NATIONAL ASSOCIATION OF Community Health Centers®

Medication-Assisted Treatment (MAT) Frequently Asked Questions: Compliance with HRSA Requirements for Scope of Project, Patient Access and Patient Payments

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I. Background

Presently, the United States is experiencing a dramatic rise in the prevalence of Substance Use Disorder (SUD) among various populations throughout the country. As key players within the health care marketplace, health centers are not immune from this trend; rather, centers are seeing an increase in SUD among their patients nationwide. In an attempt to stem the rise in SUD and treat those individuals currently afflicted, a significant number of health centers have recently received grant awards from various government agencies, including the Health Resources and Services Administration (HRSA) within the U.S. Department of Health and Human Services (HHS), aimed at supporting the provision of SUD-related services. While additional funding is necessary – and welcome – similar to other new programs established by health centers, the addition of new therapies and services raises questions regarding how and the extent to which current Health Center Program (HCP) requirements apply.

In practice, SUD-related services encompass various types of treatments based on the specific addiction disorder. One component is the provision of Medication-Assisted Treatment (MAT) services – a strategy that combines both drug and behavioral therapies to combat substance use disorders, and which may include opioid treatment programs (OTPs) such as Buprenorphine Therapy, non-opioid medication treatments and classes, and various behavioral health therapies.[1] This Frequently Asked Questions (FAQ) document focuses on some of the more common questions related to the application of HCP requirements to the provision of MAT services. In particular, this FAQ addresses questions that often arise regarding the relationship between MAT services and the health center's overall "scope of project," patient access within the context of the HCP requirement to offer services to all residents of the service area, and patient payments for MAT services.[2]

II. Scope of Project

Question #1:

How do I list MAT on my scope of project Form 5A to ensure that the MAT program is included in my HRSA-approved scope in its entirety?

Answer #1:

"MAT" is not a separate service listed on your Form 5A. Rather, "MAT" is a program comprised of various services to treat substance use disorder, including, but not limited to, opioid treatment programs (OTPs) such as Buprenorphine Therapy, non-opioid medication treatments and classes, and various behavioral health therapies. To ensure that all services provided under the MAT program are included in your HRSA-approved scope of project,

1 For additional information on MAT services in general, readers may want to access the MAT treatment page of the Substance Abuse and Mental Health Services Administration (SAMHSA) at https://www.samhsa.gov/medication-assisted-treatment.

2 This FAQ does not address clinical challenges and strategies related to the provision of MAT services, nor does it address payment requirements under third party payor programs. Further, this FAQ does not provide specific advice on the application of 42 C.F.R. Part 2 to the provision of MAT services, including whether a specific scenario would be considered a "Part 2 program" for purposes of compliance with the additional requirements related to those programs (including additional confidentiality requirements applicable to substance use disorder patient records). For additional information on clinical challenges specific to Buprenorphine Therapy, please see the NACHC opioid fact sheet entitled *"Integrating Buprenorphine Therapy for Opioid Use Disorder into Health Centers."* For additional information on confidentiality requirements related to substance use disorder please see the NACHC opioid fact sheet entitled *"Sharing Behavioral Health Information for Treatment Purposes: Mental Health and Substance Abuse Disorder."*

you should include on Form 5A each of the underlying services that comprise the MAT program. Typically, this is accomplished by including Behavioral Health Services (Substance Use Disorder Services and Mental Health Services), which is listed on Form 5A under "Additional Services." It is important to review the HRSA guidance "*Service Descriptors for Form 5A: Services Provided*" to determine whether any of the underlying services would need to be listed separately as a specialty service, such as psychiatry.

Question #2:

Can we include in our HRSA-approved scope of project a separate stand-alone site at which MAT services are provided, for example to separate patients receiving MAT from our pediatric patients?

Answer #2:

Yes. MAT services can be provided at health center sites at which other services are provided or at separate stand-alone sites within your HRSA-approved scope of project. If you decide to provide MAT services at a separate stand-alone site, the full complement of services offered under your health center project must be reasonably accessible and readily available to the patients served at the separate MAT site, either directly at your other health center sites or through established written contracts or referrals with other providers. If the separate MAT site serves an area that is different from your current service area, all residents of that new service area also must have access to the full complement of services offered under your health center project, as necessary.

