# Leveraging Federally Qualified Health Centers in California's Behavioral Health Care Continuum

California Primary Care ASSOCIATION

## CONTENTS




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November 6, 2017

**Dear California Primary Care Association (CPCA) Member and Recipient of CPCA's Behavioral Health Toolkit,**

The word integrate[1] means "to form, coordinate, or blend into a functioning or unified whole." By this definition, the process of integration can take several forms to achieve the result of a "functioning or unified whole." When applied to health and behavioral health, efforts to integrate care can look different based on multiple factors – including the needs of the client, delivery system, provider, and payer – that when done successfully deliver care as a unified whole. In California, county behavioral health systems and Federally Qualified Health Centers (FQHCs) are natural partners for advancing integrated care for individuals living with serious mental illness and substance use disorders (SUDs). For this reason, the County Behavioral Health Directors Association (CBHDA) is pleased to support CPCA's Toolkit, Leveraging Federally Qualified Health Centers in California's Continuum of Behavioral Health Care.

CBHDA represents the behavioral health authorities from California's 58 counties and two cities. The mission of CBHDA is to assure the accessibility of quality, cost-effective, culturally competent behavioral health care for Californians. Integrated care is an invaluable tool for advancing CBHDA's mission and impacting the disparate health outcomes of individuals with serious mental illness and substance use disorders, who die 25 years earlier than the general population often due to treatable medical conditions[2].

The integration models described in this toolkit include exploring contractual relationships; health center entities outside the FQHC; bi-directional co-location; and medication assisted treatment (MAT). Readers will learn about a range of options available for discussion and exploration at the local level between county behavioral health systems and FQHCs. CBHDA applauds CPCA for the development of this toolkit and believes it is a valuable resource that will support the critical work of improving health care and outcomes for Californian's with behavioral health conditions.

Sincerely,

Kirsten Barlow

Kirsten Barlow
Executive Director

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[1] Merriam-Webster Dictionary. https://www.merriam-webster.com/dictionary/integrate

[2] National Association of State Mental Health Program Directors Council. (2006). Morbidity and Mortality in People with Serious Mental Illness. Alexandria, VA: Parks, J., et al. https://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf

# Introduction

California has made tremendous strides over the last several years to improve access to care for individuals with mental health and substance use disorders (SUDs). California's extension of Medi-Cal eligibility to low-income adults up to 138% of the federal poverty line (FPL) means that these individuals have access to mental health and SUD treatment services through the Medi-Cal program for the first time. To serve these patients, Medi-Cal managed care plans (MCPs) have taken on responsibility for treating mild and moderate mental health conditions for Medi-Cal beneficiaries; while county Mental Health Plans (MHPs) have retained responsibility for Medi-Cal members that meet the medical necessity criteria for specialty mental health services. Additionally, implementation of California's Drug Medi-Cal Organized Delivery System Pilot Program (DMC-ODS), under the authority of the 1115 Medicaid waiver, provides an opportunity to grow the breadth of SUD treatment services available to Medi-Cal enrollees.

Significant investments have also been made by the federal government over the last several years to increase the capacity of federally qualified health centers (FQHCs) to better meet the mental health and substance use needs of safety net populations. Primary care is often the first point of contact for detection and treatment of mental health conditions and SUDs, which frequently accompany a substantial number of general medical illnesses, including heart disease, cancer, diabetes, and neurological illnesses.[2] The integration of mental health and SUD services into primary care practice makes services more accessible, improves coordination of care, and supports a "whole person care" approach to serving Medi-Cal beneficiaries. Further, FQHCs are well regarded for their diverse workforce and language capabilities, helping to make mental health and SUDs more accessible for many underserved populations.

FQHCs have played a critical role in providing outpatient mental health services to Medi-Cal beneficiaries in many communities. Prior to the expansion of outpatient mental health benefits in 2014, mental health services offered at FQHCs were one of the few options available to Medi-Cal beneficiaries seeking mental health care who did not meet the medical necessity criteria for specialty mental health services through the MHP. Since the 2014 expansion of mild to moderate benefits, FQHCs continue to provide behavioral health services through contracts with MCPs.

FQHCs are uniquely positioned to be an important partner for counties as healthcare delivery systems seek new methods to improve comprehensive health outcomes in diverse communities. It is imperative for counties and health centers to understand mutually beneficial collaborative models and maximize a coordinated continuum of services to targeted patients. By collaborating and working in partnership, counties and FQHCs will be better positioned to provide high-quality, culturally competent, cost-effective and patient-centered care to their mutual patient population. The FQHC and county relationship is an important place to begin a journey of building a seamless system of care, because it is a place where there is significant potential for overlap in services, shared patient populations, and the opportunity to thoughtfully leverage resources.

The California Primary Care Association (CPCA) partnered with Blue Shield of California Foundation, Harbage Consulting, and the County Behavioral Health Directors Association with the support of the Blue Shield of California Foundation to build this toolkit that outlines the history of behavioral health care in California and identifies best practice models and common barriers to overcome for integrating county and FQHC services. Our hope is to support the strengthening of relationships between FQHCs and counties in order to improve care coordination, patient experience, and outcomes for Medi-Cal enrollees with mental illness and/or substance use disorders.

*To accomplish this goal, this report is organized into the following three sections:*

## PART 1.

## The Behavioral Health Landscape

*This section includes a comprehensive overview California's mental health and SUD treatment system, including:*

- Major Mental Health Milestones in California;
- California's Behavioral Health State Administrative Structure;
- The Medi-Cal Specialty Mental Health System;
- Medi-Cal State Plan and State Plan Amendments;
- County Mental Health Programs;
- Division of Mental Health Care Services between Managed Care Plans and Mental Health Plans in California
- SUD Treatment under the DMC-ODS Pilot Program; and
- FQHC Responsibilities for Behavioral Health

## PART 2.

## County and FQHC Partnership Models to Improve Consumer Access to Specialty Mental Health and Substance Use Disorder Treatment

*This section outlines contractual and regulatory considerations for improving beneficiary access to specialty mental health and SUD services, and focuses on the following four areas of opportunity:*

- Contractual Arrangements for County Specialty Mental Health and DMC-ODS Services;
- Creating New Health Center Entities Outside of the FQHC to Provide Specialty Mental Health Services;
- Bidirectional Co-location with Specialty Mental Health and SUD Partners; and
- Medication Assisted Treatment for SUD at FQHCs

## PART 3.

## Conclusion and Final Considerations

*The final section summarizes report findings and includes considerations for next steps.*

# PART 1.
# The Behavioral Health Landscape

Nationally, one out of every five adults with mental illness has a severe mental illness (SMI), which is defined as mental or behavioral disorders that results in substantial interference with an individual's ability to participate in major life activities.[3] Compared to the general population, these individuals are more likely to have co-occurring nutritional and metabolic diseases, cardiovascular diseases, viral and respiratory tract diseases, sexual dysfunction, musculoskeletal diseases, pregnancy complications, stomatognathic diseases, and obesity-related cancers.[4] People with SUDs frequently have one or more medical problems resulting from substance use, including lung and cardiovascular disease, stroke, and cancer.[5] When left untreated, SMI and SUDs can result in worse quality-of-life and significantly shorter life expectancies in comparison to the general population. Those with SMI and SUDS die, on average, 25 years earlier than the general population.[6,7,8]

Primary care is particularly important for beneficiaries with mental health conditions and SUDs. Among persons with schizophrenia, 60% of deaths were attributed to treatable medical conditions, such as infections, pulmonary, and cardiovascular diseases.[10] Individuals with SMI are at higher risk of morbidity and mortality due to modifiable risk factors, such as smoking, alcohol consumption, obesity, poor nutrition, exposure to infectious diseases, lack of exercise, and illicit drug use.[11] This is particularly important in California, where the prevalence of diabetes, heart disease, cerebrovascular disease, arthritis, and heart failure is three times higher among Medi-Cal beneficiaries with SMI than the general Medi-Cal population.[12] Medi-Cal beneficiaries with SMI were more likely to be hospitalized for non-psychiatric reasons than a comparable group without SMI, with rates particularly high for Latinos.[13]

Access to care can be compounded by a number of factors, including racial, socioeconomic, and co-occurring disparities for persons with co-occurring mental health and substance use disorder. Nationally, nearly 60 percent of persons with substance use disorder also have at least one other mental health disorder and it is often difficult for providers to disentangle the overlapping symptoms and manifestations of drug addiction and mental illness, making diagnosis and treatment of co-occurring disorders complex.

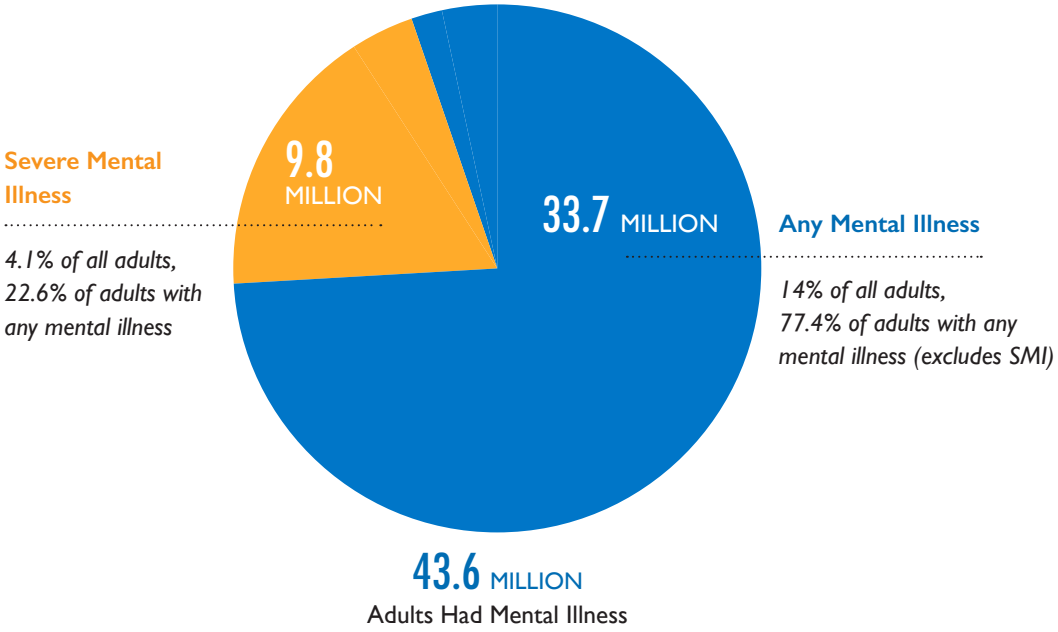
*Severe mental illness (SMI), is defined as mental or behavioral disorders that results in substantial interference with an individual's ability to participate in major life activities.*

TABLE 1.
**National Prevalence Rates by Diagnosis[9]**

| | |
|---|---|
| PSYCHOSIS | 1.1% |
| BIPOLAR | 2.6% |
| ADJUSTMENT | 2.9% |
| DEPRESSION | 6.7% |
| DISRUPTIVE | 8.9% |
| ANXIETY | 18.1% |

FIGURE 1.

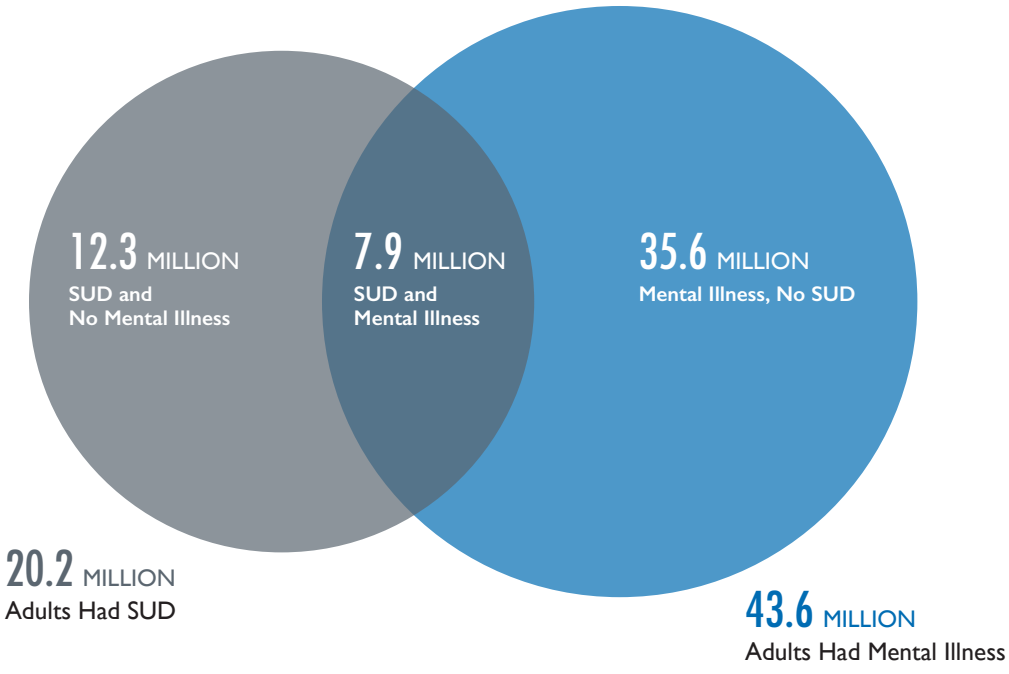
## National Prevalence of Severe Mental (SMI) Illness Among Adults With Any Mental Illness: 2014




SOURCE: *Hedden et al., Behavioral Health Trends in the United States: Results from the 2104 National Survey on Drug Use and Health.*

FIGURE 2.

