

Frequently Asked Questions about Federally- Qualified Behavioral Health Centers

BACKGROUND

In 1963, Congress committed to the establishment of a community-based mental health safety net. Federal funding was available to support the development and operation of community mental health centers (CMHCs) to serve all members of the community, regardless of their ability to pay. However, OBRA 1981 changed the federal direction with regard to the mental health system, dismantling direct federal support for a provider safety net and instead consolidating federal mental health and addiction funding into modest block grants to states.

The community mental health and addiction treatment system is under increasing pressure. Medicaid has become the primary source of funding for the system, bringing with it an increased demand for services for the Medicaid population, a risk of marginalizing non-Medicaid eligible clients. There is growing recognition that significant numbers of individuals in primary care settings are in need of specialty mental health services.

Research has found that patients with more serious mental illness experience difficulty in obtaining treatment for their illness. The 1999 U.S. surgeon general's report on mental health indicated that only 20percent of Americans with mental disorders – and fewer than half of people with severe mental disorders – receive any treatment for their conditions in a given year. Recently published data also suggests that people with serious mental illness die, on average, 25 years earlier than the general population.

NEW LEGISLATION

On June 29, 2010, Reps. Doris Matsui (D-CA) and Eliot Engel (D-NY) introduced the Community *Mental Health and Addiction Safety Net Equity Act of 2010* (H.R. 5636), which would create voluntary, national standards of care that promote recovery for persons with mental illness or addiction disorders and strengthen the safety net by placing community mental health and addiction providers on equal footing with the rest of health care – paving the way to provide the right care, at the right time, and in the community.

Answers to some frequently asked questions about the legislation appear below.

Why is FQBHC status important at this time?

Coverage expansions contained in Healthcare Reform will result in as many as 2.8 million persons with serious mental illness and addiction disorders obtaining coverage. However, due to state budget crises, mental health funding is being reduced in many states, leaving provider agencies no choice but to reduce services, close programs, and impose hiring freezes. This FQBHC definition lays the foundation for community mental health and addiction provider agencies to respond to the increased demand in services which is likely to result from health care reform.

What is the main purpose of an FQBHC?

“Federally Qualified Behavioral Health Centers” (FQBHCs), are entities designed to serve individuals with serious mental illnesses and addiction disorders by providing intensive, person-centered, multidisciplinary, evidence-based screening, assessment, diagnostic, treatment, prevention, and wellness services. Serious mental illnesses like schizophrenia, bipolar disorder and major clinical depression are chronic illnesses that require ongoing treatment. Persons living with these illnesses receive intensive interventions and supports over their life time to support community integration and to avoid costly hospitalizations.

What would the authorization of FQBHCs mean for Federally Qualified Health Centers and Rural Health Clinics?

Today, Federally Qualified Health Centers (FQHCs) employ 3,000 mental health and addiction professionals nationwide. These staff members treat mental health disorders with a sky high incidence in low income primary care populations: clinical depression and anxiety disorders. By contrast, FQBHCs compliment this integrated service model by improving intensive community-based mental health services for two high-need groups of patients/consumers with disabilities: adults with severe mental illnesses and kids with serious mental and emotional disturbances traditionally served in the public mental health system. Further, H.R. 5636 does not alter – in any way – either existing Public Health Act Section 330 funding for Community Health Centers or current Medicaid reimbursement programs for Federally Qualified Health Centers.

Will this legislation lead to the development of new addiction and mental health treatment organizations?

No, it is expected that existing organizations will choose to seek this status and agree to meet national standards in order to provide intensive, evidence-based care and facilitate linkages to other essential community health and social services. Healthcare reform brings with it new quality and reporting requirements, FQBHC status provides addiction and mental health treatment organizations with the framework to participate in this environment.

Who are the patients that will be served by FQBHCs?

Persons with serious mental illnesses and chronic addiction disorders are among the nation's most vulnerable populations – people who even if insured would nonetheless remain isolated from traditional forms of medical care because of the where they live, who they are, the behaviors that accompany their illnesses, and their higher levels of complex health care needs. As a result, they are disproportionately low income, uninsured or publicly insured.

What payment changes are included in the legislation?

A key component of HR 5636 is to ensure equity within the safety-net by extending the Medicaid Prospective Payment System to include FQBHCs. FQHCs and Rural Health Clinics have access to enhanced reimbursement for Medicaid services through the Prospective Payment System (PPS) reimbursement or other State-approved alternative payment methodology. As a result, FQHCs and look-alikes generally receive a higher rate of Medicaid and Medicare reimbursements than most other health care entities providing similar services. These federal policies are designed to ensure that FQHCs are reimbursed at levels sufficient to cover most or all of the costs of delivering care.