Please note that by establishing a separate site for MAT services, that site may be considered an identified unit within the health center that is being held out as providing (and does provide) SUD treatment services. Accordingly, you could be viewed as operating a program covered under 42 CFR Part 2 ("Part 2"), which includes additional requirements regarding the confidentiality of patient records. It is important to review the Part 2 rules whenever you implement a SUD-related program / service to determine whether it rises to the level of a Part 2 program.

Question #3:

If I apply for a HRSA grant to support the provision of MAT services and I decide to change a component of the proposed service delivery model after the grant is awarded, do I need to notify HRSA and/or submit a request to change my scope of project?

Answer #3:

The extent to which a health center must notify HRSA if the center wants to implement a post-grant award change to the delivery of MAT services depends on the type of change being proposed. In general, post-award changes that materially impact the proposed budget, as well as changes to the proposed number of patients served and/or other key representations upon which HRSA relied in awarding the grant (such as the addition of a certain number of Full Time Equivalent (FTE) providers) often require, at a minimum, notification to HRSA. To determine whether a particular change rises to that level, it is advisable to review the grant-related and standard terms and conditions listed on the Notice of Award for the particular grant. Further, HHS grants management rules set forth in 45 C.F.R. Part 75 also address when post-award changes require notification to and prior approval by the grantor agency (in this case HRSA).

Even if a proposed change requires notification to HRSA, it may or may not require submission of a formal request to change the health center's scope of project. Changes to the scope of project are governed by specific HRSA policy and guidance.[3] Typically, changes to the services provided or the sites at which the services are provided require submission of either a change in scope prior approval request or a request for a scope adjustment. It is advisable to review the HRSA policy guidance related to Scope of Project to determine whether you need to submit a post-award request to HRSA and if so, the type of request required.

3 The HRSA Scope of Project policies and guidance can be accessed at https://bphc.hrsa.gov/programrequirements/scope.html.

Finally, please note that a change to any component of the proposed MAT program could implicate the Part 2 rules and in particular, whether they would apply. For example, if the original proposal included the addition of a certain number of FTE to be fulfilled by the hiring of several individuals none of whom would have a primary function of providing SUD-related services, the provision of those services may not be covered by Part 2. If, however, the health center determines post-award that it would be more efficient to hire one individual working the same total FTE and whose primary function would be to provide SUD-related services, while this may not require prior approval from HRSA (assuming there would not be a material budgetary impact and the same number of proposed patients will be served), the provision of those services could be covered under Part 2. It is important to review the Part 2 rules whenever you implement a SUD-related program / service to determine whether it rises to the level of a Part 2 program.

III. Access to MAT Services

Question #4:

Can someone access MAT services without first being a health center patient for primary care services?

Answer #4:

Yes. Nothing within the MAT service requirements requires that a person first be a primary care patient of the health center prior to accessing MAT services. Nevertheless, it is advisable to work with your clinicians to determine whether they have concerns regarding the treatment of patients under the MAT program only and/or whether the standard of care would dictate otherwise. For example, some clinicians may be uneasy about providing MAT services to individuals who do not utilize the health center's primary care services.

Question #5:

Can we limit the provision of MAT services to our existing primary care patients or do we need to offer the services to all residents of the service area?

Answer #5:

Health centers are required to offer their full complement of in-scope services to all residents of the particular center's service area. If a service is included on the health center's Form 5A (and thus, included within its HRSA-approved scope of project), the service must be offered to all persons who live or work in the service area. This requirement includes both required and additional services, such as behavioral health services.

Chapter 4 of the *Health Center Program Compliance Manual*, however, allows health centers to "through policies and operating procedures, prioritize the availability of additional services within the approved scope of project to individuals who utilize the health center as their primary care medical home." While a health center should not deny MAT services to non-primary care patients from the outset, it can prioritize such services to its existing primary care patients.

Patient Payments for MAT Services

Question #6:

If my health center has integrated MAT services into our primary care program, can we charge self-pay patients only one fee even if we are billing insurance programs separately for the MAT services and the primary care services?

