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Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

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General Comment

May 28, 2009

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS – 4137-NC
P. O. Box 8017
Baltimore, MD 21244-8010

RE: Request for Information Regarding the Paul Wellstone and Pete Domenici

Mental Health Parity and Addiction Equity Act of 2008

To Whom It May Concern:

The National Association of Community Health Centers (NACHC) is pleased to respond to the above-cited solicitation from the Departments of Health and Human Services (HHS), Department of Labor, and the Treasury. NACHC is the national membership organization for federally-supported and federally recognized health centers (FQHCs) throughout the country, and is an Internal Revenue Code Section 501(c)(3) organization. NACHC also serves as a source of information, analysis, research, education, training, and advocacy regarding medically underserved people and communities.

BACKGROUND

There are approximately 1,200 health center entities nationwide, which serve as the health care homes to more than eighteen (18) million persons at more than 7,000 sites located in all fifty (50) states, Puerto Rico, the District of Columbia, the U.S. Virgin Islands and the Pacific Islands. Most of these health centers receive federal grants under Section 330 of the Public Health Service Act (42 U.S.C. §254b) from the Bureau of Primary Health Care (BPHC), within the Health Resources and Services Administration (HRSA).

BPHC's grants are intended to provide funds to assist health centers with the costs of providing a continuum of comprehensive preventive and primary care (including medical, behavioral health, dental, and pharmaceutical) and enabling services to uninsured and underinsured low-income patients, as well as to maintain the health center's infrastructure. Patients from eligible communities who are not low-income or who have insurance (whether public or private) are expected to pay for the services rendered. Approximately 15% of the patients served by health centers have private insurance, approximately 39% are uninsured, approximately 35% are Medicaid/SCHIP recipients, approximately 8% are Medicare beneficiaries, and approximately 3% are covered by other public sources 1.

FQHCs are required to make services available to all residents of their service area. See 42 U.S.C. §§ 254b(a)(1) 2. FQHCs must be located in or serve a federally-designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP). Additionally, a substantial number of health centers are located in or serve an area, population or facility that has been designated as a Health Professional Shortage Area (HPSA).

COMMENTS

FQHCs have long recognized that behavioral health conditions - including mental health and substance use disorder services – influence a patient's overall health status. Therefore, high-quality, accessible, and culturally competent early and sustained behavioral health services spanning the lifecycle of patients are a critical component of FQHCs' effective comprehensive preventive and primary health care and are critical in controlling the cost of health care. FQHCs recognize the need for incorporating behavioral health screening and treatment

with management of chronic conditions. Managing co-occurring behavioral health and chronic diseases can improve both physical and behavioral health 3. FQHCs are critical sources of behavioral health services to those with the highest unmet needs. Indeed, mental health and substance abuse related conditions are a major reason for patient visits to a FQHC. This is especially true in rural areas of America where FQHCs might be the only available source of health care – for primary care and for behavioral health services.

NACHC is concerned that health managed care companies refuse to include FQHCs on their provider panels and will not allow FQHC providers to join their network because the companies maintain that the FQHC is not a "licensed Mental Health agency" or a licensed provider in "independent practice." However, the behavioral health professionals that are employees or contractors of the FQHC are licensed professionals credentialed in their specialties and held to rigorous "evidence-based" performance and accountability requirements by the FQHC's Board of Directors, state laws, and the Health Resources and Services Administration (HRSA) of the Health and Human Services Administration (HHS). Nearly every FQHC provides behavioral health treatment and counseling services on site or through formal referral arrangements. Behavioral health staff include psychiatrists, clinical/counseling psychologists, clinical social workers, marriage and/or family therapists, psychiatric nurse specialists, and licensed professional counselors. The FQHC bills insurers and plans for all services provided by FQHC staff.

Related to the concern mentioned above, if there is a behavioral health carve out, the behavioral health managed care company often does not recognize the services that are provided by the FQHC as the FQHC is out-of-network. As noted above, if the FQHC tries to have its staff become part of the network, they are told the network is closed. The managed care company is not refusing treatment; however, they are not paying for treatment in settings where the patient is seeking and receiving treatment. This presents a challenge to FQHCs who have an ethical commitment to treat all patients' behavioral health needs as integral to comprehensive health care, but struggle with reimbursement issues.

NACHC recommends that:
• Plans enroll and reimburse FQHCs directly as "essential community providers" of mental health and substance use disorders and allow all appropriately licensed behavioral health clinicians to provide and be reimbursed for services
• Plans do not require providers to be in-network for coverage and reimbursement
• Plans permit out-of-network mental health and substance use disorder coverage and reimbursement as they permit out-of-network medical/surgical care coverage and reimbursement
• Plans permit patients be allowed to remain with the same practitioner and/or FQHC if a patient's plan changes. This enhances continuity of care benefits.
• Plans cover all evidence-based mental health and substance use disorder services and not "pick" only certain diagnoses or treatments
• Plans cover unlimited visits as they do for medical and surgical conditions

• Plans not charge greater co-pays for out-of-network providers

Thank you for the opportunity to comment on this Request for Information. If you have any questions about the contents of this document, please call or email me at 202-296-0158; rschwartz@nachc.com .
Sincerely,

Roger Schwartz
Associate Vice President of Executive Branch Liaison

1. In addition to those health centers receiving grant funds pursuant to one or more of the Section 330 funding programs, there are certain entities that are designated by the Centers for Medicare and Medicaid Services (CMS) as FQHCs, by virtue of the fact that they meet all of the requirements to receive a Section 330 grant, but do not receive funding from HRSA. For purposes of this comment, unless otherwise noted, we do not distinguish between grantees and FQHC look-alike entities, collectively referring to both types of organizations as “FQHCs” or “health centers.”
2 There are certain exceptions to this requirement for health centers that receive grant funds solely to serve migrant and seasonal farm workers, homeless individual and families, and/or residents of public housing.
3 Simon G. “Psychiatric Disorder and Functional Somatic Symptoms as Predicators for Health Care Use.” 1992 Psychiatric Medicine 10:49-60.