## Past Year Substance Use Disorders (SUD) and Mental Illness Among Adults Aged 18 or Older: 2014



## Major Mental Health Milestones in California

Prior to 1957, the State of California had the sole responsibility for the care and hospitalization of individuals with mental health conditions, using a network of fourteen hospitals located throughout the state. As the state hospital population grew, some communities started to recognize the need to establish outpatient care in the community to serve individuals with mental health conditions in community settings. In a further attempt to improve care and protect the individual civil rights of California residents living with mental health conditions, the Lanterman-Petris-Short (LPS) Act of 1967 ended the once common practice of lifetime institutionalization for individuals with mental illness and established the individual's right to due process prior to commitment. The law defined parameters for involuntary treatment, establishing involuntary psychiatric hold and conservatorship protocols that remain in use today. [14]

In 1991, a major change occurred in the funding of human service programs in the State of California with the enactment of the Bronzan-McCorquodale Act,[15] commonly referred to as "Realignment." 1991 Realignment transferred financial responsibility for most of the state's mental health and public health programs, and some of social service programs, from the State of California to local governments, and provided counties with dedicated tax revenues from the sales tax and vehicle license fees to pay for these changes. These mental health and public health programs included community-based mental health services administered by county departments of mental health for seriously mentally ill children and adults, state inpatient hospital services administered by the state Department of Mental Health, Institutions for Mental Diseases (IMDs) for short-term nursing care, Assembly Bill 8 County Health Services used to fund public health and medical care at county-discretion, the Medical Indigent Services Program, Local Health Services Program for small rural counties, and the County Medical Services Program (CMSP).[16]

California adopted the Medicaid Rehabilitative Option in 1993 to substantially expand coverage to include rehabilitative mental health services, including comprehensive crisis services that can be provided anywhere in the community and by a range of providers, through a State Plan Amendment (SPA). A few years later, in 1995, the 1915(b) Medicaid waiver was established to create the administrative structure and define the county programs as "prepaid inpatient health plans" (PIHPs). Under the 1915(b) Medicaid waiver, county mental health departments became responsible for both fee-for-service (FFS) and Short Doyle/Medi-Cal System psychiatric hospital systems. The 1915(b) Medicaid waiver essentially waives "freedom of choice" for the beneficiary, meaning that all Medi-Cal beneficiaries must receive their specialty mental health services through the county. Additionally, the 1915(b) Medicaid waiver shifted the risks associated with this entitlement program from the state to the counties.

The landmark Mental Health Services Act[17] (Prop 63) was approved by California voters in 2004, creating a 1% income tax on personal income in excess of $1 million, with the funding received dedicated to funding mental health services and supports. This funding source is unique to California and provides support to counties in five key areas, including: 1) community services and supports; 2) prevention and early intervention; 3) innovative programs to improve access to care; 4) capital facilities and technology to improve infrastructure; and 5) workforce education and training funds. In recent fiscal years, approximately between $1.5 and $1.75 billion is deposited into the fund annually.[18]

At the federal level, major milestones for the field include the enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, which established a new paradigm in which mental health and SUD services have equal value to medical/surgical services and differential limitations – both quantitative and qualitative – are not acceptable. In March 2016, the Centers for Medicare & Medicaid Services (CMS) finalized regulations to address the application of the requirements set forth in MHPAEA to coverage offered by Medicaid managed care organizations, Medicaid alternative benefits plans, and Children's Health Insurance Programs, prohibiting inequity between beneficiaries who have mental health conditions or SUDs in the commercial market and Medicaid/CHIP, and promoting greater consistency for beneficiaries.

Finally, the Patient Protection and Affordable Care Act (ACA) of 2010 sent a powerful message about the importance of mental health and SUD services in achieving the goals of the Triple Aim (improving the beneficiary experience of care including quality and satisfaction; improving the health of populations; and reducing the per capita cost of health care) by including mental health and SUD treatment services as one of the ten essential health benefits required to be included in all new expanded coverage options for the Medicaid program.

## California's Behavioral Health State Administrative Structure

The Short-Doyle Act of 1957 changed the relationship between the state and counties in allowing local communities to provide the state matching funds for community-based mental health services. While the California mental health delivery system has undergone a variety of changes since that time, the Short-Doyle Act was the foundation for California's unique structure, in which counties have the primary responsibility for delivering and paying for specialty mental health services, with the state providing an oversight, rather than administrative, role.

The California Department of Mental Health (DMH) was eliminated in 2012, with the agency's responsibilities divided up between the Department of State Hospitals for psychiatric hospitals and programs, and the Department of Health Care Services (DHCS) for Medi-Cal and community mental health program administration (see Figure 3 on page 10). DHCS also created a Division of Mental Health and Substance Use Disorders (MHSUDS) to oversee MHPs, and mental health and SUD benefits available through the Medi-Cal program. Previously, under the auspices of the California Department of Alcohol and Drug Programs (ADP), the Drug Medi-Cal treatment program became a function of the MHSUDS in July 2013 when ADP merged into DHCS. In its capacity, ADP provided leadership and policy coordination for the planning, development, implementation, and evaluation of a comprehensive statewide system of alcohol and other drug prevention. These functions are now the central focus of MHSUDS.

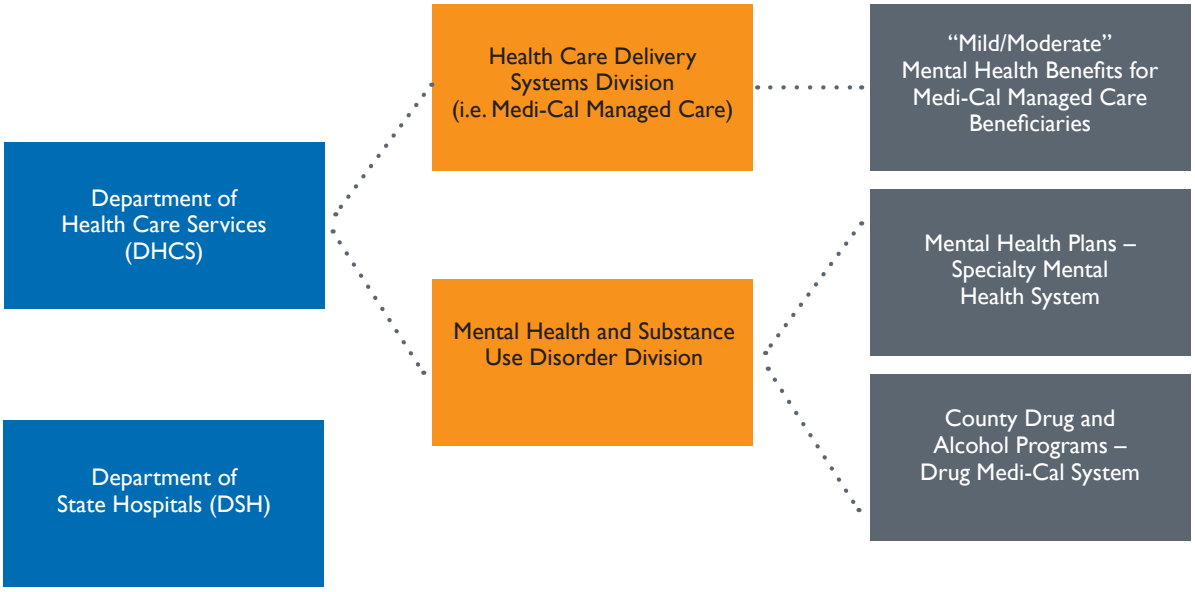
### MHSUDS DIVISION IS COMPRISED OF THREE SUB-DIVISIONS WITH UNIQUE CHARGES[19]:

1. Mental Health Services Division
   Administers mental health programs for children and youth, adults, and older adults.

2. SUD Compliance Division
   Focuses on compliance with state and federal statute, regulations, and other governing requirements like licensing, certification, monitoring, and complaints.

3. Substance Use Disorder-Program Policy and Fiscal Division
   Core functions include developing and implementing SUD prevention strategies, reviewing and approving county SUD treatment program contracts, and granting applications submitted for state and federal funds.

FIGURE 3.
California Mental Health System Structure in 2017



## The Medi-Cal Specialty Mental Health System

Under the provisions of California's 1915(b) Medi-Cal Specialty Mental Health Services waiver, MHPs are responsible for authorization and payment of a full continuum of specialty mental health services for Medi-Cal beneficiaries, from inpatient and emergency services to an array of recovery-oriented rehabilitative services. DHCS has contracted with MHPs to provide specialty mental health services to all Medi-Cal beneficiaries who meet medical necessity criteria.[20] As of 2014, MCPs are responsible for treating beneficiaries with mild to moderate mental health conditions not requiring specialty mental health services. Under the provisions of Realignment, the county provides and certifies the federally-required full funds expenditure for all Medi-Cal specialty mental health claims submitted (with some exceptions related to Proposition 30).

MHPs are not paid on a capitated basis; instead, MHPs are paid on a FFS basis. MHPs are considered to be PIHPs, meaning they provide medical services to beneficiaries under contract with the state, have responsibility for the provision of necessary inpatient hospital and/or institutional services for beneficiaries, and do not have comprehensive risk contracts (i.e. are not fully capitated to provide inpatient and outpatient services for beneficiaries).[21] Additionally, MHPs must undergo annual reviews by the external quality review organization (EQRO) and comply with federal electronic records requirements.

While California's 1915(b) waiver has been renewed for a new five-year term (2015 through 2020), CMS continues to raise substantial concerns regarding beneficiary access and delivery system quality. The waiver's Special Terms and Conditions (STCs) attempt to address these concerns through a number of new county and state reporting requirements, including the development of a statewide performance dashboard. These requirements come on the heels of various recent initiatives related to performance measurement in the mental health system, including initiatives related to the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) assurance and the Mental Health Services Act.

## Medi-Cal State Plan and State Plan Amendments

Medicaid State Plans are agreements between the federal government and states on the rules and policies that govern each state Medicaid program and allows states to draw down federal matching funds for Medicaid program activities and services. The Medicaid State Plan includes assurances that the state will administer its program in accordance with federal laws and lays out programmatic details, such as the populations and services that are covered, reimbursement methodologies for providers, and administrative activities performed by the State to achieve program goals. In order to request changes and update policies of the Medicaid program, states must submit a State Plan Amendment (SPA) to CMS for review and approval.

In California, MHPs may provide additional services through Medi-Cal SPAs, which are approved by CMS and allow counties to receive federal reimbursement for services delivered in non-traditional settings, using non-traditional providers, with a focus on recovery and rehabilitative care.

### KEY SPAS IN CALIFORNIA INCLUDE:

**Medi-Cal Rehabilitative Mental Health Services Option**
*(SPA #10-016; approved on March 21, 2011 with an effective date of October 1, 2010)*

Allows for expanded coverage of community-based services, including assessments, rehabilitation, crisis intervention and stabilization, therapy, medication support, service plan development, and training/counseling for family members. Rehabilitative Mental Health Services are available to Medi-Cal beneficiaries that meet medical necessity criteria established by the State, and are based on the beneficiary's need for Rehabilitative Mental Health Services as determined by an assessment and documented in the client plan.

**Medi-Cal Targeted Case Management Option**

*(SPA #10-012B; was approved on December 20, 2010 with an effective date of July 1, 2010)*

Allows counties to provide Medi-Cal beneficiaries access to needed medical, alcohol and drug treatment, educational, social, prevocational, vocational, rehabilitative, and/or other community services. Services available for federal reimbursement include activities such as communication, coordination, and referral; monitoring service delivery to ensure access to services; monitoring beneficiary progress; plan development; and placement services. Similar to rehabilitative mental health services, targeted case management services are available to Medi-Cal beneficiaries that meet medical necessity criteria established by the state, based on the beneficiary's need for targeted case management as determined by an assessment and documented in the client plan.

## County Mental Health Programs

California's 1915(b) Medi-Cal Specialty Mental Health Services waiver identifies MHPs as responsible for authorization and payment of a full continuum of specialty mental health services for Medi-Cal beneficiaries (see Table 2). This responsibility includes inpatient and post-stabilization services, and recovery-oriented rehabilitative and targeted case management services, including crisis services. Medi-Cal beneficiaries must meet medical necessity criteria in order to receive services through the MHP. Medical necessity criteria include having a qualifying diagnosis, demonstrating specified impairments, and meeting specific intervention criteria, and may differ depending on what the determination is being made for (i.e. inpatient, outpatient, or outpatient for beneficiaries under the age of 21).[22]

TABLE 2.
### Services Available Through the County Mental Health Plan

**Rehabilitative Mental Health Services**

- Mental Health Services (individual, group, or family-based interventions)
- Medication Support Services
- Day Treatment Intensive
- Day Rehabilitation
- Crisis Intervention
- Crisis Stabilization
- Adult Residential Treatment
- Crisis Residential Treatment Services
- Psychiatric Health Facility Services

**Targeted Case Management**

- Comprehensive Assessment and Periodic Reassessment
- Development and Periodic Revision of a Client Plan
- Referral and Related Activities
- Monitoring and Follow-up Activities

**Psychiatric Inpatient Hospital Services**

**EPSDT Services, including Supplemental Services** (i.e. Therapeutic Behavioral Services; Therapeutic Foster Care; Intensive Home-Based Services)

Under the provisions of Realignment and the 1915(b) waiver fiscal provisions, the county provides and certifies the federally-required full funds expenditure for the majority of Medi-Cal specialty mental health claims submitted directly by the county or by the counties' sub-contractors. MHPs are then reimbursed at the applicable federal medical assistance percentage (FMAP) on an interim basis based on the approved FFS claims submitted by the MHP and adjudicated by the Short Doyle 2 system. Per federal requirements for healthcare services furnished by PIHPs, and consistent with the Certified Public Expenditure (CPE) reimbursement provisions of the CMS-approved 1915(b) Medi-Cal Specialty Mental Health Services waiver, MHPs are required to submit annually a summary cost report to DHCS to monitor appropriate allocation of costs to the Medicaid program and to reconcile the interim claims payments with actual MHP costs.

DHCS contracts with MHPs to provide specialty mental health services to all Medi-Cal beneficiaries who meet the specified medical necessity criteria. The MHP must ensure that all medically necessary covered specialty mental health services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished. Per the state-county MHP (managed care) contract, MHPs must meet a number of requirements related to availability and accessibility of services.[23] MHPs must ensure the availability of services to address beneficiaries' emergency and urgent psychiatric conditions 24 hours a day, 7 days a week. Counties must also ensure timely access to routine services required to meet beneficiary needs.

In order to meet requirements related to availability and accessibility of services, MHPs must maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors and is sufficient to provide adequate access to all covered services. In establishing and monitoring the network, the MHP must consider the anticipated number of Medi-Cal eligible beneficiaries, the expected utilization of services, the expected number and types of providers in terms of training and experience needed to meet expected utilization, the number of network providers who are not accepting new beneficiaries, the geographic location of providers and their accessibility to beneficiaries, out of network services, and provider credentialing. The MHP must have written policies and procedures in place for selection, retention, credentialing and re-credentialing of providers. Organizational providers must comply with numerous requirements related to beneficiary records, staffing, access to psychiatry, and medication storage, among others. All sub-contracted providers are required to complete and submit an annual cost report to the MHP. The cost report must be completed consistent with state, county, and federal Medi-Cal requirements, in the format required by the county, and submitted for review by the MHP in a timely manner.

MHPs must comply with federal managed care requirements related to beneficiary protections, such as establishing and maintaining beneficiary problem resolution processes, and program integrity. MHPs must maintain programs for quality management, quality improvement, and utilization management to improve processes to provide better care to beneficiaries. Additionally, MHPs are subject to annual external quality review by the state-designated EQRO, and triennial compliance reviews by the state DHCS.[24] The focus of these reviews is to assure that the MHPs are meeting the federal and state requirements related to access, network adequacy, beneficiary experience, and quality improvement.