Answer #6:

Health centers retain flexibility when it comes to designing their fee schedules (charge masters), provided that the two core requirements are met: the fee schedule must be consistent with locally prevailing rates or charges and must be designed to cover the reasonable costs of operation. Chapter 16 of the *Health Center Program Compliance Manual* provides each health center with the discretion to "determine[s] whether to charge a single fee for related health center services, medically-related

supplies, and/or equipment. Examples include, but are not limited to, charging a single fee for a well-child visit and the immunizations provided during that visit or combining all prenatal care visits and labs into a single fee."

Nevertheless, in general, a health center's fee schedule is supposed to form the basis for charges for both self-pay patients and for third party payors. Further, many third party payor programs do not allow the health center to bill the payor differently than the center bills self-pay patients (which would prohibit the center from billing the insurance program two separate claims while billing self-pay patients a single fee) and/or may have specific coverage rules regarding how services must be billed. Thus, to determine whether you can bill one bundled fee to self-pay patients while billing insurance programs for separate services, it is important to review the requirements and restrictions of the specific third party payor programs/plans.

Question #7:

Can we charge self-pay patients a bundled rate for MAT services (for example, a weekly rate for all the services provided to an individual patient under the MAT program), which in turn would be the basis for the application of sliding fee discounts?

Answer #7:

As noted above, health centers have flexibility in designing their fee schedules to include "bundled rates" for related services, supplies and/or equipment. Thus, under HRSA rules, you can combine the related services into a single fee, which in turn, would be the basis for the discounted fees under the sliding fee discount program. However, as also noted above, the fee schedule typically functions as the basis for third party payor rates as well. Thus, whether you can charge a single bundled rate to the self-pay patients while billing third party payor programs for the individual services will depend in part on the requirements and restrictions of the specific third party payor programs/plans.

Question #8:

Our patients with commercial insurance coverage for MAT services are required to pay very high co-payment amounts, which we fear could disincentivize the patients from continuing their treatment plans. Can we discount these out-of-pocket costs?

Answer #8:

Health centers can – and should – discount out-of-pocket costs consistent with the requirements of Chapter 9 of the *Health Center Program Compliance Manual.* In particular, out-of-pocket costs should be reduced to ensure that a patient is not paying more than he/she would pay based on his/her payment level, provided that such reductions are not prohibited under the third party payor / health plan contract and/or state law.

Chapter 16 of the Health Center Program Compliance Manual also requires health centers to waive or reduce payments to the extent necessary to ensure access to care. This would apply to out-of-pocket costs for insured patients as well as payments for self-pay patients. Accordingly, a health center could waive or reduce out-of-pocket costs if not doing so would create a barrier to care, regardless of whether the person is eligible for the sliding fee discount program.

Question #9:

Our health center provides MAT-related services both as part of the overall program and individually. For example, some of the therapies available to the MAT patients under the overall MAT program are also available to non-MAT patients on an individual basis. Can we develop separate sliding fee discount schedules for the MAT versus non-MAT services?

Answer #9:

As noted above, health centers have flexibility in designing their fee schedules to which the sliding fee discounts will be applied. This flexibility includes the ability to bundle certain services together under a single CPT code in order to charge a single fee for such services, even if specific components of the "single" bundled service (such as certain therapies) have separate CPT codes that are used

when the services are provided as individually for patients who do not need the full MAT program. Accordingly, if you have a fee schedule that includes a bundled charge for the entire program and individual charges for specific components, application of the sliding fee discount to such charges would result in different discounted fees based on whether a patient is enrolled in the MAT program or receives individual services.

Please note that Chapter 9 of the *Health Center Program Compliance Manual* also allows health centers to have multiple sliding fee schedules based on broad service types or distinct sub-categories of service types. If the MAT services are not available to non-MAT patients on an individual service basis and if such MAT services are fundamentally different from other behavioral health services provided to non-MAT patients, you may be able to develop a different sliding fee discount schedule for the MAT program based on those services falling within a "distinct sub-category" of overall behavioral health services.

Question #10:

Our health center has behavioral health professionals who will be treating MAT patients using the same CPT codes as they would with a non-MAT patient. Can we consider this a separate service even if the providers are using the same codes?

Answer #10:

Unlike the situation described in question #9 above, if the health center is using the same CPT codes to treat patients served under the MAT program and those individuals not served under the MAT program, the services themselves would not be distinct. Accordingly, the health center would use the same fee schedule and sliding fee discount schedule when billing both MAT patients and non-MAT patients.

For further information, contact

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