

# Profiles of Integrated Care: Working with an FQHC



Behavioral health treatment providers who want to fully integrate primary care into their organization have a variety of options. These include, but are not limited to:

- hiring a doctor or nurse practitioner themselves;
- contracting with a hospital or a private practice to bring primary care providers on-site; or
- contracting with a city or county health department, health center, or other nonprofit primary care provider to bring primary care providers on-site.

Each of these options has positives and negatives, and each behavioral health treatment provider should look at all options and determine which one is best for its situation and clients. Because many people with severe mental illnesses—also called consumers—are covered by Medicaid, and because federally qualified health centers (FQHCs) are paid a higher rate for services for Medicaid patients, many behavioral health treatment providers choose to work with FQHCs on integrating behavioral and physical health care. This profile outlines the basics of an FQHC and how behavioral health treatment providers can work with FQHCs to integrate care.

## What Is an FQHC?

In simple terms, an FQHC is a public or private nonprofit organization that provides preventive and primary care—including mental, dental, and behavioral health care—to people of all ages, whether or not they are able to pay for that care. Specifically, FQHCs must meet certain criteria outlined in Sections 1861(aa)(4) and 1905(1)(2)(B) of the Social Security Act<sup>1</sup>. The Health

Resources and Services Administration (HRSA) oversees the FQHCs. For more information about FQHCs, please visit <http://www.bphc.hrsa.gov/about>.

FQHCs bill insurance companies for care provided to insured patients. For the most part, patients of FQHCs are either publicly insured or uninsured. The federal government pays FQHCs for the cost of care they provide to Medicare and Medicaid patients. On the other hand, the federal government pays a fixed rate to non-FQHC providers for care to Medicare and Medicaid patients. This fixed rate is often less than the cost of care provided.

FQHCs use a sliding-fee scale to determine how much each patient pays for care out of his or her pocket. This scale is based on household size and income. FQHCs also receive cash grants through Section 330 of the Public Health Service Act. These grant funds offset the costs of uncompensated care, or care that neither the patient nor other payor can or will pay for.

## What Is an FQHC Look-Alike?

HRSA designates some nonprofit primary care providers as FQHC Look-Alikes. As the name implies, FQHC Look-Alikes are very similar to FQHCs and receive cost-based reimbursement for their Medicaid and Medicare services. The main difference is that FQHC Look-Alikes do not receive Section 330 grant funds for uncompensated care.

### Contact information

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<sup>1</sup> See [http://www.socialsecurity.gov/OP\\_Home/ssact/title18/1861.htm](http://www.socialsecurity.gov/OP_Home/ssact/title18/1861.htm) and [http://www.ssa.gov/OP\\_Home/ssact/title19/1905.htm](http://www.ssa.gov/OP_Home/ssact/title19/1905.htm).

# Things to Think about when Partnering with an FQHC

Through helping behavioral health treatment providers integrate physical health care into their practices, the Ohio Coordinating Center for Integrating Care has compiled a list of things that providers should think about when partnering with an FQHC.

## **Clinical Considerations**

- Patient/provider fit
  - Will patients feel more comfortable coming to the behavioral health treatment site or to the FQHC for primary care?
  - Are the primary care providers comfortable providing care to people with severe mental illnesses?
  - Will there need to be two ways to deliver physical health care to consumers? (e.g., psychiatrically stable consumers may go to the FQHC for physical health care, while consumers with a high-level of psychiatric needs may go to the behavioral health treatment site for physical health care.
- Behavioral and physical health care provider interaction protocols
  - How will behavioral and physical health care providers discuss one-time illnesses, such as colds or minor infections? This might include illness diagnosis and management, including prescriptions or other medication.
  - How will behavioral and physical health care providers regularly collaborate for management of chronic physical illnesses?
- Prevention and wellness services
  - Does the FQHC partner offer prevention and wellness services consumers can access? How can the partnership work together to create these services?

## **Operational Considerations**

- Confidentiality and release forms
  - What release forms does each partner use? How will these be modified to include the other partner for applicable patients? Will consumers have to fill out forms for each provider or one joint form?
- Scheduling process
  - How does each partner currently schedule patients? Who will consumers call to

- schedule primary care appointments?
- How many patients does each partner typically see in an hour? How long will primary care appointments for patients with severe mental illnesses realistically take? How can these be scheduled in the FQHC, which may be used to shorter appointment times?
- How will information about scheduled appointments be shared between partners?
- Referral and intake
  - What process does each partner use for intake or referrals? How can these be streamlined to avoid duplication and confusion?
- Alignment of informational technology (IT) and electronic medical records (EMR)
  - What software does each partner use for billing, scheduling, and patient records? How can these be aligned?

## **Fiscal Considerations**

- Manage the differences between the way the two systems bill for services (i.e., FQHCs have a flat fee-for-service, while behavioral health providers bill in 15-minute increments)
  - How can billing practices be aligned?
- Billing alignment (coding/process/priority)
  - What process does each partner use for billing, including coding and priorities? How can these be streamlined?
- Insurance/payer mix
  - What is the payer mix for each partner and for patients/consumers of the integrated care project? How will this mix be managed across partners?

## **Quality Improvement Considerations**

- Goals
  - What are the joint goals and timeline for operational, fiscal, and patient/consumer outcomes?
- Steering/oversight
  - Which employees from each partner will provide oversight? How will this occur?
- Data collection
  - How will each partner collect and report data to assess success of the partnership and physical health outcomes of patients/consumers?