Finally, California's 1915(b) waiver assures beneficiaries "the right to obtain FQHC services outside [of the] waiver program through the regular Medicaid Program.[25]" This provision protects beneficiary access to FQHC services outside of the 1915(b) waiver, even though beneficiary choice of provider is waived when receiving specialty mental health services available through the waiver.

## Division of Mental Health Care Services between Managed Care Plans and Mental Health Plans in California

Even before the January 2014 addition of mild-to-moderate mental health benefits, MCPs and county MHPs were required to establish Memorandums of Understanding (MOUs) to coordinate services for members receiving county specialty mental health services. However, the January 2014 reforms amended MOU requirements to address how plans and counties will coordinate mild-to moderate and as well as specialty mental health services. Such agreements are intended to support MCPs and counties working together to ensure that members receive timely and medically appropriate mental health services. For example, under the 2014 benefit expansion, each MCP is required to ensure that all members receive mental health screening by their PCP. Members with positive screening results may be treated by the PCP within the PCP's scope of practice (e.g., prescribing anti-depressants). If individuals appear to have a mental health condition that is beyond the PCP's scope of practice, the beneficiary is evaluated by a mental health provider using a tool identified in the MOU between the MCP and county. In the case of FQHCs, a referral is typically made to mental health providers co-located within the organization to provide this screening onsite. Once screened, if the level of impairment is deemed mild to moderate or the recommended treatment does not otherwise meet medical necessity criteria for the Medi-Cal specialty mental health services, then the MCP must provide access to outpatient mental health services through a contracted network provider, often an FQHC. Meanwhile, members who screen positive for significant impairment are referred to the county MHP. Once found eligible for county MHP services, the member's mental health treatment is arranged and paid for by the county MHP, but medical services remain the responsibility of the MCP.

The expansion of Medi-Cal coverage to childless adults under the Affordable Care Act (ACA) and the "carve-in" of mild-to-moderate behavioral health into Medi-Cal managed care has vastly increased the amount of behavioral health care offered by FQHCs. In 2016, FQHCs served as the primary care medical home to 54% of the newly insured under the ACA, and saw one out of every seven Californians. In response to the needs of their patients, FQHCs have expanded access to behavioral services, with 72% offering co-located or fully integrated behavioral health and primary care. FQHCs are unique in that a broad spectrum of services are available within the umbrella of the FQHC designation, and there are no restrictions based on serious versus mild to moderate diagnoses. Even a patient who meets eligibility criteria for enrollment in a county MHP may continue to receive mental health services through the FQHC, as long as the services themselves are within the FQHC's scope. In this case, the FQHC is able to bill DHCS directly for those services, bypassing the county MHP and providing a fully integrated continuum of services, making them an ideal provider for this community.

FQHCs are uniquely positioned to be an important partner for counties as healthcare delivery systems seek new methods to improve comprehensive health outcomes in diverse communities. It is imperative for counties and health centers to understand mutually beneficial collaborative models that and maximize a coordinated continuum of services to targeted patients. By collaborating and working in partnership with FQHCs, counties will be better positioned to provide high-quality, culturally competent, cost-effective and patient-centered care.

## Substance Use Disorder Treatment under Drug Medi-Cal and the Organized Delivery System Pilot Program

Most SUD services for Medi-Cal beneficiaries are provided through the Drug Medi-Cal (DMC) program. The DMC program has historically offered a relatively limited benefit, primarily consisting of methadone and outpatient counseling. Under the traditional DMC structure, DHCS contracts with counties for the administration and delivery of DMC services and, under the provisions of Realignment, the county provides and certifies the federally-required full funds expenditure for all DMC claims submitted. Unlike with MHPs, there were minimal requirements for care coordination and quality improvement in the original DMC program, resulting in recent federal scrutiny related to program integrity.

In 2015, CMS approved California's implementation of the Drug Medi-Cal Organized Devliery System (DMC-ODS) pilot under the provisions of the state's broader 1115 waiver to test the organized delivery of SUD services in the Medi-Cal program. The pilot includes a substantial expansion of covered services to offer a more complete continuum of care to beneficiaries and provides the state, counties, and providers the chance to jointly develop the resources necessary to address existing service gaps.

County participation in the DMC-ODS pilot is optional. As of this report's publication, 40 counties have either submitted implementation plans for consideration or have been approved for participation by DHCS and CMS. (This number includes eight northern counties that will participate in the pilot as a regional system of care managed by Partnership Health Plan.)

Counties in the DMC-ODS pilot are required to provide a range of SUD services to all eligible Medi-Cal beneficiaries, including early intervention, outpatient services, intensive outpatient services, short-term residential services (up to 90 days with no facility bed limit), withdrawal management, opioid/narcotic treatment program (NTP) services, recovery services, case management, and physician consultation. Counties may also decide to provide additional medication assisted treatment (MAT), partial hospitalization, and recovery residences, although these are not required.

### CRITICAL ELEMENTS OF THE DMC-ODS PILOT INCLUDE THE FOLLOWING ENHANCEMENTS TO THE DELIVERY SYSTEM:

- Employs a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment;
- Increases local control by providing opportunities for greater administrative oversight by the counties;
- Adds utilization controls and increases program oversight;
- Requires that evidence-based practices for SUD treatment be used;
- Provides more intensive services for beneficiaries involved in the criminal justice system; and,
- Increases coordination with physical and mental health services

County SUD programs that opt into the pilot also become managed care plans. They operate under the same pre-paid inpatient health plan (PIHP) designation as specialty mental health plans and must likewise comply with federal managed care regulations. As managed care entities, ODS counties gain the authority to select, and contract with, a network of quality providers to more effectively meet treatment needs. County ODS programs must monitor their provider networks and ensure timely access to all covered services for eligible beneficiaries. This includes maintaining written policies and procedures for selection, retention, credentialing and

re-credentialing of providers, and guaranteeing beneficiary protections through timely notices of action and problem resolution processes. They must also undertake and document quality and utilization management activities to improve processes and provide better care to beneficiaries. County delivery system performance, and compliance with managed care regulations, are assessed through annual external quality reviews by the state-designated EQRO and annual compliance reviews by the state DHCS.

Providers that contract with ODS counties must implement certain standardized clinical and documentation processes. While procedures may differ by county, most providers will be responsible for assessing clients for placement into appropriate levels of care using ASAM diagnostic criteria, and for creating detailed treatment plans that conform to ODS documentation requirements. All sub-contracted providers must implement and document the use of two evidence-based practices selected from an identified list. With the exception of NTPs, ODS providers are required to complete and submit annual cost reports. The cost report must be consistent with state, county, and federal Medi-Cal requirements, produced in the format required by the county, and submitted for review in a timely manner.

In order to claim federal financial participation (FFP), counties must certify the total allowable expenditures that were incurred through providing DMC-ODS waiver services by county-operated or sub-contracted providers. The waiver allows counties to propose interim payment rates that differ from the state-developed rates used for DMC services in non-ODS counties (all NTP services will continue to use the state rates).[26] The state then works with the county to negotiate and approve the proposed rates, which are ultimately reconciled to cost.

Counties that do not opt into the ODS may continue to administer Drug Medi-Cal services as specified in California's Medicaid state plan. Covered state plan DMC services currently include outpatient and intensive outpatient treatment, naltrexone treatment, methadone through NTPs, inpatient hospital detoxification, and residential SUD treatment for the perinatal population only. Non-pilot counties may also subcontract with community-based providers, but contract requirements will differ from those in ODS counties because state plan DMC programs are not managed care plans. As noted above, counties will receive payment at rates set by the state.

## Federally Qualified Health Center Responsibilities for Behavioral Health

In 2014, the 1,150 total licensed community clinics and health centers in California served over six million beneficiaries, with a total of 18.2 million encounters.[27] Of these visits[28], over half (56%) were Medi-Cal beneficiaries.[29] Before the 2014 expansion of outpatient mental health benefits to treat "mild to moderate" mental health conditions, Medi-Cal beneficiaries with mental health conditions that did not meet medical necessity criteria for specialty mental health services available through the MHP had access to limited outpatient mental health services. Their limited access was gained through FQHCs and RHCs, who are reimbursed for mental health and medical services through the prospective payment system (PPS) rate. FQHCs and RHCs are eligible for reimbursement as long as the service provided is within the FQHC's or RHC's federally designated scope of services and provided by an FQHC or RHC billable provider.

Though many FQHCs provide mental health and SUD treatment on-site, most are not required to do so. Section 330 of the Public Health Service Act defines behavioral, mental health, and substance abuse services as "additional health services" that FQHCs may choose to provide directly to its beneficiaries.[30] At minimum, FQHCs must offer referrals for beneficiaries to receive treatment for mental health and SUD if they are not provided directly.[31] This is not the case for health centers designated under Section 330(h) of the Public Health Service Act, Healthcare for the Homeless Health Centers, which are required to provide substance use disorder services.

FQHC are required to offer a range of services that correspond to the needs of their local community and target population. Because each FQHC serves a different population, services are different for each FQHC and FQHC site. In many cases, FQHCs have built behavioral health into their service delivery model to respond to the needs of their community, and are able to offer a spectrum of behavioral health services as long as those services are within the FQHC's federally approved scope of services, and are offered by a billable provider. FQHC billable providers include physicians, nurse practitioners and physicians assistants, licensed clinical social workers, psychologists, and, as of January 1, 2018, marriage and family therapists. While FQHCs are able to offer a wide spectrum of behavioral health services within their approved federal scope, they are limited in the types of services they can provide due to billable provider requirements. For behavioral health, this means FQHCs can offer only the services of psychiatrists, psychologists, LCSWs and MFTs (beginning January 1 2018).

The Health Resources and Services Administration (HRSA) encourages collaboration with other organizations to promote beneficiary access to care available outside of the FQHC walls, discussed in more detail in Part 3 of this report. However, special legal considerations come as a result of Section 330 of the Public Health Services Act, which lays out the requirements for FQHCs to secure and maintain 330 grant funding, provides payment protections, and allows for other benefits such as participation in the 340B prescription drug discount program

### Defining Prospective Payment System

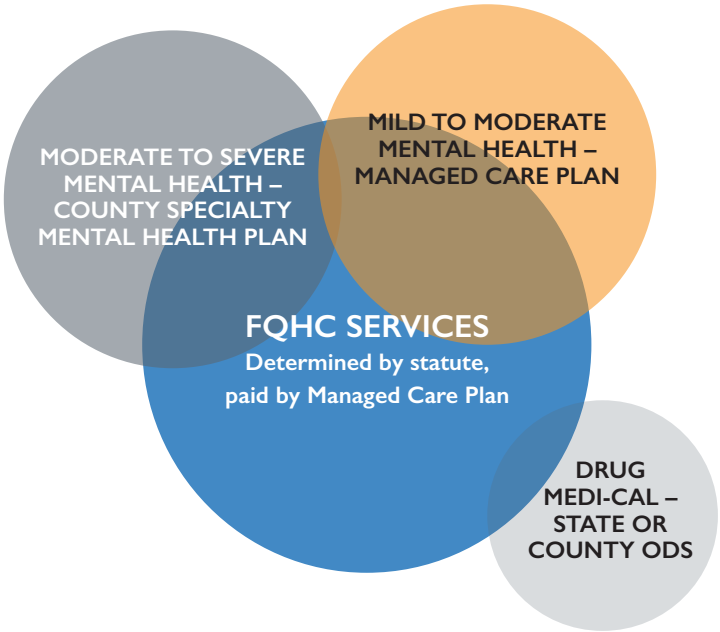
FQHCs and RHCs are reimbursed on a per-visit basis, using a PPS rate. A "visit" is defined as a face-to-face encounter between an FQHC or RHC Medi-Cal patient and health care provider identified in the state plan's definition of an FQHC or RHC visit. In California, this definition includes mental health providers such as physicians (including psychiatrists), psychiatric nurse practitioners or physician assistants, clinical psychologists, and licensed clinical social workers (LCSWs). Marriage and Family Therapists (MFTs) were adopted a billable providers in 2016. Mental health services are included in the calculation of the PPS rate and are not separately billable when performed on the same day as a physical health visit. FQHCs in California are currently limited to one billable visit per day, with the exception of dental visits (which can be billed on the same day as a physical or mental health visit).[20]

and professional liability coverage under the Federal Tort Claims Act (FTCA)[32]. Of particular importance is Policy Information Notice (PIN) #97-27: Affiliation Agreements of Community and Migrant Health Centers, which emphasizes the precarious balance between complying with Section 330 requirements and being able to provide integrated services through affiliation and other agreements. The PIN emphasizes that collaborative arrangements could potentially jeopardize a FQHC's compliance with 330 requirements if done incorrectly, particularly affiliations "between health centers and entities that are not subject to the same section 330 grant-related requirements."[33]

There are a variety of models that have been implemented in primary care settings to facilitate access to mental health and SUD treatment alongside physical health care. Three collaborative models that are often used include co-located (in which mental health and SUD services are provided in the same location, but not necessarily at the same time), coordinated (in which mental health and/or SUD treatment may be provided in a different setting, but is done in collaboration with primary care), and integrated (where mental health and/or SUD treatment is embedded into and informed by the primary care medical visit, often using health information technology) models of care.[34] Successful implementation of each of these models depends upon a variety of factors, including local relationships with behavioral health providers, interpretation of privacy laws governing the sharing of beneficiary information, and knowledge of the community mental health agencies available to collaborate on beneficiary care.[35]

FIGURE 4.

## Role of the FQHC in the Delivery of Behavioral Health Services for Medi-cal Beneficiaries




*This model demonstrates the unique role of the FQHC in the delivery of behavioral health services. The FQHC, by virtue of its federal designation, may elect a scope of services that includes not only services to the mild-to-moderate population, but also to an extent, services provided to MHP-eligible beneficiaries and those in Drug Medi-Cal.*

# PART 2.

## County and FQHC Partnership Models to Improve Beneficiary Access to Specialty Mental Health and Substance Use Disorder Treatment

CPCA identified the following four (4) arrangements as areas to explore in order to improve access to the full continuum of behavioral health care for FQHC patients:

1. Contractual Arrangements for Specialty Mental Health (SMH) and substance use disorder (SUD) systems;
2. Creating New Health Center Entities Outside of the FQHC to provide SMH and SUD Services;
3. Bidirectional Co-location with SMH and SUD Partners; and
4. Medication Assisted Treatment for SUDs

This section includes a summary of key considerations and practical implications for each arrangement, and, as applicable, any policy barriers and opportunities for policy change. Supporting regulatory citations and sources are included in the appendix.

