medi-Cal Health Plan benefit package to include SU services
  - Leveraging Cost Savings on the Health Side to pay for part of the costs
- Implement Medical Homes and Accountable Care Organizations
  - With new payment mechanisms and integration as an expectation
### The Situation in Public Behavioral Healthcare

#### Table 1: California Fee for Service Medi-Cal Analysis - 2007

<table>
<thead>
<tr>
<th>Metric</th>
<th>Medi-Cal FFS Total</th>
<th>Medi-Cal FFS SMI</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal FFS Enrollees</td>
<td>1,580,440</td>
<td>166,786</td>
<td>11%</td>
</tr>
<tr>
<td>Medi-Cal FFS Costs</td>
<td>$6,186,331,620</td>
<td>$2,395,938,298</td>
<td>39%</td>
</tr>
<tr>
<td>Medi-Cal FFS Cost/Enrollee</td>
<td>$3,914</td>
<td>$14,365</td>
<td>3.7 SMI/Non-Ratio</td>
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</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>SMI %</th>
<th>Non-Ratio %</th>
<th>SMI/Non-Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>11%</td>
<td>9%</td>
<td>1.2</td>
</tr>
<tr>
<td>Ischemic Heart Disease</td>
<td>3%</td>
<td>97%</td>
<td>3.2</td>
</tr>
<tr>
<td>Chronic Respiratory Disease</td>
<td>2%</td>
<td>98%</td>
<td>5.0</td>
</tr>
<tr>
<td>Arthritis</td>
<td>7%</td>
<td>93%</td>
<td>13.0</td>
</tr>
<tr>
<td>Health Failure</td>
<td>3%</td>
<td>97%</td>
<td>3.2</td>
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<table>
<thead>
<tr>
<th>Metric</th>
<th>SMI</th>
<th>Non-Ratio</th>
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<tbody>
<tr>
<td>Inpatient Episodes</td>
<td>100</td>
<td>293</td>
</tr>
<tr>
<td>ER Visits</td>
<td>337</td>
<td>1,167</td>
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<tr>
<td>Inpatient Acute Days</td>
<td>609</td>
<td>2,094</td>
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<tr>
<td>Primary Care Visits</td>
<td>128</td>
<td>492</td>
</tr>
<tr>
<td>Specialist Visits</td>
<td>1,211</td>
<td>6,058</td>
</tr>
</tbody>
</table>

And are costing the healthcare system a great deal of money
Healthcare Reform and Parity Changes Everything...

- Federal Healthcare reform will trigger dramatic changes in how health and MH/SU services are organized.
- These changes will create a tipping point in how the healthcare needs of persons with serious mental illness and the MH/SU healthcare needs of all Americans are addressed.
- Which will change the way MH/SU services are funded and fit into the new healthcare ecosystem.