POLICY BRIEF

Certified Community Behavioral Health Clinics and Federally Qualified Health Centers: A qualitative analysis of relationships between Medicaid-funded community behavioral healthcare models in Michigan

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Background

Unlike other community mental health clinics, Certified Community Behavioral Health Clinics (CCBHCs) are required to coordinate their care with Federally Qualified Health Centers (FQHCs). Specifically, CCBHCs must establish "care coordination expectations with FQHCs (and, as applicable, Rural Health Clinics) to provide healthcare services, to the extent the services are not provided directly through the CCBHC" in the form of an informal or formal agreement, though the latter is preferred. The design and purpose of existing CCBHC–FQHC relationships remain relatively unknown. To fill this gap in knowledge, this project explores the relationships between CCBHCs and FQHCs including both CCBHCs enrolled in the Section 223 Demonstration Program and CCBHCs with Substance Abuse and Mental Health Services Administration (SAMHSA) expansion grants. We answer two questions. First, what is the structure of arrangements between CCBHCs and FQHCs? By structure, we refer to the formalization, location, and origin of CCBHC–FQHC arrangement. Our second question asks, what is the purpose (e.g., primary care or behavioral health referrals, primary care screening) of FQHC–CCBHC partnerships?

Methods

We conducted semi-structured interviews with 13 CCBHCs and 3 FQHCs in Michigan, which is not only a Section 223 Medicaid Demonstration state but also contains numerous CCBHCs participating in the SAMHSA Expansion Grant program. To sample CCBHCs, we used a purposive sampling approach to achieve participant variation in federal CCBHC program participation and Medicaid managed behavioral healthcare region. From February to March 2022, we conducted semi-structured interviews with the administrative and clinical leadership of 13 CCBHCs in Michigan. Interviewed FQHCs were also recruited using a purposive sampling approach in which we contacted all clinics in Michigan with publicly available contact information. We conducted 30-minute, semi-structured interviews with FQHC administrative leadership in July 2022. Interview data were video-recorded, transcribed, and iteratively coded using thematic analysis. The Institutional Review Board at the University of Michigan approved this study.

Key Findings

We found that the majority of CCBHCs converted existing FQHC partnerships into formalized care coordination arrangements in the form of memorandums of understanding or agreements. In addition to care coordination agreements, two CCBHCs also contracted an FQHC as a designated collaborating organization. The three organizations that had yet to establish any formalized FQHC partnership are relatively new CCBHCs, who do not participate in the Section 223 Demonstration and only received their SAMHSA Expansion awards in 2021, and expressed interest and discussed plans in establishing these arrangements.

The majority of the interviewees describe their organization's CCBHC–FQHC formalized partnerships as involving co-location or nearby access with same-day appointments. Other organizations expressed interest in co-location but faced challenges in maintaining the number of patients necessary to sustain the shared location. No Michigan CCBHC–FQHC partnership involved electronic health record integration.

Relationships between CCBHCs and FQHCs primarily serve to facilitate primary care referrals from the CCBHC to the FQHC. Referrals of less complex behavioral health patients from CCBHCs to FQHCs have become less common since clinics started participating in federal CCBHC programs. Referrals from FQHCs to CCBHCs happen less frequently and typically involve patients with complex or severe mental health conditions. FQHCs and the majority of CCBHCs provide services to patients with mild-to-moderate mental health or substance use disorders. Put another way, individuals with mild and moderate mental illness and substance use disorders are typically served by the clinic—CCBHC or FQHC—they initially enter.

All interviewees, regardless of whether they had an FQHC arrangement, report that they directly provide some or all required primary care screening and monitoring services. Despite seeing the value of providing other primary care services to their patients, nearly all clinics have chosen not to provide this care directly primarily because they cannot guarantee consistent demand and value offering patient choice in primary care provider.

Conclusions

Examining the design and utility of CCBHC–FQHC arrangement best practices will aid policymakers in understanding the dynamics of behavioral health and primary care integration at the community level. Future research can examine the implications of a shared patient population for FQHCs and CCBHCs, particularly the potential workforce implications. Other research should examine the facilitators and barriers to electronic health record integration between CCBHCs and FQHCs. This project in particular may be well suited for the CCBHC Expansion Grant Implementation Science Pilot.

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