It is important to note that each of the four models outlined in this brief focus on deepening systematic integrated care between county SMH and FQHC services. In this sense, integration should be thought of across multiple dimensions, including clinical, physical, financial, operational, and informational. This report will not detail best practices to improve care coordination between independent, siloed systems of care. There is a significant body of literature dedicated to improving care coordination among various parts of the delivery system. Appendix A includes a list of resources that describe collaborative efforts between counties and community health centers to coordinate care, share clients' information to optimize care, and achieve quality outcomes.

### ARRANGEMENT 1:

### *Contractual Arrangements for County Specialty Mental Health and Substance Use Disorder System Services*

Contractual Arrangements are an option for providing SMH or SUD services for patients of the FQHC, through a contractual arrangement between the FQHC and the county mental health plan (MHP) or the SUD system of care. Under this arrangement, FQHCs provide and receive payment for specialty mental health services or SUD services outside of the PPS rate, and serve as a contractor to the Drug Medi-Cal program or county MHP.

#### CHALLENGES FOR FQHCS IN CONTRACTING WITH MHPS AND DMC-ODS:

**Reimbursement Challenges**

FQHCs are reimbursed for Medi-Cal services through a bundled PPS rate. Senate Bill 323 (Mitchell), which was signed by the Governor in October of 2017, clarified that FQHCs may enter into contracts with county MHPs and enroll as Drug Medi-Cal providers and receive reimbursement for these services outside of the PPS rate. However, under the law, the FQHC must ensure that the same costs are not reimbursed in the bundled PPS rate and under an MHP or DMC contract. The FQHC may prove the cost of providing MHP or DMC contracted services are outside of the PPS rate by providing those services at a separate site, re-basing their rate to 'carve out' related costs, or otherwise proving that the PPS rate does not include SMH or DMC services. FQHCs seeking a contractual arrangement for SMH or DMC should seek the advice of experienced legal counsel to ensure they are meeting the requirements of the law.

### New Requirements

Entering into a contractual relationship creates requirements for the FQHC that are significantly different than the requirements associated with standard FQHC practice. For example, documentation and claiming requirements are unique to the specialty mental health system and may not conform to existing health center medical record and staff documentation training systems. The cost report processes for FQHCs may not meet mental health and SUD cost reporting requirements, meaning that additional cost reports may need to be completed, which require separate cost allocation methodologies. FQHCs serving as county-subcontracted providers would need to ensure compliance with both FQHC regulatory provisions, state licensure requirements, and county contractual obligations, which may present substantial internal administrative burden.

### 330 Grantee Requirements

FQHCs may face challenges in meeting 330 grant requirements when creating agreements with non-330 grantee entities. FQHCs must demonstrate their ability to maintain the level and quality of the required primary health services for the target population when proposing to add a specialty service. If a service is included in the approved scope of project, it must be available equally to all beneficiaries, regardless of ability to pay, and be available through a sliding fee scale.

### Ability to Access FQHC Services

California's Medi-Cal program includes mandatory enrollment into county MHPs for beneficiaries that meet the medical necessity criteria. Medi-Cal beneficiaries have the right to obtain FQHC services outside of the MHP through the regular Medi-Cal program. This protects beneficiaries' ability to access FQHC services outside of the MHP and for FQHCs to be paid for the FQHC services provided to these beneficiaries. It is unclear and untested with the Centers for Medicare and Medicaid Services (CMS) whether an FQHC operating as a sub-contractor of an MHP would be able to provide specialty mental health services and ensure access to the FQHC services that the beneficiary is entitled to outside of the waiver.

## Practical Implications

Implementation of this arrangement will require close coordination and communication between the MHP/SUD system and the FQHC, and, if SMH/DMC services are offered at the same site as FQHC services, (may require the approval of the Department of Health Care Services). Entering into a contractual relationship will introduce complications that must be addressed explicitly in the contract and will create requirements for the FQHC that are significantly different than the requirements associated with standard FQHC practice. For example, documentation and claiming requirements are unique to the specialty mental health system and may not conform to existing health center medical record and staff documentation training systems. Existing cost report processes may not meet mental health cost reporting requirements and, thus, additional cost reports may need to be completed requiring separate cost allocation methodologies. FQHCs serving as county-subcontracted providers would need to ensure compliance with both FQHC regulatory provisions and county contractual obligations, which may present a substantial internal administrative burden.

## Key Considerations for Contractual Arrangements with County Specialty Mental Health Plans and Drug Medi-cal-Organized Delivery Systems

| KEY CATEGORIES FOR CONSIDERATION | CONTRACT WITH MHP | CONTRACT WITH DMC-ODS IN OPT-IN COUNTIES |
|---|---|---|
| **CONTRACTUAL CONSIDERATIONS** | *In order for the MHP to establish a sub-contract for services, there are numerous requirements that must be met, including, but not limited to:*<br><br>**Provider Selection.** The MHP must have written policies and procedures in place for selection, retention, credentialing, and re-credentialing of providers.<br><br>**Provider Certification.** The MHP must confirm and verify through a site visit that the provider meets all Medi-Cal licensing and certification requirements, as outlined in regulation and contract. The MHP must determine which Rehabilitation and Targeted Case Management services the provider is eligible to provide, consistent with Medi-Cal state plan and waiver requirements. For example, "Medication Support" is a rehabilitative mental health service outlined in the state plan that has coverage, provider qualification, treatment plan, and location requirements that must be met for certification, documentation, and claiming purposes.<br><br>**Provider Requirements.** Organizational providers must comply with numerous requirements related to beneficiary records, staffing, access to psychiatry, and medication storage, among others. All sub-contracted providers are required to complete and submit an annual cost report to the MHP. The cost report must be completed consistent with state, county, and federal Medi-Cal requirements, in the format required by the county and submitted for review by the MHP in a timely manner<br><br>**Subcontractor Monitoring.** The county must monitor the performance of its subcontractors on an ongoing basis for compliance with the terms of their contract and must subject the subcontractors' performance to periodic formal review, at a minimum in accordance with the recertification requirements. If the contracting county identifies deficiencies or areas for improvement, the county contractor and the subcontractor must take corrective action to resolve these issues. | **Selective Provider Network.** The DMC-ODS pilot is administered locally within each county. Each county provides or arranges for the provision of SUD treatment for its Medi-Cal beneficiaries. Access cannot be limited in any way when counties select providers.<br><br>*DMC-ODS Providers must meet the following requirements:*<br><br>**Professional staff requirements.** Must be licensed, registered, certified, or recognized under California scope of practice statutes. Professional staff must provide services within their individual scope of practice and be supervised as required under their respective scope of practice laws.<br><br>**Non-professional staff.** Must receive appropriate on-site orientation and training prior to performing their assigned duties.<br><br>**Training and Certification.** Professional and non-professional staff are required to have the required experience and training by the time of hiring. Providers must have a license certification issued by the state that is in good standing and be trained in the ASAM Criteria prior to providing services and meet quality assurance standards, including any additional standards established by the county.<br><br>**Timely Access.** Contractors are required to meet standards for timely access to care and services as specified in the county implementation plan and state-county intergovernmental agreement. Medical attention for emergency and crisis medical conditions must be provided immediately.<br><br>**Culturally Competent Services.** Providers must ensure that culturally competent policies, procedures, practices, and services are embedded in the organizational structure and upheld in day-to-day operations. Translation services must be available for beneficiaries, as needed.<br><br>**Medication Assisted Treatment (MAT).** Providers must have procedures for linking beneficiaries with MAT. Staff must establish regular communication with physicians of beneficiaries who are prescribed these medications, unless the beneficiary refuses to consent. |

## Key Considerations for Contractual Arrangements with County Specialty Mental Health Plans and Drug Medi-cal-Organized Delivery Systems (continued)

| KEY CATEGORIES FOR CONSIDERATION | CONTRACT WITH MHP | CONTRACT WITH DMC-ODS IN OPT-IN COUNTIES |
|---|---|---|
| **LICENSING AND CERTIFICATION** | **MHP Certification.** The MHP is responsible for the certification of specialty mental health providers. MHP certification is based on mode of service (i.e., medication support or mental health services). The certification standards are outlined in the MHP contract and require the county to conduct an onsite review of all certified providers. The FQHC would need to show evidence of compliance with the MHP certification requirements, regardless of their community clinic licensure. A separate license is not required for outpatient services. | **Drug Medi-Cal Certification.** The DHCS Provider Enrollment Division (PED) is responsible for certification for all DMC providers. Providers must undergo the state certification process to contract with the county as part of the DMC-ODS network. Certification is based on the mode of service (i.e., outpatient drug-free, intensive outpatient, residential). A separate license is not required for outpatient services. |
| **REIMBURSEMENT** | **Medi-Cal Specialty Mental Health Claims Submission Requirements.** All claims for mental health rehabilitative and targeted case management services must conform to state and county Short Doyle II claims adjudication and documentation requirements. Claims for sub-contracted services are certified by the county as meeting all state and federal Medicaid requirements and submitted for processing through the state-operated Short Doyle system. Individual sub-contractor reimbursement rates are established, consistent with state and federal requirements, for each covered service by the county annually and are specified in the provider contract. Claims for services are subject to eligibility verification, share of cost determination, and other payment liabilities determination (i.e., Medicare) as appropriate.<br><br>**Annual Cost Report.** All sub-contracted providers are required to complete and submit an annual cost report to the MHP. The cost report must be completed consistent with state, county, and federal Medi-Cal requirements, in the format required by the county, and submitted for review by the provider within the timeframes specified in the contract.<br><br>**Medi-Cal Mental Health Cost Report Review / Audit.** The MHP reviews the cost report on an annual basis to confirm that the reimbursements provided to the sub-contractor meets the lower of cost or customary charge, and other federal requirements. The provider is required to show documented verification that the costs charged to the Medi-Cal MHP have been allocated consistent with state and federal requirements, and do not constitute duplicate or ineligible payments. If it is determined that an overpayment has occurred, the provider will be required to return the full overpayment amount to the MHP in the contract-specified timeframe. | **Interim Rates.** Counties participating in the DMC-ODS must submit for annual state approval interim rates for each covered mode of service. Federal financial participation is available to DMC-ODS pilot counties that certify the total allowable expenditures incurred in delivering covered services. County-operated providers are reimbursed based on actual costs. Subcontracted fee-for-service providers are reimbursed based on actual expenditures. Annual Cost Report. Providers must submit an annual cost report that reflects the providers serving Medi-Cal beneficiaries consistent with the authorities specified in the approved terms and conditions of the waiver. Actual costs are then reconciled to the interim payments made throughout the year to determine if a federal over or under-payment was made to the county. |

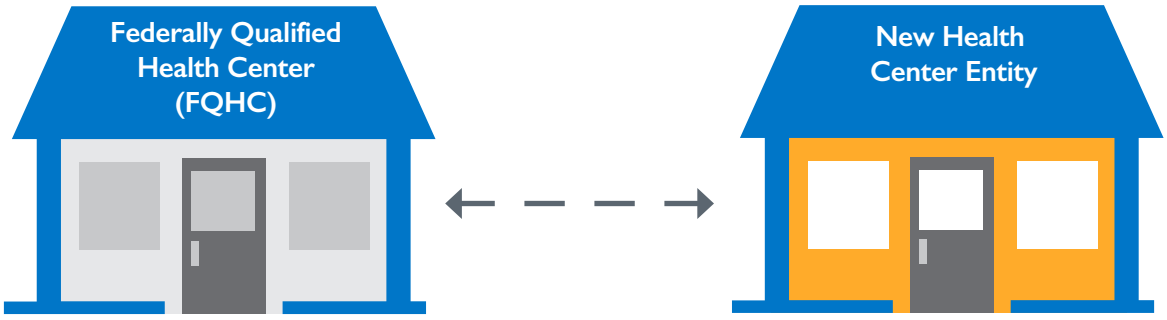
Key Considerations for Contractual Arrangements with County Specialty Mental Health Plans and Drug Medi-cal-Organized Delivery Systems (continued)

| KEY CATEGORIES FOR CONSIDERATION | CONTRACT WITH MHP | CONTRACT WITH DMC-ODS IN OPT-IN COUNTIES |
|---|---|---|
| **COMPLIANCE WITH OTHER EXISTING STATE AND FEDERAL LAWS** | **Anti-Kickback Statute.** Anti-kickback statute prohibits payment in return for beneficiary referrals. It also prohibits payment intended to induce the purchasing, leasing, ordering, or arranging of any good, facility, service, or item paid for by federal health care programs. FQHCs should work with an appropriate legal counsel to ensure that contractual arrangements are in compliance with anti-kickback statute, anti-trust violation, tax-exempt status, Medicaid and Medicare reimbursement, and state law.<br><br>**Federal Procurement Standards.** The FQHC must assure that procurement of services was consistent with federal procurement standards if federal funds are used. | |

## ARRANGEMENT 2:

### *Creating New Health Center Entities Outside of the FQHC to Provide Specialty Mental Health and Substance Use Disorder Services*

Creating a New Provider Organization is an option in which a new provider entity is established and collaborates closely with the FQHC and other local partners to provide mental health and SUD services to individuals and families in the community. The new entity is not an FQHC; it is a separate entity that is owned and governed by the FQHC. The new organization may be for-profit or non-profit, depending upon the goals of the partnership arrangement. The county and FQHC may consider this arrangement for situations where serious gaps in access need to be filled due to geographic or demographic considerations. For example, this arrangement may be most appropriate when an identified high-risk and / or underserved population requires highly-specialized and focused care, or when there is no other provider covering an isolated geographic region of the county.




*The new Health Center entity is not an FQHC; it is a separate entity that is owned and governed by the FQHC.*

*The new health center can collaborate closely with the FQHC and other local partners to provide mental health and SUD services to individuals and families in the community.*

### CHALLENGES IN CREATING A NEW HEALTH CENTER ENTITY FOR SMH AND SUD SERVICES:

**Section 330 Requirements**

Section 330 grantees planning to open a new site must demonstrate that the expansion will not require additional 330 grant funding. FQHCs must also consider whether the new site duplicates existing services, and whether the provision of services represents a duplicative payment risk.

**Anti-kickback Statute and Stark Law**

Establishing contracts for specialty mental health or substance use disorder services when the FQHC has a financial interest may violate federal anti-kickback statute. FQHCs entering into arrangements where a referral is being made to a partner entity with a financial relationship to the referring entity for specialty services should also review whether such an arrangement violates federal Stark Law, which has broad application to referrals made by a Medicaid provider to another organization. FQHCs should review these laws with appropriate legal counsel when considering the establishment of a new health center entity for the purpose of referral to treatment.

**Reimbursement Considerations**

In order for the new organization to offer and be reimbursed for Medi-Cal specialty mental health services, such as rehabilitative and targeted case management services, the site must be certified by the county and under county contract to offer services as part of the MHP network. To offer and be reimbursed for services covered by DMC, the new provider organization must be certified by the state as a DMC provider and under contract with the county to be included in the DMC network.

## Practical Implications

Careful consideration should be given to the efficiency and effectiveness of this arrangement from a beneficiary access, administrative, and cost effectiveness perspective. The benefit to the beneficiary of integrated and coordinated care may be diluted with this arrangement depending on the location of and ease of access to the separate site. A MHP or county SUD program and a FQHC may consider this arrangement in situations where serious gaps in access need to be filled from a geographic or high-risk beneficiary specialty needs perspective. For example, this arrangement may be most appropriate when an identified high-risk population requires highly specialized and focused care, or when there is no other provider covering an isolated geographic region of the county. In order for the new organization to offer and be reimbursed for Medi-Cal specialty mental health services, such as rehabilitative and targeted case management services, the site must be certified by the county and under county contract to offer services as part of the MHP network. In order to offer and be reimbursed for SUD treatment services covered by Drug Medi-Cal, the new provider organization must be certified by the state and under contract with the county to be included in the DMC network.

Furthermore, it is critically important for FQHCs to review anti-kickback law(s) and Stark Law with an appropriate legal counsel when considering the establishment of a new health center entity for the purpose of referral to treatment.

## ARRANGEMENT 3:
## *Bidirectional Co-location with Specialty Mental Health and Substance Use Disorder Partners*

Bidirectional Co-Location provides an opportunity to increase access and better coordinate care for individuals with co-occurring chronic health and mental health conditions and / or SUDs. Successful implementation requires collaborative planning and the development of written coordination / co-location protocols between the partner organization and the FQHC.

**MODEL 1:** Specialty MH/SUD Co-located within FQHC

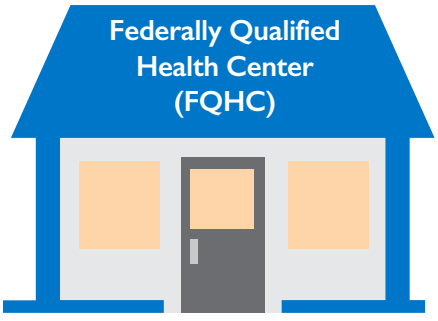
Specialty mental health providers and/or SUD treatment providers offer SMH and/or SUD services at the FQHC site to facilitate successful referrals to specialty care and improve care coordination. The county (or county subcontractor) places their own staff at the FQHC site to offer specialty mental health/SUD services. SMH/SUD staff and providers are not employed or reimbursed by the FQHC.

**MODEL 2:** FQHC Primary Care Co-located within Specialty Site

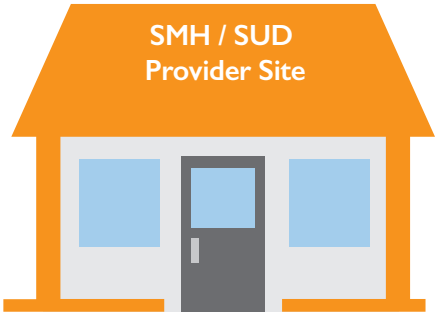
FQHC staff offer primary care services at the county (or county sub-contracted) SMH and/or SUD site to increase access to primary care and improve care coordination. FQHCs place their own providers and staff at a specialty mental health or SUD treatment provider site to offer primary care services. FQHC staff and providers are not employed or reimbursed by the specialty provider.

There is no arrangement for payment between the co-locating entities. While the provider organizations share physical space, they remain separate for administrative and reimbursement purposes. This arrangement allows for a bi-directional extension of services and the opportunity for greater care coordination without necessitating any payment transaction between the FQHC and the partner organization.

## Two Models for Co-Location




**MODEL 1**
*Specialty MH/SUD Co-located within FQHC.*




**MODEL 2**
*FQHC Primary Care Co-located within Specialty Site.*

## Key Considerations for Bidirectional Co-location with SMH and SUD Partners

| KEY CATEGORIES FOR CONSIDERATION | MODEL 1: MH / SUD PROVIDER AT FQHC SITE | MODEL 2: FQHC PROVIDER AT SPECIALTY MH / SUD SITE |
|---|---|---|
| LICENSING AND CREDENTIALING | **Verification of Partner Organizations.** It is the responsibility of the FQHC to ensure that referral partners are properly licensed and credentialed to perform the activities for which they are contracted. FQHCs should work with the non-FQHC organization to verify this. For provider arrangements that do not meet the criteria for Federal Tort Claims Act (FTCA) coverage, FQHCs should ensure that the provider has an alternative form of malpractice insurance. | **Intermittent Clinics.** The FQHC may choose to open an "intermittent clinic" onsite or adjacent to a partner mental health or SUD treatment organization. The intermittent clinic must be open for no more than 30 hours per week. An intermittent clinic must meet other relevant requirements, including administrative regulations and requirements pertaining to fire safety. Intermittent clinic sites must also be included in the "parent" FQHC HRSA Scope of Project. An intermittent site does not have a separate license or separate PPS rate from the parent FQHC.<br><br>Separately Licensed FQHC Site. If the FQHC chooses to open a separately licensed site adjacent to the partner mental health and / or SUD organization, it would need to be done through the state licensure process and meet all applicable requirements. |
| NOTIFICATION | **State Notification.** FQHCs must provide written notice to the California Department of Public Health (CDPH) of a change in service no less than 60 days before adding the service. FQHCs will need to review whether co-location with county providers reflects a change in service at the delivery site in advance of commencing operation to ensure compliance.<br><br>**Federal Notification.** If the co-location involves a formal referral arrangement (i.e., the FQHC maintains responsibility for the beneficiary treatment plan and provides appropriate follow-up care based on outcome of the referral), then the FQHC must receive HRSA's approval prior to adding the service. | **Federal Notification.** If the co-location involves a formal referral arrangement (i.e., the FQHC maintains responsibility for the beneficiary treatment plan and provides appropriate follow-up care based on outcome of the referral) or is included in the FQHC's scope of project, then the FQHC must receive HRSA's approval prior to adding the service. |
| SCOPE CHANGE CONSIDERATIONS | **Supplanting Existing Services vs. Referral.** A scope change may be required if the FQHC is supplanting services that were previously available to beneficiaries through the FQHC. If a service is both provided and billed for by another entity, it is not considered to be part of the FQHC's Scope of Project. The establishment of the referral arrangement and any follow-up care provided by the FQHC subsequent to the referral is considered to be part of the FQHC's scope of project. FQHCs should work with a BPHC Project Officer to determine whether a scope change is needed. | **Intermittent Clinics and Referral.** Intermittent clinic sites must be in the parent FQHC's HRSA Scope of Project and must inform Medi-Cal of its operation. The establishment of a referral arrangement and any follow-up care provided by the FQHC subsequent to the referral is considered to be part of the grantee's scope of project. FQHCs should work with a BPHC Project Officer when considering co-location arrangements. |

Key Considerations for Bidirectional Co-location with SMH and SUD Partners (continued)

| KEY CATEGORIES FOR CONSIDERATION | MODEL 1: MH / SUD PROVIDER AT FQHC SITE | MODEL 2: FQHC PROVIDER AT SPECIALTY MH / SUD SITE |
|---|---|---|
| **REIMBURSEMENT** | **Supplement vs. Supplant.** Mental health and / or SUD treatment services offered to Medi-Cal beneficiaries by a partner organization at the FQHC site would be paid for through the partner organization's existing reimbursement structure. If the co-located arrangement offers services that take the place of services that were previously available to beneficiaries through the FQHC and included in the PPS rate, a scope of service change may be necessary. FQHCs should work with their BPHC Project Officer and seek fiscal / legal counsel to determine whether existing FQHC services are being supplanted in the new arrangement and whether a change in scope would meet the threshold for rate adjustment. | **Considerations for Intermittent Clinics.** FQHC primary care services offered to Medi-Cal beneficiaries at an intermittent site that is co-located with a partner organization would be reimbursed as FQHC services through the parent clinic's PPS rate, subject to the right of the FQHC to request a rate adjustment as appropriate.<br><br>**New FQHC Site.** If the FQHC opened a new, separately licensed site that is co-located with the partner organization, a new PPS rate would need to be established pursuant to state and federal guidelines. |

## Practical Implications

Co-location provides an opportunity for improved coordination of care for beneficiaries with co-occurring chronic health and mental health conditions and/or SUDs. This population represents a high-risk and high service utilization cohort that will experience significant benefit from the effective implementation of this arrangement. Successful implementation will require collaborative planning and the development of written coordination and co-location protocols on the part of the partner organization and the FQHC. Agreements might focus on high-risk population identification, the specification of care coordination activities, and agreement regarding the desired outcomes. The benefits of improved outcomes from a utilization and cost perspective may accrue to the beneficiary's health plan, so consideration should be given to including payers in the local planning efforts.

## ARRANGEMENT 4:
### *Medication Assisted Treatment for Substance Use Disorder In or Out of Drug Medi-cal*

Medication Assisted Treatment combines behavioral therapy and medications to treat substance use disorders, including opioid and alcohol use disorders. FQHCs have the potential to serve as a critical access point for the expansion of MAT in the primary care setting, helping to close gaps in access and improve the integration of care for patients.

FQHC's may offer MAT therapies as part of the DMC provider network using one of the models referenced in this document; or may expand their ability to offer MAT under the FQHC's authority and structure. Under this arrangement, FQHCs provide critical access to MAT for health center patients without becoming a DMC-certified provider. FQHCs provide MAT services using a billable provider and receive the PPS rate for those encounters.

Physicians and advanced practice clinicians must obtain a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver (X number) to order, stock, and administer buprenorphine. Such medications may be prescribed, dispensed, or administered in the office or clinic setting.

The provider bills the medical service just as any other medical service provided by his/her provider type. If the FFS physician administers the drug in the office, this is termed a "physician administered drug." The physician is reimbursed for the drug and the administration directly. If the medication is not administered directly to the patient, and the physician writes a prescription for the patient to pick up at a pharmacy for self-administration, the drug cost is covered under the FFS Pharmacy Benefit.

Physicians must complete an eight-hour training to qualify for a waiver. Physicians apply for a waiver and forward this application to the Department of Justice Drug Enforcement Administration (DEA), which assigns the physician a special identification number. Physicians are required to include this number on all buprenorphine prescriptions for opioid dependency treatment, along with their regular DEA registration number.

Qualified practitioners to request approval to treat up to 275 patients (prior to the new rule practitioners could only treat up to 100 patients)

## Practical Implications

This arrangement allows FQHCs to provide critical access to MAT for patients without having to go through the process of becoming a DMC certified provider and meeting the contract provisions of the county. FQHCs stand to serve as critical access points to expand MAT in an integrated primary care setting, addressing both access and quality from a beneficiary and delivery system perspective.

## Key Considerations for Medication Assisted Treatment in/out of DMC

| KEY CATEGORIES FOR CONSIDERATION | MAT PROVIDED AS FQHC SERVICE | CONTRACTUAL ARRANGEMENTS OR NEW PROVIDER ORGANIZATION FOR MAT UNDER DMC-ODS |
|---|---|---|
| **REQUIRED MAT SERVICES** | Medi-Cal beneficiaries may access MAT services outside of the DMC-ODS pilot program under certain circumstances. Health Centers may offer certain MAT services through an enrollment of physicians as Fee-For-Service (FFS) providers.<br><br>Example services include:<br>• office or other outpatient visit for the evaluation and management of a new or established patient;<br>• counseling and/or coordination of care with other providers or qualified health care professionals or agencies that are consistent with the nature of the problem(s) and the patient's and or family's needs; and<br>• medication induction services.<br><br>Health centers should consult the Medi-Cal Provider Manual and their Regional DHCS Representative for guidance on allowable services and codes for MAT services for FFS providers. | • FDA approved medications except methadone (any DMC setting). Methadone is only available to Medi-Cal beneficiaries through certified NTP.<br>• Ordering, prescribing, administering, and monitoring of MAT<br>• Utilization of long-acting injectable naltrexone at DMC facilities, including NTPs<br>• County-proposed interim rates for additional MAT outside of a NTP setting, including buprenorphine, disulfiram, naloxone, and long-acting injectable naltrexone. |
| **CONTRACTUAL CONSIDERATIONS** | Health centers should seek legal and fiscal counsel to determine whether or not implementing a MAT program would meet the threshold to qualify for a rate adjustment through the scope of service change process. | DMC-ODS Pilot Program Counties must require through contract that providers have procedures and protocols in place to assure care coordination and linkage to other services and supports for beneficiaries receiving MAT. Provider staff shall maintain regular communication with the physicians of the clients who are prescribing these medications, unless the client chooses not to consent to signing a 42 CFR part 2 compliant release of information for this purpose. |
| **COVERED MEDICATIONS** | **Buprenorphine.** Available to all Medi-Cal beneficiaries who demonstrate medical necessity for use of the medication.<br>• **Treatment Authorization Requirements (TAR):** Not required.<br>• **Pharmacy Coverage:** If the physician prescribes and administers a medication onsite, the activity is covered as a FFS medical benefit. The physician (FQHC) is reimbursed for the prescribing and administering activity directly. Alternatively, if the physician writes a prescription for the beneficiary to pick-up the medication at a pharmacy for self-administration, the drug cost is covered under the FFS Pharmacy Benefit.<br><br>**Naloxone.** Available to all Medi-Cal beneficiaries who are at risk of opioid overdose.<br>• **TAR:** Not required.<br>• **Pharmacy Benefit:** Qualified practitioners can write a prescription for naloxone. The beneficiary can fill the prescription at any Medi-Cal provider pharmacy. Since the drug is administered at the time and place of the overdose, the medication would remain in possession of the beneficiary or caregiver. The drug cost is paid for through the Pharmacy Benefit.<br><br>**Disulfiram.** Available to all Medi-Cal beneficiaries who demonstrate medical necessity for use of the medication.<br>• **TAR:** not required.<br>• **Available as a Pharmacy Benefit** | |

## Key Considerations for Medication Assisted Treatment in/out of DMC (continued)

| KEY CATEGORIES FOR CONSIDERATION | MAT PROVIDED AS FQHC SERVICE | CONTRACTUAL ARRANGEMENTS OR NEW PROVIDER ORGANIZATION FOR MAT UNDER DMC-ODS |
|---|---|---|
| **COVERED MEDICATIONS** | **Long-acting injectable Naltrexone.** Available to all Medi-cal beneficiaries who demonstrate medical necessity for use of the medication.<br>• **TAR:** Always required. If injectable Naltrexone is administered at an outpatient, intensive outpatient treatment, or residential treatment site, a state TAR is not required; however, counties may choose to impose a TAR at the county level.<br>• **Pharmacy Coverage:** If the physician prescribes and administers a medication onsite, the activity is covered as a FFS medical benefit. The physician (FQHC) is reimbursed for the prescribing and administering activity directly. Alternatively, if the physician writes a prescription for the beneficiary to pick-up the medication at a pharmacy for self-administration, the drug cost is covered under the FFS Pharmacy Benefit. | |

# PART 3.
## Conclusion and Final Considerations

Each of the four arrangements outlined require effective and collaborative local communication and partnership between counties, community-based mental health and SUD providers, and FQHCs. The arrangements presented are intended to focus and facilitate this communication with the goal of improving access and care coordination for beneficiaries with co-morbid conditions. When counties and FQHCs are successful in these efforts, beneficiaries receive improved care. Beneficiaries with co-morbid chronic health and mental health conditions/SUDs may have the most to gain in terms of increased longevity and improved physical and mental health status. As a result, these local care integration and coordination efforts should focus on implementation from an improved beneficiary experience and results perspective. Measurement and reporting of these results by the county and the FQHC may provide the most effective policy impetus for adoption and expansion of these arrangements locally.

The relative value of the options outlined will vary from county to county and from FQHC to FQHC. The element that brings this value to the table is starting the conversation locally, using tools such as this document to set the agenda. The shared responsibility to assure access to needed services in the community must be acknowledged by the county and the FQHC as the starting point to create effective health and behavioral health partnerships at the local level.

# Appendix

## APPENDIX A:
## *Improving Care Coordination*

County delivery systems and FQHCs need to build new infrastructure and strengthen relationships to coordinate care more effectively for individuals with mental health needs, particularly since individuals' needs can fluctuate from mild to moderate to severe. Coordinating care across discrete systems requires the development of new tools, infrastructure, and communication strategies to address systemic barriers to integration. In an environment that is increasingly focused on cross-system partnerships and coordination of services managed by separate agencies, thoughtfully developed and implemented practices can facilitate a seamless experience of care at the consumer level.

### THE LITERATURE POINTS TO SEVERAL BEST PRACTICES TO IMPROVE CARE COORDINATION:

**Defining operational best practices for data sharing and measurement.** Despite the data-sharing requirements for delegated entities, like mental health payers, there are no current mandates for routine data sharing and integration between MCP and county MHPs. Integrating these data would significantly enhance opportunities for coordinated management. Absent integrated record sharing agreements between payers, service providers can improve care coordination by creating MOU's for shared patient data between provider organizations[36].

**Establishing clear policies and procedures to facilitate smooth transitions across and between systems.** Transitioning patients across and between systems can be challenging. To the extent that provider systems can cut through the bureaucratic red tape to establish mutually acceptable policies, procedures, and documentation standards, the coordination burden becomes less complex and patients are able to access quality, timely care. One example method to improve shared care planning is establishing a county-wide universal releases of information that allows FQHC and county providers to freely discuss and manage mutual patients.

**Mitigate organizational differences by augmenting regular communication between service organizations and individual providers.** Health plans and counties operate with different practices and procedures and are driven by different incentives. Developing working relationships that include all perspectives equally is an important, ongoing collaborative effort. Establishing routine meetings and mechanisms for face-to-face communication between parties ensures that system challenges and barriers to access are addressed as they arise[37].

**Overcoming workforces challenges across both systems.** In many rural and Central Valley counties in particular, a severe workforce shortage of mental health professionals (particularly psychiatrists) exacerbates the challenge of providing a continuum of mental health services. Expanded use of tele-psychiatry and incentivizing team based care approaches with providers working at the top of their license and skill could help to address this workforce shortage[38]. There is a significant role and opportunity to utilize unlicensed providers (e.g. peers, CHWs, SUD counselors and promotoras) in care coordination.

## APPENDIX B:
## *Relevant Regulatory Citations*

### ARRANGEMENT 1:
### CONTRACTUAL ARRANGEMENTS FOR COUNTY SPECIALTY MENTAL HEALTH AND DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM SERVICES

*42 U.S. Code § 254b(a), Health Centers*

- "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 (…); and as may be appropriate for particular centers, additional health services (…) necessary for the adequate support of the primary health services"

*Title 9 § 1810.355, Excluded Services*

- "MHPs shall not be responsible to provide or arrange and pay for(…) Medi-Cal services that may include specialty mental health services as a component of a larger service package (…including) Specialty mental health services provided by Federally Qualified Health Centers, Indian Health Centers, and Rural Health Clinics."

*HRSA PIN #97-27, Affiliation Agreements of Community and Migrant Health Centers (July 22, 1997)*

- "In many instances, centers do not risk loss of integrity or autonomy with potential affiliation agreements. For example, contracts for specific services (e.g., ancillary services and allied health services) generally do not pose such risks (unless, for example, significant management or clinical services will be furnished by another entity)."
- "BPHC is greatly concerned about health center autonomy in affiliations between health centers and entities that are not subject to the same section 330 grant-related requirements. The basic mission, goals and objectives of the other entities may vary markedly, and their commitment to community-based care for the underserved may be less than that required of health centers. While health center-to-health center affiliation agreements that contain elements which do, or may, pose risks to center integrity or autonomy are included in the subject of this PIN, BPHC is less concerned about threats to health center autonomy when section 330 funded C/MHCs are affiliating with other section 330 funded C/MHCs, given that the requirements are the same and the monitoring processes for section 330 funded C/MHCs provide a greater assurance of compliance."
- "In light of governance requirements specified in the law and regulations, health centers considering an affiliation agreement should examine the proposed affiliation to assure that their governing boards will remain in compliance with all relevant governance provisions."
- "This notice serves as an alert that BPHC, in reviewing affiliation agreements, will evaluate: 1) the composition and expertise of the health center board, 2) any authorities, functions or responsibilities relative to the health center that are delegated to one or more entities from outside the health center, and 3) authority to select or remove any health center governing board members by one or more entities from outside the health center."

- "This notice serves as an alert that BPHC, in reviewing affiliation agreements, will evaluate: 1) the role of the governing board, center staff, and any entity or entities from outside the health center, in determining the overall plan and budget for the center; 2) employment arrangements of key management staff of the health center, including the executive director, finance director and medical director; 3) role of the health center's governing board relative to personnel policies and procedures of the health center; 4) role of the health center's governing board relative to financial management of the health center; 5) role of the health center's governing board in evaluating center activities; and 6) the systems used by the health center for information, cost accounting, reporting and monitoring."
- "This notice serves as an alert that BPHC, in reviewing affiliation agreements, will evaluate: 1) commitment to the medically underserved population(s) that are the basis for the grant or FQHC Look-Alike status; 2) the impact of the affiliation on availability, accessibility, continuity, and acceptability of health center services; 3) any limitations by an outside entity or entities on health center relationships (i.e., any limitations on other health center affiliation agreements); and 4) role of the health center's governing board relative to health care policies and procedures of the health center.
- "Centers are encouraged to seek legal advice from their own counsel in order to assure that organizational documents and contractual agreements accurately reflect the parties' affiliation objectives. In addition, legal advice about the proposed affiliation should be sought in the following areas: 1. anti-kickback statutes, commonly referred to as the fraud and abuse provisions, 2. antitrust, 3. tax-exempt status of the health center, 4. Medicaid and Medicare reimbursement issues, and 5. State law."
- "Although it is beyond the scope of this notice to provide authoritative guidance on this topic, it is important that centers consider the provisions of the Medicare and Medicaid anti-kickback statute [42 U.S.C. 1320a-7b(b)]. This statute makes it a felony for a person or entity to knowingly and willfully offer, pay, solicit, or receive remuneration with the intent to induce a referral, or in return for a referral, under Medicare or a State health care program. Applicable State health care programs are Medicaid, the Maternal and Child Health Block Grant program, and the Social Services Block Grant program. Apart from the criminal penalties, a person or entity is also subject to exclusion from participation in the Medicare and State health care programs for a knowing and willful violation of the statute pursuant to 42 U.S.C. 1320a-7(b)(7). The anti-kickback statute is very broad. Prohibited conduct covers not only remuneration intended to induce referrals of patients, but also remuneration intended to induce the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid for by Medicare or a State health care program. Illegal remuneration may be furnished directly or indirectly, overtly or covertly, in cash or in kind, and covers situations where there is no payment at all, but merely a discount or other reduction in price or the offering of free goods."
- "Centers are encouraged to seek legal advice from their own counsel about the implications of any proposed affiliation agreement under the fraud and abuse statutes, and in particular, under the anti-kickback provisions described above."
- "Centers considering entering into affiliation agreements that may affect their compliance with Federal grant-related requirements should contact the appropriate Health Resources and Services Administration (HRSA) Field Office (see the list attached to this PIN) to initiate consultation, including discussion and review of all relevant documents, i.e., any document in which the terms of the relationship between the health center and the affiliate are stipulated, as early in the center's decision-making process as feasible. The relevant documents may include, but are not limited to, the proposed affiliation agreement, articles of incorporation of the center, by-laws of the center, management services agreement, successor-in-interest agreement, credit agreement, Memorandum of Agreement, Memorandum of Understanding, and/or other contract such as a lease."

*HRSA PIN #2008-01, Defining Scope of Project and Policy for Requesting Changes (Dec. 31, 2007; Revised January 13, 2009)*

- "Grantees should ensure that all agreements/contracts/arrangements with other providers and organizations comply with section 330 requirements and administrative regulations for the Department of Health and Human Services."
- "It is preferable that grantees directly employ providers; however, there can be certain situations under which it may be necessary and appropriate for grantees to engage in alternative arrangements. Grantees must ensure that for all contracted clinical staff or volunteers, there is a separate, written agreement."
- "[…]not all provider arrangements in the scope of project are covered by FTCA. For example, volunteer providers, physicians contracted under a professional corporation or employed by another corporation, as well as interns/residents/medical students not employed by the health center may be included as part of scope of project, but are not covered under FTCA. If providers are employees of another company, the health center would still need to have a separate written agreement with the providers."

*State Medicaid Manual 2088.6 – Recipient Access to Federally Qualified Health Center (FQHC) Services*

- "You must make FQHC services available to all recipients. However, the following conditions apply to this general statement:

Where recipients voluntarily enroll in an HMO or a primary care provider in a §1915(b) waiver program, they have exercised their right not to choose FQHC services as a result of their decision to enroll. Thus they are not entitled to obtain FQHC services outside of the structure of their HMO or primary care provider. They may elect to disenroll in order to regain access to an FQHC.

Where a recipient is in a mandatory §1915(b) waiver program with a choice between several HMOs, PHPs, FFS primary care case management programs (FFS-PCCMs), or PCCMs in an HIO setting, the requirement for you to make FQHC services available has been met as long as:

- FQHCs are available to the recipient as either a contracting entity or case manager;
- Enrollment at the FQHC source is accessible (within accepted community standards for distance and travel times) and not at or over capacity; and
- The recipient has made a choice to enroll with one of the non-FQHC contractors or case managers.

Where the recipient did not have the opportunity to enroll with an FQHC as a primary care contractor or case manager, then he/she must be able to gain access to FQHC services outside of the waiver, and you must pay for these services. However, you may require that all FQHC services be coordinated through the case manager to assure proper management of all care being provided. You need not contract or have agreements with all available FQHCs in order to guarantee availability of these services. Rather, you must contract or have agreements only with sufficient numbers so that the recipient choice remains available, i.e., that participating FQHCs located within accepted community standards for distance and travel time are not filled to capacity.

As long as there is at least one FQHC available to recipients as a case manager in a managed care setting, you cannot be required to contract with others nor are you required to pay for FQHC services provided by other FQHC providers for enrollees who had the opportunity to choose this type of provider as a case manager initially. However, this does not prohibit a plan affiliated case manager from referring his or her enrollees to an FQHC for a particular service."

*California Health & Safety Code 1204(a)*

- "Clinics eligible for licensure pursuant to this chapter are primary care clinics and specialty clinics. Only the following defined classes of primary care clinics shall be eligible for licensure: A 'community clinic' means a clinic operated by a tax-exempt nonprofit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services. In a community clinic, any charges to the patient shall be based on the patient's ability to pay, utilizing a sliding fee scale. No corporation other than a nonprofit corporation, exempt from federal income taxation (…) shall operate a community clinic; provided, that the licensee of any community clinic so licensed on the effective date of this section shall not be required to obtain tax-exempt status under either federal or state law in order to be eligible for, or as a condition of, renewal of its license. No natural person or persons shall operate a community clinic."
- "Nothing in this subdivision shall prohibit a community clinic or a free clinic from providing services to patients whose services are reimbursed by third-party payers, or from entering into managed care contracts for services provided to private or public health plan subscribers(…) For purposes of this subdivision, any payments made to a community clinic by a third-party payer, including, but not limited to, a health care service plan, shall not constitute a charge to the patient."

*1915(b) Waiver for MCO, PIHP, PAHP, PCCM Programs and FFS Selective Contracting Programs (approved by the Centers for Medicare and Medicaid Services (CMS) for a five year term, from July 1, 2015 through June 30, 2020)*

- "In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:(…) The program is mandatory and the enrollee has the right to obtain FQHC services outside this waiver program through the regular Medicaid Program."

*Mental Health Plan Contract Boilerplate*

- **Available Services.** "The Contractor shall ensure that all medically necessary covered Specialty Mental Health Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary covered Specialty Mental Health Service solely because of diagnosis, type of illness, or condition of the beneficiary except as specifically provided in the medical necessity criteria applicable to the situation"
- **Meeting Beneficiary Needs.** "The Contractor shall make all medically necessary covered Specialty Mental Health Services available(…)and shall ensure: 1) The availability of services to address beneficiaries' emergency psychiatric conditions 24 hours a day, 7 days a week. 2) The availability of services to address beneficiaries' urgent conditions(…)24 hours a day, and 7 days a week. 3) Timely access to routine services determined by the Contractor to be required to meet beneficiaries' needs(…)The Contractor shall provide second opinions(…)out-of-plan services(…)a beneficiary's choice of the person providing services to the extent feasible"
- **Network Adequacy.** "At a minimum, the Contractor shall meet the following requirements: Maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services covered under this contract. In establishing and monitoring the network, the Contractor must consider the following: a) The anticipated number of Medi-Cal eligible clients. b) The expected utilization of services, taking into account the characteristics and mental health needs of beneficiaries. c) The expected number and types of providers in terms of training and experience needed to meet expected utilization. d) The numbers of network providers who are not accepting new beneficiaries. e) The geographic location of providers and their accessibility to beneficiaries, considering distance, travel time, means of transportation ordinarily used by Medi-Cal beneficiaries, and physical access for disabled beneficiaries. f) (…) if the Contractor is unable to provide necessary medical services covered

under the contract to a particular beneficiary, the Contractor must adequately and timely cover these services out of network for the beneficiary, for as long as the Contractor is unable to provide them. g) (…) the Contractor shall require that out-of-network providers coordinate authorization and payment with the Contractor(…)the Contractor must ensure that the cost to the beneficiary for services provided out of network pursuant to an authorization is no greater than it would be if the services were furnished within the Contractor's network. h) The Contractor shall demonstrate that its providers are credentialed as required"

- **Timely Access to Care.** "The Contractor shall comply with the requirements set forth (…), including the following: 1) Meet and require its providers to meet Department standards for timely access to care and services, taking into account the urgency of need for services. 2) Require subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the Contractor shall require that hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the Contractor, or another Mental Health Plan. 3) Make services available to beneficiaries 24 hours a day, 7 days a week, when medically necessary. 4) Establish mechanisms to ensure that network providers comply with the timely access requirements; 5) Monitor network providers regularly to determine compliance with timely access requirements; 6) Take corrective action if there is a failure to comply with timely access requirements."
- **Documentation Requirements.** "The Contractor must, when requested by the Department, submit documentation to the Department, in a format specified by the Department, and after receiving reasonable advance notice of its obligation, to demonstrate that the Contractor: 1) Offers an appropriate range of specialty mental health services that is adequate for the anticipated number of beneficiaries for the service area. 2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area(…)whenever there is a change in the Contractor's operation that would cause a decrease of 25 percent or more in services or providers available to beneficiaries, the Contractor shall report this to the Department, including details regarding the change and plans to maintain adequate services and providers available to beneficiaries."
- **Beneficiary Protections.** "The Contractor must implement procedures to: 1) Coordinate the services that the Contractor either furnishes or arranges to be furnished to the beneficiary with services that the beneficiary receives from any other Medi-Cal managed care plan or MHP(…)2) Ensure that, in the course of coordinating care, each beneficiary's privacy is protected in accordance with all federal and state privacy laws(…)to the extent that such provisions are applicable. 3) Enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan serving the Contractor's beneficiaries(…). The Contractor shall notify the Department in writing if the Contractor is unable to enter into an MOU or if an MOU is terminated, providing a description of the Contractor's good faith efforts to enter into or maintain the MOU. The MHP shall monitor the effectiveness of its MOU with Physical Health Care Plans."
- **Time Requirements.** "The Contractor shall act on an authorization request for treatment for urgent conditions within one hour of the request(…)the Contractor shall define service authorization request in a manner that at least includes a beneficiary's request for the provision of a service."
- **Emergency Psychiatric Conditions.** "The Contractor shall pay for services for emergency psychiatric conditions received by a beneficiary from providers, whether or not the provider has a subcontract with the Contractor. Such services shall not be subject to prior authorization."
- **Emergency Post-Stabilization Services.** "The Contractor shall comply(…)regarding emergency, post stabilization services. For purposes of this section, emergency and post stabilization services includes acute psychiatric inpatient hospital professional services(…)which are related to an emergency medical condition or post-stabilization care."

- **On-site review.** "On-site review is not required for primary care and psychological clinics, as defined in the Health and Safety Code section 1204.1 and licensed under the Health and Safety Code. Services provided by the clinics may be provided on the premises in accordance with the conditions of the clinic's license."
- **Subcontractor Monitoring.** "The Contractor shall monitor the performance of its subcontractors on an ongoing basis for compliance with the terms of this contract and shall subject the subcontractors' performance to periodic formal review, at a minimum in accordance with the recertification requirements. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the subcontractor shall take corrective action"
- **Beneficiary Rights.** "the Contractor shall: 1) Notify all beneficiaries of their right to change providers; 2) Notify all beneficiaries of their right to request and obtain the following information: a) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the beneficiary's service area, including identification of providers that are not accepting new patients. b) Any restrictions on the beneficiary's freedom of choice among network providers. c) Beneficiary rights and protections(…). d) The amount, duration, and scope of benefits available under this Contract in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled. e) Procedures for obtaining benefits, including authorization requirements. f) The extent to which, and how, beneficiaries may obtain benefits from out-of-network providers. g) The extent to which, and how, after-hours and emergency coverage are provided, including: What constitutes an emergency medical condition, emergency services, and post-stabilization services(…) ii. The fact that prior authorization is not required for emergency services. iii. The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent. iv. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract. v. The fact that(…)the beneficiary has a right to use any hospital or other setting for emergency care. vi. The post-stabilization care services rules (…) h) Cost sharing, if any. i) How and where to access any benefits that are available under the State Plan but are not covered under this Contract, including any cost sharing, and how any necessary transportation is provided(…), for a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service(…) the Contractor must provide information about the services it does not cover on moral or religious grounds(…)the Contractor shall comply with all of the following requirements: a) Assure that each beneficiary has adequate information about the Contractor's problem resolution processes by taking at least the following actions: i. Including information describing the grievance, appeal, and expedited appeal processes in the Contractor's beneficiary booklet and providing the beneficiary booklet to beneficiaries as described in Section 7 of this contract; ii. Posting notices explaining grievance, appeal, and expedited appeal process procedures in locations at all Contractor provider sites; Notices shall be sufficient to ensure that the information is readily available to both beneficiaries and provider staff. The posted notice shall also explain the availability of fair hearings after the exhaustion of an appeal or expedited appeal process, including information that a fair hearing may be requested whether or not the beneficiary has received a notice of action(…)For the purposes of this Section, a Contractor provider site means any office or facility owned or operated by the Contractor or a provider contracting with the Contractor at which beneficiaries may obtain specialty mental health services; iii. Pursuant to Cal. (…)making available forms that may be used to file grievances, appeals, and expedited appeals and self-addressed envelopes that beneficiaries can access at all Contractor provider sites without having to make a verbal or written request to anyone. iv. (…)giving beneficiaries any reasonable assistance in completing the forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability."

- **Grievance and Appeals.** "the Contractor shall: a) Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance or appeal. The log entry shall include, but not be limited to, the name of the beneficiary, the date of receipt of the grievance, appeal, or expedited appeal, and the nature of the problem; b) Record in the grievance and appeal log or another central location determined by the Contractor, the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the beneficiary. If there has not been final disposition of the grievance, appeal, or expedited appeal, the reason(s) shall be included in the log, c) Provide a staff person or other individual with responsibility to provide information requested by the beneficiary or the beneficiary's representative regarding the status of the beneficiary's grievance, appeal, or expedited appeal; d) Acknowledge the receipt of each grievance, appeal, and expedited appeal to the beneficiary in writing; e) Identify in its grievance, appeal, and expedited appeal documentation, the roles and responsibilities of the Contractor, the provider, and the beneficiary; f) Notify the beneficiary, in writing, of the final disposition of the problem resolution process including the reasons for the disposition; and g) Notify, in writing, any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal(…)Unless specifically prohibited by this contract or by federal or state law, Contractor may delegate duties and obligations of Contractor under this contract to subcontracting entities if Contractor determines that the subcontracting entities selected are able to perform the delegated duties in an adequate manner in compliance with the requirements of this contract. In addition, Contractor may accept the certification of a provider by another Mental Health Plan, or by the Department, in order to meet the Contractor's obligations under Section 4. However, regardless of any such delegation to a subcontracting entity or acceptance of a certification by another MHP, Contractor shall remain ultimately responsible for adequate performance of all duties and obligations under this contract."
- **Quality Management Program.** "The Contractor's Quality Management (QM) Program shall improve Contractor's established outcomes through structural and operational processes and activities that are consistent with current standards of practice. The Contractor shall have a written description of the QM Program which clearly defines the QM Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement. The QM Program shall be evaluated annually and updated as necessary. The QM Program shall conduct performance monitoring activities throughout the Contractor's operations. These activities shall include, but not be limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances. The Contractor shall ensure continuity and coordination of care with physical health care providers. The Contractor shall coordinate with other human services agencies used by its beneficiaries. The Contractor shall assess the effectiveness of any MOU with a physical health care plan. The Contractor shall have mechanisms to detect both underutilization of services and overutilization of services(…)The Contractor shall have a QM Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed. The QM Work Plan shall include: 1) Evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review (…)2) Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service; 3) A description of completed and in-process QM activities, including performance improvement projects. The description shall include: a) Monitoring efforts for previously identified issues, including tracking issues over time; b) Objectives, scope, and planned QM activities for each year; and, c) Targeted areas of improvement or change in service delivery or program design. 4) A description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area. This shall include goals for responsiveness for the Contractor's 24-hour toll-free telephone number,

timeliness for scheduling of routine appointments, timeliness of services for urgent conditions, and access to after-hours care; and 5) Evidence of compliance with the requirements for cultural competence and linguistic competence"

- **Quality Improvement Requirements.** "The Contractor's QI program shall monitor the Contractor's service delivery system with the aim of improving the processes of providing care and better meeting the needs of its beneficiaries. B. The Contractor shall establish a QI Committee to review the quality of specialty mental health services provided to beneficiaries. The QI Committee shall recommend policy decisions; review and evaluate the results of QI activities, including performance improvement projects; institute needed QI actions; ensure follow-up of QI processes; and document QI Committee meeting minutes regarding decisions and actions taken(…)QI activities shall include: 1) Collecting and analyzing data to measure against the goals, or prioritized areas of improvement that have been identified; 2) Identifying opportunities for improvement and deciding which opportunities to pursue; 3) Identifying relevant committees internal or external to the Contractor to ensure appropriate exchange of information with the QI Committee; 4) Obtaining input from providers, beneficiaries and family members in identifying barriers to delivery of clinical care and administrative services; 5) Designing and implementing interventions for improving performance; 6) Measuring effectiveness of the interventions; 7) Incorporating successful interventions into the Contractor's operations as appropriate; and 8) Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review."
- **Cost Reports.** "The Contractor shall submit a fiscal year-end cost report no later than December 31 following the close of each fiscal year unless that date is extended by the Department(…)and/or guidelines established by the Department. Data submitted shall be full and complete and the cost report shall be certified by the Contractor's Mental Health Director and one of the following: (1) the Contractor's chief financial officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to, the Contractor's chief financial officer, or (3) the Contractor's auditor controller, or equivalent. The cost report shall include both Contractor's costs and the cost of its subcontractors, if any. The cost report shall be completed in accordance with instructions contained in the Department's Cost and Financial Reporting System Instruction Manual which can be accessed through the Department's Information Technology Web Services (ITWS) for the applicable year, as well as any instructions that are incorporated by reference thereto; however, to the extent that the Contractor disagrees with such instructions, it may raise that disagreement in writing with the Department at the time the cost report is filed, and shall have the right to appeal such disagreement pursuant to procedures (…) the Department shall provide technical assistance and consultation to the Contractor regarding the preparation and submission of timely cost reports. If the Contractor does not submit the cost report by the reporting deadline, including any extension period granted by the Department, the Department(…)may withhold payments of additional funds until the cost report that is due has been submitted. C. Upon receipt of an amended cost report, which includes reconciled units of service, and a certification statement that has been signed by the Contractor's Mental Health Director and one of the following: 1) the Contractor's Chief Financial Officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to the Contractor's Chief Financial Officer, or (3) the county's auditor controller, or equivalent, the Department shall preliminarily settle the cost report."

## ARRANGEMENT 2:
## CREATING NEW HEALTH CENTER ENTITIES OUTSIDE OF THE FQHC TO PROVIDE SPECIALTY MENTAL HEALTH SERVICES

*42 U.S.C. §1320, Criminal penalties for acts involving Federal health care programs*

- "Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind – (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program(…) shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both."

*HRSA PIN #2007-019, Service Area Overlap: Policy and Process (March 12, 2007)*

- "A grantee or FQHC Look-Alike that wishes to expand its service area by opening a new site may submit a change in scope request at any time. For grantees, they must demonstrate that this expansion will not require additional grant funds."
- "For purposes of determining which sites are included within a health center's scope of project, a service site is any place where a health center, either directly or through a sub-recipient or contract arrangement, provides required primary health services and/or approved additional services to a defined service area or population. Service sites are defined as locations where all of the following conditions are met: health center encounters are generated by documenting in the medical record face-to-face contacts between patients and providers; providers exercise independent judgment in the provision of services to the patient; services are provided directly by or on behalf of the grantee, whose governing board retains control and authority over the provision of the services at the location; and services are provided on a regularly scheduled basis (e.g., daily, weekly, first Thursday of every month). However, there is no minimum number of hours per week that services must be available at an individual site/location. Administrative offices or locations that do not provide direct health care services are not service sites."
- "In order to maximize limited resources and access to care for their patients, health centers should coordinate and collaborate with other section 330 grantees, FQHC Look-Alikes, State and local health services delivery projects, and programs in the same or adjacent service areas serving underserved populations to create a community-wide service delivery system. Section 330 of the PHS Act specifically requires that applicants for health center funding have made 'and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the center' (PHS Act section 330(k)(3)(B)). (…) the goal of collaboration is to utilize the strengths of all involved organizations to best meet the overall health care needs of the area's underserved population. In addition, continued collaboration among providers will help to ensure that organizations are aware of and, where possible, maximize the benefits of, existing or potential service area overlaps."
- "Issues of service area overlap are raised primarily in five types of situations, listed below:
  - an existing grantee health center, new entity, or FQHC Look-Alike applies for NAP or other funding to serve an area which includes all or part of the service area of another existing grantee health center;

- an existing grantee health center or FQHC Look-Alike requests a "Change in Scope" to open a new health center service site to serve all or part of the service area of another health center, or to provide new services to all or part of the service area of another health center;
- an existing grantee health center, non-grantee health center, or FQHC Look-Alike applies for NAP funding, other section 330 funding, or requests a Change in Scope at the same time as another grantee health center, non-grantee health center, or FQHC Look-Alike proposes to serve an area which, at the time of the application, is not served by either organization;
- an existing grantee health center or FQHC Look-Alike relocates an existing clinic to an area served by another health center; or an organization applies for FQHC Look-Alike status to serve an area or population already served by an existing grantee health center."

- "HRSA will be guided by the following overarching principles listed below when assessing individual situations of service area overlap:
  - Meeting the health care needs of the community and target population is paramount in decisions related to service area overlap;
  - Federal grant dollars should be distributed in such a way as to minimize the potential for unnecessary duplication and/or overlap in services, sites, or programs;
  - HRSA recognizes the advantage of using existing resources with proven capabilities to maintain effective and efficient delivery of health care within communities;
  - When a newly identified group of underserved people within a community already served by a health center is proposed to be served by a new site (e.g., homeless people within the service area), this potentially unmet need in the community will be considered when reviewed for service area overlap. If the health care needs of the relevant medically underserved population group within a service area are not being met, geographic service area boundaries will not serve as a barrier to the approval of the application, even where the service area does in fact overlap with that of an existing grantee health center or FQHC Look-Alike;
  - HRSA encourages openness and collaboration among providers(…)The goal of collaboration is to utilize the strengths of all involved organizations to best meet the overall needs of the area's underserved population; and
  - HRSA has a responsibility to ensure the efficient distribution of Federal resources. Therefore, when the potential exists for patients to be drawn from an existing health center to a new organization or proposed site, HRSA will consider the financial impact on the existing health center. In doing so, HRSA may examine the past performance of the existing health center and its historical and current ability to meet the needs of the community."

## ARRANGEMENT 3:
## BIDIRECTIONAL CO-LOCATION WITH SPECIALTY MENTAL HEALTH AND SUBSTANCE USE DISORDER PARTNERS

*California Health and Safety Code 1206*

- An intermittent clinic is operated on separate premises from the licensed clinic and is only open for limited services of no more than 30 hours a week. An intermittent clinic must meet administrative regulations and requirements, pertaining to fire and life safety.

*California Health & Safety Code 1212(b)*

- Clinics must provide written notice to the California Department of Public Health of a change in service no less than 60 days before adding the service.

*HRSA PAL #2011-02, Health Center Collaboration (November 23, 2010)*

- "When assessing whether contractual arrangements between a health center and another provider are the most appropriate form of collaboration, the following factors must be considered by both parties:

  1) Health centers are responsible for maintaining oversight over all sites and services within their federally approved scope of project, including assuring that patients have access to the health center's full range of services;

  2) Health centers must assure that all services included under their federally approved scope of project, including those performed under contract, are available to patients regardless of their ability to pay;

  3) Health Center Program grantees must comply with section 330 of the PHS Act and the HHS grant regulations, including those specific to the provision of required services (and payment for those services to the extent that they are not provided directly by the health center) and to procurement of goods and services(…); and

  4) Benefits that are afforded to health centers from programs other than under Section 330 (i.e., Federal Tort Claims Act coverage, 340B pricing, reimbursement as a FQHC under Medicare/Medicaid/CHIP) are determined by the applicable laws and rules of the respective programs. Therefore, the terms of the contractual agreement should be constructed accordingly."

- "BPHC Project Officers can assist health centers in reviewing proposed collaborative agreements from the standpoint of compliance with programmatic requirements. It is always recommended that these agreements be reviewed by the health center's own legal counsel for considerations beyond program compliance."

*HRSA PIN #2007-019, Service Area Overlap: Policy and Process (March 12, 2007)*

- "In order to maximize limited resources and access to care for their patients, health centers should coordinate and collaborate with other section 330 grantees, FQHC Look-Alikes, State and local health services delivery projects, and programs in the same or adjacent service areas serving underserved populations to create a community-wide service delivery system. Section 330 of the PHS Act specifically requires that applicants for health center funding have made 'and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the center.' (…) the goal of collaboration is to utilize the strengths of all involved organizations to best meet the overall health care needs of the area's underserved population. In addition, continued collaboration among providers will help to ensure that organizations are aware of and, where possible, maximize the benefits of, existing or potential service area overlaps."

- "HRSA encourages openness and collaboration among providers. The goal of collaboration is to utilize the strengths of all involved organizations to best meet the overall needs of the area's underserved population"

*HRSA PIN #2008-01, Defining Scope of Project and Policy for Requesting Changes (Dec. 31, 2007; Revised January 13, 2009):*

- "Under a formal written referral arrangement, the grantee maintains responsibility for the patient's treatment plan and will be providing and/or paying/billing for appropriate follow-up care based on the outcome of the referral. These referral arrangements should be formally documented in a written agreement that at a minimum describes the manner by which the referral will be made and managed and the process for referring patients back to the grantee for appropriate follow-up care. Under these types of formal referral arrangements, if the actual service is provided and paid/billed for by another entity, then the SERVICE IS NOT included in the grantee's scope of project. However, establishment of the referral arrangement and any follow-up care provided by the grantee subsequent to the referral is considered to be part of the grantee's scope of project. For example, a grantee may have a referral arrangement for diagnostic X-ray with a hospital. As part of the referral arrangement, the hospital performs the diagnostic X-ray, bills the patient for the services and provides feedback and/or results to the grantee for appropriate follow-up care. The diagnostic X-ray service would NOT be part of the grantee's scope of project but the establishment of the referral and follow-up care provided by the grantee would be part of the grantee's scope of project."
- "Grantees should ensure that all agreements/contracts/arrangements with other providers and organizations comply with section 330 requirements and administrative regulations for the Department of Health and Human Services. Grantees should also ensure that providers for any formal arrangements/agreements are properly credentialed and licensed to perform the activities and procedures expected of them by the grantee."
- "While grantees may deliver a service by several different methods, a service will only be included in the grantee's scope of project if it is delivered directly by the grantee or through a formal written agreement such as a contract, purchase agreement, and/or written arrangement (…) Although the arrangement with another provider under a formal referral arrangement is within a grantee's scope of project, the actual service provided by the other provider under the arrangement is not included in a grantee's scope of project; therefore, if a grantee has been providing a service only through a formal or informal referral arrangement and wishes to begin providing this service directly or through formal agreement as part of their scope of project (…)), the grantee MUST submit a change in scope request to add the service to the scope of project and begin providing this service. Cases where a grantee moves a service(s) from one site to another site in the approved scope of project do not require prior approval. However, in doing so, grantees should assure that the population accessing the service at the original site will continue to have reasonable access to the service once it is relocated."

*HRSA PIN #2009-02, Specialty Services and Health Center's Scope of Project*

- "Services supported by the Federal section 330 grant must include certain 'required primary health services' listed in the Health Center Program's authorizing statute. Health centers may also provide additional health services that are 'necessary for the adequate support of the [required] primary health services' and that are 'appropriate to meet the health needs of the populations served by the health center.' Although the Health Center Program's authorizing statute does not specifically prohibit health centers from offering particular services. Department of Health and Human Services (DHHS) grants regulations and policy require prior approval before new services may be added to a health center's federally-approved scope of project."
- "(…)when requesting a change in scope to add a specialty service to the Federal scope of project the, a health center must demonstrate how the new service will support the provision other required primary care services provided by the health center. In other words, the health center must show that the proposed services function as a logical extension of the required primary care services already provided by the

health center and/or that the proposed services complement the required primary health care services. Examples or services that may be a complementary extension of primary health care include: (…)psychiatric consultations, examinations and differential diagnoses. where the health center serves a substantial number of patients with mental health and/or substance abuse diagnoses"

- "Section 330 authorizes the provision of non-required "additional" health services when appropriate to meet the needs of the target population. Therefore, when requesting a change in scope to add a specialty service to the Federal scope of project, a health center must demonstrate and document the target population's need for the proposed service. Unmet need should be described both in narrative format and with data. In addition, when proposing the addition of a specialty service, the health center must demonstrate its ability to maintain the level and quality of the required primary health services currently provided to the target population."
- "(…)the provision of any additional service must not compromise the provision of required primary health care services. In summary, when requesting a change in the Federal scope to add a specialty service to the scope of project, a health center must demonstrate that adding the new service 1) will not jeopardize the health center's overall financial stability and 2) will be accomplished with no additional section 330 grant funds."
- "If a specialty service is provided at a location that does not meet the definition of a service site, the health center must document the manner by which the referral will be made and managed and the process for facilitating appropriate follow-up care at the health center. Additionally. health centers must ensure services are provided in culturally and linguistically appropriate manner based on the target population(s). And finally, once a service is included in the approved scope of project, it must be available equally to all patients regardless of ability to pay and available through a sliding fee scale"
- "In circumstances where the provider arrangement docs not meet the criteria for FTCA coverage, health centers should ensure that the provider has sufficient alternative malpractice insurance."

### ARRANGEMENT 4:
### MEDICATION ASSISTED TREATMENT FOR SUBSTANCE USE DISORDER

***HRSA PAL 2004-01, Use of Buprenorphine in Health Center Substance Abuse Treatment Programs (December 5, 2003)***

- "To receive a waiver to practice opioid addiction therapy with approved Schedule III, IV, or V narcotics, a physician must notify the Center for Substance Abuse Treatment (CSAT) in SAMHSA of his or her intent to begin dispensing or prescribing this treatment. This Notification of Intent must be submitted to SAMHSA before the initial dispensing or prescribing of opioid therapy. This can be done either by (1) filling out the waiver notification form attached to this PAL (Attachment A) and faxing it to the Center for Substance Abuse Treatment, Attention: Opioid Treatment Waiver Program at 301-443-3994 or mailing to the address on the form or (2) filling out and submitting the form on-line at SAMHSA's buprenorphine web site at http://www.buprenorphine.samhsa.gov/pls/bwns/waiver. The Notification of Intent must contain information on the physician's qualifying credentials (as defined below) and additional certifications. And, as stated above, physicians must attest to their capacity to refer opioid addiction therapy patients for appropriate counseling and other non-pharmacologic therapies. The physician must also agree to provide no more than 30 patients with such addiction therapy at any one time. (Note that the 30 patient limit applies to both physicians in solo practice and to entire group practices, and is not affected by the number of a physician's or group's practice locations.)"

- "The Drug Addiction Treatment Act of 2000 (DATA 2000) now gives physicians the ability both to treat opioid dependence and to monitor patient compliance safely and conveniently in the office, clinic, or hospital. DATA 2000 expands the clinical context of medication-assisted opioid addiction treatment by allowing qualified physicians to dispense or prescribe specially approved schedule III, IV, and V narcotic medications for the treatment of opioid addiction in treatment settings other than the traditional Opioid Treatment Program (i.e., methadone clinic)."
- "As part of the approval process, the Drug Enforcement Administration (DEA) will assign the physician a special identification number. DEA is preparing regulations that will require this ID number to be included on all buprenorphine prescriptions for opioid addiction therapy, along with the physician's regular DEA registration number."

## End Notes

[1] 42 Code of Federal Regulations, § 51c.107(c), "Prior approval by the Secretary of revisions of the budget and project plan is required whenever there is to be a significant change in the scope or nature of project activities."

[2] Institute of Medicine, Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (DC: 2006).

[3] Hedden, S. et al., Substance Abuse and Mental Health Services Administration, Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health (2014), http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.htm#idtextanchor074.

[4] De Hert et. al., "Physical Illness in Patients with Severe Mental Disorders: Prevalence, Impact Of Medications And Disparities In Health Care," World Psychiatry 10, no. 1 (2011): 52–77.

[5] National Institute on Drug Abuse, Drugs, Brains, and Behavior: The Science of Addiction (2014), www.drugabuse.gov/sites/default/files/soa_2014.pdf

[6] Substance Abuse and Mental Health Services Administration, Mental and Substance Use Disorders (2014), http://www.samhsa.gov/disorders.

[7] Health & Education: Statistics, National Institutes of Health & National Institute of Mental Health, accessed February 15, 2016, www.nimh.nih.gov/health/statistics/index.shtml.

[8] Bradford D.W. et. al., Department of Veterans Affairs, Veterans Health Administration Health Services Research & Development Service, Effects of Care Models to Improve General Medical Outcomes for Individuals with Serious Mental Illness, (DC: 2011), www.hsrd.research.va.gov/publications/esp/smi.pdf

[9] Health & Education: Statistics, National Institutes of Health & National Institute of Mental Health.

[10] Park, J. et al., National Association of State Mental Health Program Directors Medical Directors Council, Morbidity and Mortality in People with Serious Mental Illness (2006), http://nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf

[11] Ibid.

[12] Waiver Technical Assistance Collaborative & Human Services Research Institute, California Mental Health and Substance Use Needs Assessment Final Report, (2012), www.dhcs.ca.gov/provgovpart/Documents/1115%20Waiver%20Behavioral%20Health%20Services%20Needs%20Assessment%203%201%2012.pdf. SMI is defined in this instance as populations meeting the medical necessity criteria for Drug Medi-Cal or mental health services under the Specialty Mental Health Services 1915(b) Waiver.

[13] Ibid.

[14] California Welfare and Institutions Code, § 5150 & § 5250.

[15] California Welfare and Institutions Code, § 5600.

[16] Bronzan-McCorquodale Act, Chapter 89, Statutes of 1991.

[17] Mental Health Services Act, (Revised July 2013), http://prop63.org/download.php?f=MHSA_July2013.pdf

[18] California Department of Health Care Services, Mental Health Services Act Expenditure Report: Fiscal Year 2015-16, (February 2015), www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Mental%20Health/MHSA_Expenditure%20Report-Jan2015.pdf.

[19] DHCS MHSUDS Website: www.dhcs.ca.gov/services/Pages/MHSUDS.aspx

[20] California Code of Regulations, Title 9, Chapter 11, § 1830.210

[21] 42 Code of Federal Regulations, § 438.2

[22] California Code of Regulations, Title 9, § 1830.205; California Code of Regulations, Title 9, § 1830.210

[23] California Department of Health Care Services, Medi-Cal Managed Care Boilerplate Contracts, accessed June 2, 2016, www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.

[24] 42 Code of Federal Regulations, §438

[24] 1915(b) Medi-Cal Specialty Mental Health Services Waiver, www.dhcs.ca.gov/services/MH/Documents/1915(%20b)_SMHS_Waiver.pdf.

[26] NTP/OTP reimbursement is set pursuant to California Welfare and Institutions Code, § 14021.51.

[26] California Primary Care Association, Community Clinics and Health Centers 2016 Clinic Profile, (2016), http://cpca.org/cpca2013/assets/File/Policy-and-Advocacy/Advocates%20-%20State%20Profile%202016.pdf.

[28] See California Welfare and Institutions Code, §14132.100(g) for FQHC and RHC "visit" definitions.

[29] Ibid.

[30] Section 330 of the Public Health Services Act, codified at 42 U.S. Code, Chapter 6(a), Subchapter II Part D subpart i § 254(b)

[31] Health Resources and Services Administration, Specialty Services and Health Centers' Scope of Project, Policy Information Notice 2009-02, (2009), http://bphc.hrsa.gov/programrequirements/pdf/pin200902.pdf

[32] Section 330 of the Public Health Services Act, codified at 42 U.S. Code, Chapter 6(a), Subchapter II Part D subpart i § 254(b)

[33] Health Resources and Services Administration, Affiliation Agreements of Community and Migrant Health Centers, Policy Information Notice 1997-27, (1997), http://bphc.hrsa.gov/programrequirements/pdf/pin199727.pdf.

[34] More information about the three models of care collaboration is available in Collins, C. et. al., Evolving Models of Behavioral Health Integration in Primary Care, (2010), www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf

[35] Ibid.

[36] Promising Practices to Integrate Physical and Mental Health Care for Medi-Cal Members. Center for Health Care Strategies, Inc. June 2016.

[37] Promising Practices to Integrate Physical and Mental Health Care for Medi-Cal Members. Center for Health Care Strategies, Inc. June 2016.

[38] Improving Mental Health Services Integration in Medi-Cal: Strategies for Consideration. Blue Sky Consulting Group. May 2017.

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